PRINTED: 01/12/2022 FORM APPROVED OMB NO. 0938-0391

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | (X3) DATE SU COMPLE | |
|--------------------------|---|---|---------------------|---|------------------------|----------------------------|
| | | 495315 | B. WING _ | | 10/26 | /2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | ,, |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| E 000 | Initial Comments | | E 0 | 00 | | |
| E 037 SS=C | survey was conducted 10/26/2021. Correct compliance with 42 C Requirement for Long EP Training Program | CFR Part 483.73, g-Term Care Facilities. | E 0 | 37 | 12 | 2/1/21 |
| | §441.184(d)(1), §460 §483.73(d)(1), §483. §485.68(d)(1), §485 | 6.54(d)(1), §418.113(d)(1), 0.84(d)(1), §482.15(d)(1), 475(d)(1), §484.102(d)(1), .625(d)(1), §485.727(d)(1), 6.360(d)(1), §491.12(d)(1). | | | | |
| | Hospitals at §482.15 at §484.102, "Organi OPOs at §486.360, F (1) Training program the following: (i) Initial training in er policies and procedu staff, individuals provarrangement, and vo expected roles. (ii) Provide emergence least every 2 years. (iii) Maintain docume preparedness training (iv) Demonstrate staff procedures. (v) If the emergency procedures are significant must conduct training procedures. | cy preparedness training at entation of all emergency g. If knowledge of emergency preparedness policies and ficantly updated, the [facility] g on the updated policies and | | | | |
| | *[For Hospices at §4 | 18.113(d):] (1) Training. The | | | | |
| AROBATORY | DIRECTOR'S OR PROVIDER | SUPPLIER REPRESENTATIVE'S SIGNATUE | DE | TITI F | (YE | S) DATE |

Electronically Signed 11/18/2021

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

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | IPLE CONSTRUCTION NG | | DATE SURVEY COMPLETED |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 1 | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| E 037 | policies and proced hospice employees services under arral expected roles. (ii) Demonstrate sta procedures. (iii) Provide emerge least every 2 years. (iv) Periodically reviemergency prepare employees (includir special emphasis planter procedures necessation of the service | of the following: emergency preparedness ures to all new and existing and individuals providing ingement, consistent with their Iff knowledge of emergency incy preparedness training at ew and rehearse its dness plan with hospice ing nonemployee staff), with aced on carrying out the eary to protect patients and entation of all emergency ing. In the provide emergency ing on the updated, the hospice ing on the updated policies and inficantly updated, the following: emergency preparedness ures to all new and existing oviding services under olunteers, consistent with their ing, provide emergency ing every 2 years. aff knowledge of emergency entation of all emergency entation of all emergency entation of all emergency | E | 037 | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | IPLE CONSTRUCTION NG | (> | (3) DATE SURVEY COMPLETED |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | l | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | DE | 10/20/2021 |
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| E 037 | *[For PACE at §460.8 organization must do (i) Initial training in er policies and procedu staff, individuals provarrangement, contract volunteers, consister (ii) Provide emergence least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to case of an emergence (iv) Maintain docume (v) If the emergency procedures are signiff must conduct training procedures. *[For LTC Facilities and Program. The LTC fat following: (i) Initial training in er policies and procedustaff, individuals provarrangement, and vo expected role. (ii) Provide emergence least annually. (iii) Maintain docume preparedness training (iv) Demonstrate staff procedures. | g on the updated policies and 34(d):] (1) The PACE all of the following: mergency preparedness res to all new and existing iding on-site services under ctors, participants, and it with their expected roles. Expreparedness training at f knowledge of emergency g informing participants of go, and whom to contact in Expreparedness policies and ficantly updated, the PACE g on the updated policies and it §483.73(d):] (1) Training cility must do all of the inergency preparedness res to all new and existing iding services under lunteers, consistent with their expreparedness training at intation of all emergency | E | 037 | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | | OATE SURVEY OMPLETED |
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| E 037 | CORF must do all of (i) Provide initial training preparedness policies and existing staff, ind under arrangement, a with their expected ro (ii) Provide emergence least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. All new pand assigned specific the CORF's emergen their first workday. Thinclude instruction in alarm systems and si equipment. (v) If the emergency procedures are signiff must conduct training procedures. *[For CAHs at §485.6] The CAH must do all (i) Initial training in empolicies and procedure reporting and extinguand where necessary personnel, and guest: cooperation with firefi authorities, to all new individuals providing and volunteers, consi roles. (ii) Provide emergence least every 2 years. (iii) Maintain documer | the following: Ing in emergency Is and procedures to all new Inviduals providing services Ind volunteers, consistent Ites. It preparedness training at Intation of the training. It knowledge of emergency Itersonnel must be oriented Itersonsibilities regarding Itersonsibilities regar | EO | 37 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | IPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED |
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| | | 495315 | B. WING _ | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 |
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| E 037 | procedures are signimust conduct training procedures. *[For CMHCs at §488 CMHC must provide preparedness policie and existing staff, incurder arrangement, with their expected redocumentation of the demonstrate staff knoprocedures. Thereat emergency prepared years. This REQUIREMENT by: Based on staff interview it was determ failed to have a compreparedness plan. Facility staff failed to documentation of the preparedness training preparedness training preparedness training documentation that fainitial & annual emergeness and interview of the facility plan and interview we (administration staff in the preparedness of the facility) plan and interview we (administration staff in the procedure of the facility) plan and interview we (administration staff in the procedure of the facility) plan and interview we (administration staff in the procedure of the facility) plan and interview we (administration staff in the procedure of the facility) plan and interview we (administration staff in the procedure of the facility) plan and interview we (administration staff in the procedure of the facility) plan and interview we (administration staff in the procedure of the procedure of the facility) plan and interview we (administration staff in the procedure of | r preparedness policies and ficantly updated, the CAH g on the updated policies and 5.920(d):] (1) Training. The initial training in emergency is and procedures to all new dividuals providing services and volunteers, consistent poles, and maintain training. The CMHC must powledge of emergency iter, the CMHC must provide mess training at least every 2 is not met as evidenced riew and facility document ned that the facility staff polete emergency g and annual emergency g and annual emergency g offerings and acility staff have received gency preparedness training. | EO | 1. Emergency Preparedness Traicompleted by 12/01/2021 2. No residents were affected by the deficient practice 3. Staff re-education by the ED/de On Annual Emergency Preparedness Training by 12/01/2021. 4. The Administrator is responsible maintaining compliance. Administ will ensure that Emergency Preparedness revice on annual calendar. An In-service on annual calendar. An In-services will be monitored through Quality Assurance Process Improvements of the property of the facility monthly QAPI meeting. Quality | his esignee ess e for trator iredness nual ugh vemen.t |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 495315 | B. WING | | | l ' | C 26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| E 037 | preparedness training preparedness training documentation that fainitial & annual emerg ASM # 1 stated that the evidence of training. On 10/20/2021 at 4:5 staff member] # 1, exterior of clinical service president of open nurse, and ASM # 5, nursing, were made. No further information INITIAL COMMENTS An unannounced Mesurvey was conducted 10/26/2021. Three counsubstantiated with VA00051670- unsubstantiated with VA00051670- unsubstantiated with 42 CFR Part 483 Requirements. The Lisurvey/report will follow. | facility's initial emergency and annual emergency of grand annual emergency of offerings and acility staff have received gency preparedness training. They were not able to provide they were not able to provide to p.m., ASM [administrative ecutive director, ASM # 2, vices, ASM # 3, regional rations, ASM # 4, clinical interim assistant director of aware of the above findings. In was provided prior to exit. In was provided prior to exit. In dicare/Medicaid standard and 10/19/2021 through complaints (VA00051181-no deficiencies, stantiated with no 3403- substantiated with exestigated during the re required for compliance of Federal Long Term Care if e Safety Code | | 0000 | Monitoring schedule modified based or findings. 5. 12/01/2021. | | |
| | | o.m., Immediate Jeopardy area of Behavioral Health | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 495315 | B. WING | | | | 26/2021 |
| | ROVIDER OR SUPPLIER | OODSTOCK | | 803 | REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MAIN ST OODSTOCK, VA 22664 | | |
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| F 000 | pattern, and the facilitinformed. 10/22/2021 Immediate Jeopardy | e and Severity Level four by administration was I at 6:37 p.m. the was abated and was pattern. The Life Safety | F | 000 | | | |
| F 550 SS=D | Resident Rights/Exer CFR(s): 483.10(a)(1)(1)(1)(1)(1)(2)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1) | cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, and communication with and | F: | 550 | | | 12/1/21 |
| | with respect and dign resident in a manner promotes maintenand | and in an environment that be or enhancement of his or ognizing each resident's ity must protect and | | | | | |
| | access to quality care severity of condition, must establish and m practices regarding tr | cility must provide equal eregardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. | | | | | |
| | rights as a resident of or resident of the Unit | right to exercise his or her f the facility and as a citizen | | | | | |
| | or resident of the Unit | ted States. | | | | | |

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | , , | ATE SURVEY OMPLETED | | | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | ' | 1072072021 |
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| F 550 | resident can exercisinterference, coercifrom the facility. §483.10(b)(2) The refree of interference, reprisal from the facility and to be supexercise of his or he subpart. This REQUIREMENT by: Based on observate record review, it was staff failed to provide dignity for one of 41 sample, Resident # The facility staff failer Foley urinary cather Urine in the catheter hall while Resident # The findings included Resident #28 was a 4/21/20. Resid | esident has the right to be coercion, discrimination, or reprisal esident has the right to be coercion, discrimination, and cility in exercising his or her opported by the facility in the er rights as required under this er rights as required under the facility er care in a manner to ensure residents in the survey eresidents in the survey eresidents in the survey eresidents in the survey eresidents in the facility on the facility o | F 5 | 1. Resident #28 had a dignity bay on catheter bag on 10/20/2021. 2. Quality review completed and residents affected by catheter with privacy cover on 10/20/2021. 3. Staff re-education by the DON/designee completed on cath care and resident dignity 11/18/20. 4. The Administrator is responsible maintaining compliance. The Dire Nursing/designee to complete quamonitoring using daily round sheet ensure catheters with dignity bag 3 times weekly for 4 week then m for 6 months to ensure compliance maintained. Follow up based on frand reported to the facilities mont meeting. Quality Monitoring schemodified based on findings. 5. 12/01/2021. | no other hout neter 021 e for ector of ality ets to in place onthly e indings hly QAPI | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
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| F 550 | Indwelling Foley Cathobstructive uropathy. tubing below the lever from entrance room of the control of the cont | neter r/t (related to)Position catheter bag and I of the bladder and away door." a.m. and 9:49 a.m., Resident bed and was not able to be ident's Foley catheter bag ed to the bed frame and was if the bed that was facing the e catheter bag was visible b.m., an interview was (licensed practical nurse) #1. acy bag should cover a eter bag and she would feel ad a catheter and the urine e to others. b.m., an interview was egistered nurse) #1, the nented Resident #28's care he documented to keep ter bag and tubing aware ben door for privacy. b.m., ASM (administrative e executive director) and of clinical services, [director de aware of the above | F | 550 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---|-----|--|-------------------------------|----------------------------|
| | | 495315 | B. WING _ | | | | C 26/2021 |
| NAME OF PROVIDER OR S | | /OODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST //OODSTOCK, VA 22664 | | |
| | CH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | T BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| (1) "A urin to drain ar informatio | ary cathete nd collect ui n was obtai | r is a tube placed in the body rine from the bladder." This ned from the website: | F | 550 | | | |
| F 558 SS=D Reasonate CFR(s): 4 §483.10(e) services in accommo preference endanger other resident record revisitant failed for two of Residents The facility Resident reach. The findin 1. The facility Resident reach. Resident reach. Resident reach. | ole Accomm 83.10(e)(3) e)(3) The rig in the facility dation of re- es except w the health of dents. UIREMENT in observation facility doct view, it was if to provide 41 resident is #8 and #28 y staff failed #28's call be gs include: sility staff fai ring bell wa #8 was adm Resident #8 imited to ma | by/ency/article/003981.htm odations Needs/Preferences that to reside and receive with reasonable sident needs and then to do so would be safety of the resident or is not met as evidenced in, resident interview, staff ument review and clinical determined that the facility accommodation of needs in the survey sample, 3. It to ensure Resident #8 and sell or ring bell was within the resident's interview included but agor depressive disorder, weakness. Resident #8's | F! | 558 | 1. Resident #8 and #28 call bells and/oringing bell placed in reach by the nurs staff on 10/20/2021. 2. Quality review completed and no oth residents affected by call bell not being 3. Staff re-education completed on 11/18/2021 by DON/designee on call b system and ensuring the call bells and/ringing bells within the resident reach. 4. The Administrator is responsible for maintaining compliance. The DON/designee will complete quality monitoring of call bells and/or ringing bells, using daily round sheets 3 times week for 4 weeks then monthly for 6 months to ensure compliance. Follow ubased on findings and reported to the facilities monthly QAPI meeting. Quality | ell for per | 12/1/21 |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | 1 | C / 26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST OODSTOCK, VA 22664 | 1 10 | 720/2021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOU | | 3E | (X5) COMPLETION DATE | | |
| F 558 | assessment reference resident as being concoded Resident #8 a assistance of two or Resident #8's electric during the survey. On 10/19/21 at 10:00 in bed. An interview resident who stated to call bell. On 10/19/21 at 10:50 Resident #8 was lyin bell was observed or positioned against the thead of Resident #8 the head of Resident #8 Resident #8's compre 8/26/20 documented | a set assessment with an the date of 8/2/21, coded the gnitively intact. Section G is requiring extensive imore staff with bed mobility. It call bell was not operational of a.m., Resident #8 was lying was conducted with the ghat he sometimes uses his of a.m. and 3:45 p.m., is in bed. A hand held ring in a night stand that was in a wight was ewall, to the side and behind in the was the wall, to the side and behind in the was the wall, to the side and behind in the was the wall, to the side and behind in the was the wall, to the side and behind in the was the wall, to the side and behind in the was the wall, to the side and behind in the wall was the wall, to the side and behind in the wall was the wall, to the side and behind in the wall was the wall, to the side and behind in the wall was the wall wa | F | 5558 | Monitoring schedule modified based of findings. 5. 12/01/2021 | n | | | |
| | resident's call light is the resident to use it On 10/20/21 at 1:41 conducted with LPN LPN #1 stated residering bells within react to get a hold of staff. On 10/19/21 at 3:47 conducted with CNA #1. CNA #1 stated shells are within reside completes her round | paired mobilityBe sure the within reach and encourage for assistance as needed." p.m., an interview was (licensed practical nurse) #1. ents should have call bells or h so they have an easy way p.m., an interview was (certified nursing assistant) he checks to ensure call ents' reach when she s. CNA #1 stated call bells dents' reach in case there is | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | l | 26/ 2021 |
| | ROVIDER OR SUPPLIER | NOODSTOCK | • | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | | |
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| F 558 | not mobile. CNA #1 Resident #8's nights' bell was not within the placed it on an over resident's reach. On 10/20/21 at 5:12 staff member) #1 (the ASM #2 (the director made aware of the a The facility policy reg documented, "Resides system to notify staff Hand bells or tap typ reach of any resident call bell" No further information 2. The facility staff facil | ecause some residents are was shown the ring bell on tand. CNA #1 stated the ring the resident's reach and bed table within the sp.m., ASM (administrative to executive director) and of clinical services) were bove concern. Garding the call bell system tent must have, at all times, a when assistance is needed. The bells will be placed within the affected by an inoperable on was presented prior to exit. Ided to ensure Resident #28's each. Ided to the facility on 28's diagnoses included but the present the properties of dementia. Resident #28's eata set assessment with an are date of 8/31/21, coded the last moderately impaired. Sident #28 as requiring to of one staff with bed a.m. and 11:07 a.m., | F | 558 | | | |

| ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE COMP | SURVEY |
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| F 558 | Resident #28's composite A/29/20 documented, falls r/t (related to) a his call light is within ruse it for assistance as be sure you tell him who conducted with LPN (LPN #1 stated residering bells within reach to get a hold of staff. On 10/19/21 at 3:47 pconducted with CNA (#1. CNA #1 stated should be within reside completes her rounds should be within reside | rehensive care plan dated "(Resident #28) is at risk for n/o (history of) fallsBe sure reach and encourage him to as needed. Due to blindness, where the call bell is." o.m., an interview was licensed practical nurse) #1. nts should have call bells or a so they have an easy way o.m., an interview was (certified nursing assistant) ne checks to ensure call | F | 558 | | | |
| | staff member) #1 (the | o.m., ASM (administrative executive director) and of clinical services) were nove concern. | | | | | |
| F 580 SS=D | Notify of Changes (Inj CFR(s): 483.10(g)(14 §483.10(g)(14) Notific (i) A facility must imm | | F: | 580 | | | 12/1/21 |
| | | her authority, the resident | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---------------------------|--|-----------|-------------------------------|--|--|
| | | 495315 | B. WING | | | C 26/2021 | | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 1 20 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 580 | results in injury and head head head head head head head hea | en there isving the resident which has the potential for requiring has a factor of the restance of the potential form of the end of the potential form of the end of the potential form of the facility must ensure that has a specified in \$483.15(c)(2) and the facility must ensure that has a promptly notify the dent representative, if any, and or roommate assignment form of the potential form of the entrights under Federal or the entries of the | F 5 | 80 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|--|---|-------------------------------|---------------------------|
| | | 495315 | B. WING | | | C 10/26/2 | 2024 |
| NAME OF P | ROVIDER OR SUPPLIER | 1000.10 | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | 10/20/2 | 2021 |
| TVAIVIL OF T | TOVIDER OR GOLT EIER | | | 803 SOUTH MAIN ST | - | | |
| CONSULA | TE HEALTH CARE OF V | VOODSTOCK | | WOODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | _ | (X5) DMPLETION DATE |
| F 580 | Continued From page | e 14 | F 5 | 80 | | | |
| | locations that compris part, and must specific room changes between under §483.15(c)(9). This REQUIREMENT by: Based on staff interview, it was determ failed to notify the phyalter treatment for two survey sample, Resident physician when the mavailable for administ 7/29/21, and failed to physician when the maximum treatment for two surveys amples are physician when the maximum treatment for administ 7/29/21, and failed to physician when the maximum treatment for two surveys amples are physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the maximum treatment for the failed to physician when the failed to physician | I to notify Resident #24's nedication Eliquis was not | | 1. Resident #24 and #129 phy notified on 10/26/2021 of med being available. 2. Quality review of in-house resure physician notification of medications not available. Residentified will have notification physician. 3. Staff re-education on physic notification and steps to take we medications not available by the DON/designee. | esidents to the tothe tothe tothe cian when | ot | |
| | 3/29/20. Resident #2 were not limited to dia and a history of strok minimum data set as: assessment reference resident's cognitive si making as modified in Review of Resident # a physician's order da 2.5 mg (milligrams) - times a day for periph | e date of 8/27/21, coded the kills for daily decision | | 4. The Administration is responsible to maintaining compliance. The DON/designee will complete to monitoring of progress notes of morning meeting weekly for 4 monthly for 6 months to ensur compliance. Follow-up based and reported to the monthly Queeting. Quality monitoring so modified based on findings. 5. 12/01/2021 | quality during weeks the e on finding | en | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|-----|---|-------------------------------|----------------------------|
| | | 495315 | B. WING | | | · | 26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | 1011 | 20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 580 | Eliquis 2.5 mg- one to day. On 7/5/21 at 5:0 p.m., the nurse did not as being administered the code, "9=other/Se note dated 7/5/21 documedication and was redated 7/29/21 documedication was when Eliconducted with Eliconducted With LPN (2001) at 1:41 pconducted with LPN (2001) at 1 | o) documented the order for ablet by mouth two times a 20 p.m. and 7/29/21 at 5:00 by document the medication of the MAR documented be Nurse Notes." A nurse's cumented, "out of reordered." A nurse's note ented, "not available." sident #24's clinical record hysician was notified on the requise was not administered. The MAR documented be Nurse's note ented, "out of reordered." A nurse's note ented, "not available." sident #24's clinical record hysician was notified on the requise was not administered. The MAR document provided in the record of the recorder of the provided in the pr | F | 580 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | | 36/2024 |
| | ROVIDER OR SUPPLIER | L | | ; | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | <u> 107.</u> | 26/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 580 | Continued From page | | F | 580 | | | |
| | No further information References: | n was presented prior to exit. | | | | | |
| | strokes or blood clots fibrillation (a condition irregularly, increasing in the body and possi not caused by heart v information was obtai | is) is used help prevent in people who have atrial in in which the heart beats the chance of clots forming bly causing strokes) that is ralve disease." This ned from the website: by/druginfo/meds/a613032.h | | | | | |
| | the blood vessels that This information was | ar disease is a condition of t supply the feet and legs. obtained from the website: ov/ency/article/000170.htm | | | | | |
| | 4/22/21. Resident #1 were not limited to hig and COVID-19. Resi minimum data set ass | sessment with an e date of 10/3/21, coded the | | | | | |
| | guaifenesin (1) liquid | s order dated 9/27/21 for 100 mg (milligrams)/5 ml nl by mouth every four hours | | | | | |
| | the order for guaifene | ation record) documented | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING | | , | C 1 0/26/2021 | | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | • | | | |
| (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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | | |
| F 580 | On 9/28/21 at 12:00 at 4:00 a.m. and 8:00 a.m. and 4:00 a.m., the medication as be documented the code Notes." A nurse's note dated order from supply." / 9/28/21 documented nurse's note dated 9/ not available." Anoth 9/29/21 documented nurse's note dated 9/ not available." Further review of Resignation (including nurses' no physician was notifice guaifenesin was not resident #129's come 6/25/21 failed to documented nurse's note dated 9/ not available." Further review of Resignation of the complexity of the c | ars for a cough for 15 days. p.m. and 4:00 p.m., 9/29/21 p.m., and 9/30/21 at 12:00 he nurse did not document ing administered. The MAR e, "9=other/See Nurse 9/28/21 documented, "on Another nurse's note dated , "on supply order." A /29/21 documented, "drug her nurse's note dated , "drug not available." A /30/21 documented, "drug sident #129's clinical record tes) failed to reveal the d on the above dates when administered. Aprehensive care plan dated ument information regarding if guaifenesin was not p.m., an interview was (licensed practical nurse) #1. hysician should be notified is not available for esident because the to change the order. a.m., ASM (administrative | F 5 | 80 | | | | |
| | | e executive director) and of clinical services) were bove concern. | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | | 7. 501251 | | | С | |
| | | 495315 | B. WING | | 10 | 0/26/2021 | |
| | ROVIDER OR SUPPLIER | /OODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CO 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | DDE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 580 | This information was | | F s | 580 | | | |
| F 622 SS=D | tml Transfer and Dischare CFR(s): 483.15(c)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1) | ge Requirements (i)(ii)(2)(i)-(iii) and discharge- requirements- ermit each resident to and not transfer or at from the facility unless- scharge is necessary for the d the resident's needs facility; scharge is appropriate s health has improved ident no longer needs the the facility; viduals in the facility is e clinical or behavioral ividuals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not paperwork for third party | F | 522 | | 12/1/21 | |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING | | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | , | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 622 | or (F) The facility cease (ii) The facility may n resident while the ap § 431.230 of this cha exercises his or her r discharge notice fron 431.220(a)(3) of this discharge or transfer or safety of the reside facility. The facility n that failure to transfe. §483.15(c)(2) Docum When the facility tran resident under any or in paragraphs (c)(1)(section, the facility m or discharge is docum medical record and a communicated to the institution or provider (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of par section, the specific is be met, facility attem needs, and the service facility to meet the needs (ii) The documentation (A) The resident's ph discharge is necessa (A) or (B) of this section | se to operate. Ot transfer or discharge the peal is pending, pursuant to opter, when a resident right to appeal a transfer or in the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the foust document the danger or or discharge would pose. The circumstances specified in the circumstances specified in the resident's formation is receiving health care the resident's medical record transfer per paragraph (c)(1) for this resident need(s) that cannot puts to meet the resident to eavailable at the receiving seed(s). The required by paragraph (c) in the made by-ysician when transfer or ary under paragraph (c) (1) in transfer or ary under paragraph (c) in transfer or ary under paragraph (c) (1) | F 62 | 22 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | FIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | woodstock | | STREET ADDRESS, CITY, STATE, ZIP 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO T DEFICIENCE | | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | | |
| F 622 | this section. (iii) Information provimust include a minin (A) Contact information responsible for the contact information (B) Resident represe contact information (C) Advance Directive (D) All special instructions care, as applicable to ensistent with §483 any other documents a safe and effective This REQUIREMEN by: Based on staff internand clinical record refacility staff failed to requirements transfer forty-one residents in Resident #71. The facility staff failed transfer documentation of the care of the reincluding contact information of the care of the reinstructions, and all as applicable to ensitransition of care for provided to the receinstructions. | ragraph (c)(1)(i)(C) or (D) of ded to the receiving provider num of the following: ion of the practitioner are of the resident. entative information including we information ctions or precautions for propriate. care plan goals; ary information, including as discharge summary, .21(c)(2) as applicable, and ation, as applicable, to ensure transition of care. T is not met as evidenced view, facility document review eview, it was determined the evidence transfer discharge er to the hospital for one of an the survey sample, d to evidence required ion/documents, to include: of the practitioner responsible sident, resident information primation, advance directives, plan goals, special care other necessary information ure safe and effective | F | 1. The facility was not abl documentation for Reside facility initiated transfer. 2. Quality review complete initiated transfers since 11 identify any other resident practice. Residents identif sent to the receiving facilit 3. Licensed staff re-education to the receiving facility and the | ent #71 for the ed for facility 1/01/2021 to ts affected by the fied information ty. ation completed on esignee. sponsible for The te the | | |

| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING | | MULTIPLE CONSTRUCTION JILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | | C 26/2021 | |
| | ROVIDER OR SUPPLIER | /OODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG | | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 622 | The findings include: Resident #71 was ad 9/8/21. Resident #71 were not limited to: opulmonary disease 'Conon-reversible lung d (inflammation of the scirrhosis of the liver (othe normal liver tissue and nodules in flow and function) (3) (defect in the electricaresults in abnormal consistency assessment, a final assessment, with an of 9/15/21, coded the of 15 on the BIMS (broatstaus) score, indicatic cognitively intact. Review of Resident # the resident was trans 9/26/21 for shortness A review of the nursing 9/26/21 at 11:47 PM, "Resident stated that breath], O2 [oxygen] resident wanted to go stated, "yes." Writer of [blood pressure], Oxysaturation of 85 percentationer made aw | mitted to the facility on 's diagnoses included but hronic obstructive cOPD' (chronic isease) (1), cellulitis skin beneath the tissue) (2), chronic condition in which e is replaced by fibrous terfering with normal blood and bundle branch block al tissues of the heart that bonduction) (4). recent MDS (minimum data we day Medicare admission assessment reference date resident as scoring 14 out itief interview for mental ing the resident was 71's clinical record revealed eferred to the hospital on of breath and hypoxia. In g progress note dated documented in part, he was SOB [shortness of on 5L [liter] was 85%, I funny." When asked if to to the hospital, resident completed vital signs 150/97 igen at 5 liters with | F | 522 | for 4 weeks then monthly for 6 months. Follow up based on findings and report to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
|--|--|---|----------------------------|--|------------------------------|
| | | 495315 | B. WING | | 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLETION |
| F 622 | arrived, and transporthe hospital. On 10/20/21 at 7:36 staff member) #1, the in requested paper on the documenting, papers. Second states the papers are no-weared for the paper was considered for the paper was consider | cy medical technicians) orted resident on a stretcher to S AM, ASM (administrative ne executive director, brought work for Resident #71, with a 'Resident #71, no transfer aff person helped me check, where to be found." Onducted on 10/20/21 at 2:55 or staff member) #4, the social When asked about transfer ents' sent to the hospital, elieve there is care plan goals led out." Onducted on 10/21/21 at 6:55 sed practical nurse) #8. When entation is sent with a resident ospital, LPN #8 stated, "Care a transfer form, we notify the ey of the transfer." O PM, ASM (administrative ne executive director, ASM #2, al services, ASM #3 the ent of operations and ASM #4 nurse were made aware of fer/ Discharge Notification and licy dated 3/6/2018, "When the center transfers | F 62 | 2 | |
| | circumstances listed the transfer or disch | dent under any of the d, the facility will ensure that narge is documented and tion is communicated to the | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---|-----|--|-------------------------------|----------------------------|
| | | 495315 | B. WING | | | | C 26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | • | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST /OODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| | information must inclucentact information of for the care of the resincluding contact info comprehensive care instructions, and all of as applicable to ensuransition of care." No further information References: (1) Barron's Dictionar Non-Medical Reader, Chapman, page 120. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 108. (3) Barron's Dictionar Non-Medical Reader, Chapman, page 121. (4) Barron's Dictionar Non-Medical Reader, Chapman, page 121. (4) Barron's Dictionar Non-Medical Reader, Chapman, page 121. (5) Barron's Dictionar Non-Medical Reader, Chapman, page 121. (6) Barron's Dictionar Non-Medical Reader, Chapman, page 91. (7) Notice Requirements CFR(s): 483.15(c)(3) Notice Before a facility transport resident, the facility mass resident, the facility mass resident, the reasons for the mass resident representative(s) of the reasons for the mass resident representative(s) of the reasons for the mass resident representative facility mass resident representative(s) of the reasons for the mass resident representative(s) of the resident | institution or provider. This ade but is not limited to: If the practitioner responsible sident, resident information rmation, advance directives, plan goals, special care ther necessary information re safe and effective In was provided prior to exit If y of Medical Terms for the 5th edition, Rothenberg and ry of Medical Terms for the 5th edition, Rothenberg and | | 622 | | | 12/1/21 |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | C 1 0/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | . | 10720/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 623 | discharge in the resaccordance with paragraph (c)(5) of §483.15(c)(4) Timin (i) Except as specific (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be resident is transferr or di (A) The safety of ince the endangered und this section; (B) The health of ince the endangered, und this section; (C) The resident's hallow a more immediate the required by the resident paragraph (c) (D) An immediate the required by the resident has reduced by the resident h | ons for the transfer or ident's medical record in ragraph (c)(2) of this section; of the items described in this section. g of the notice. ed in paragraphs (c)(4)(ii) and and an interpretation in this section must be at least 30 days before the ed or discharged. In ade as soon as practicable is scharge whendividuals in the facility would be paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of the interpretation in the section; ansfer or discharge is dent's urgent medical needs, and in the facility for 30 dents of the notice. The written paragraph (c)(3) of this section lowing: | F 62 | 23 | | |
| | notice specified in p must include the fol (i) The reason for to (ii) The effective dat (iii) The location to to transferred or disch | paragraph (c)(3) of this section lowing: ransfer or discharge; te of transfer or discharge; which the resident is | | | | |

| | ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | ' ' | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|---------------------|--|------------------------------|----------------------------|
| | | 495315 | B. WING _ | | | C 0/26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 623 | and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, addrest telephone number of Long-Term Care Omit (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities, the mailing telephone number of the protection and addevelopmental disabilities of the Developmental disabilities of the develop | address (mailing and email), er of the entity which ets; and information on how orm and assistance in and submitting the appeal es (mailing and email) and the Office of the State budsman; y residents with intellectual isabilities or related end and email address and the agency responsible for vocacy of individuals with elities established under Part etal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and ty residents with a mental esabilities, the mailing and lephone number of the or the protection and als with a mental disorder er Protection and Advocacy unals Act. | F 6 | 23 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|----------------------------|---|---------------------------|
| | | 495315 | B. WING | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION |
| F 623 | the facility, and the rwell as the plan for trelocation of the res 483.70(I). This REQUIREMEN by: Based on staff interreview, and clinical redetermined that the notification to the ontransfer/discharges survey sample, Res #45. 1. The facility staff far of Resident #331's of 9/17/21. 2. The facility staff far notification of transfer Resident #71, when to the hospital on 9/20/21. The facility staff far notification of transfer on 08/05/20. The findings include 1. Resident #331 was not transfer on 08/05/20. | re Ombudsman, residents of esident representatives, as he transfer and adequate dents, as required at § T is not met as evidenced view, facility document ecord review, it was facility staff failed to evidence abudsman of hospital for four of 41 residents in the dents #331, #71, #129, and alled to notify the ombudsman lischarge to the hospital on the resident was transferred 26/21. The stransferred to the hospital illity staff failed to provide for the transfer to the miled to evidence that the tified of a facility-initiated 21 for Resident # 45. | F 623 | 1. The facility was unable to provide documentation the RR and Ombudsm were notified for resident #71, #129, # and #45. 2. Quality review completed on transfer/discharges on 11/18/2021 for facility initiated transfers since 11/01/2 Residents identified information sent to RR and Ombudsman. 3. Licensed nurse re-educated on issuitransfer notices and Social Services re-educated on notification of RR and Ombudsman on 11/18/2021 by DON/designee 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete the transfer/discharge quality monitor for discharges to ensure compliance is maintained weekly for 4 weeks then monthly for 6 months. Follow up base on findings and reported to the facilitie monthly QAPI meeting. Quality Monitoring schedule modified based of findings. | rall 2021. to uing any ed |
| | 10/19/21 with diagno | ecently readmitted on oses including a broken right nistory of a stroke. On the | | 5. 12/01/2021. | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG | - | (X3) DATE SURVEY COMPLETED |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | (EACH CORRE | SPLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY) | |
| F 623 | assessment with an date) of 7/30/21, the severely cognitively decisions, having so BIMS (brief interview A review of Resident revealed the followin Nursing Progress No called to the resident practitioner) because non-thickened ginge her family. On arrivir resident had been pl rescue squad was came and transporter hospital." Further review of the information provided was hospitalized from readmitted to the factor on 10/20/21 at 3:12 member) #4, the soci interviewed. She state email the ombudsmed discharged to the hospital stated she keeps con notifications in a boo provide evidence the notified in writing regidischarge to the hospital on 10/20/21 at 4:50. | inimum data set), a quarterly ARD (assessment reference resident was coded as being impaired for making daily ored three out of 15 on the reformental status. #331's clinical record g progress note: "9/17/21 of Text: This nurse was a room by NP (nurse eresident was choking on rale that was given to her by right to the resident room, acced on her sideThe falled. The rescue squad did the resident to the resident's census by the facility revealed she in 9/17/21 until she was illity on 10/12/21. p.m., OSM (other staff is services manager, was ted it is her responsibility to an when a resident is spital. OSM #4 also stated if sending a fax to the roof a resident discharge. She one of these ombudsman k. OSM #4 was asked to a ombudsman had been arding Resident #331's | F | 23 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | CODE | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 623 | 3 Continued From page 28 | | F | 523 | | |
| | the director of clinical regional vice preside #4, the regional clinical these concerns. On 10/21/21 at 8:36 facility did not have enotification of Reside hospital on 9/17/21. A review of the facilit Notification and Righ part: "Before a center resident the center median." | I services, ASM #3, the nt of operations, and ASM cal nurse, were informed of a.m., ASM #2 stated the evidence of the ombudsman ent #331's discharge to the to Appeal," revealed, in r transfers or discharges a nustsend a copy of the ative of the Office of the | | | | |
| | 2. Resident #71 was 9/8/21. Resident #71 were not limited to: opulmonary disease 'Conon-reversible lung of (inflammation of the cirrhosis of the liver (the normal liver tissue and nodules in flow and function) (3) (defect in the electric results in abnormal of Resident #71's most set) assessment, a fi assessment, with an of 9/15/21, coded the | COPD' (chronic lisease) (1), cellulitis skin beneath the tissue) (2), chronic condition in which e is replaced by fibrous aterfering with normal blood and bundle branch block all tissues of the heart that onduction) (4). recent MDS (minimum data we day Medicare admission assessment reference date e resident as scoring 14 out rief interview for mental | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING | | , , | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|----------------------------|----------------------------|
| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | E | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 623 | the resident was tra 9/26/21 for shortness on 10/20/21 at 7:36 staff member) #1, trin requested paper note documenting, ombudsman notification ombudsman notification ombudsman for Resonsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, OSM #4 stated, "Th (responsible party), bed hold." When as this role, oscillation in the stated party in th | #71's clinical record revealed insferred to the hospital on its of breath and hypoxia. AAM, ASM (administrative interesting executive director, brought work for Resident #71, with Resident #71, no | F 6 | 223 | | |
| | References: | | | | | |

| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL | | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | PLE CONSTRUCTION G | , , | ATE SURVEY OMPLETED |
|--|--------|--|--|-----------|--|----------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG CONTINUED FROM INCOME REGULATORY OR LSC IDENTIFYING INFORMATION) F 623 Continued From page 30 (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 121. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 121. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 121. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 91. 3. Resident #129 was admitted to the facility on 4/22/21. Resident #129's diagnoses included but were not limited to high blood pressure, diabetes and COVID-19. Resident #129's quarterly minimum data set assessment with an assessment reference date of 10/3/21, coded the | | | 495315 | B. WING _ | | | |
| FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFY INFORMATION FREGULATORY FREG | | | WOODSTOCK | | 803 SOUTH MAIN ST | ' | 10/20/2021 |
| (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 108. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 121. (4) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 91. 3. Resident #129 was admitted to the facility on 4/22/21. Resident #129's diagnoses included but were not limited to high blood pressure, diabetes and COVID-19. Resident #129's quarterly minimum data set assessment with an assessment reference date of 10/3/21, coded the | PRÉFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP | HOULD BE | (X5) COMPLETION DATE |
| Review of Resident #129's clinical record revealed a nurse's note dated 9/20/21 that documented the resident was discharged to the hospital on 9/20/21, due to an elevated temperature, an elevated heart rate and respiratory complications. Further review of Resident #129's clinical record failed to reveal written notification of the transfer was provided to the ombudsman. On 10/20/21 at 2:55 p.m., an interview was conducted with OSM (other staff member) #4, the social services manager. OSM #4 stated she faxes or emails the ombudsman with notice of resident transfers and places the notice in a binder. OSM #4 was asked to provide evidence | F 623 | (1) Barron's Diction Non-Medical Reade Chapman, page 12 (2) Barron's Diction Non-Medical Reade Chapman, page 10 (3) Barron's Diction Non-Medical Reade Chapman, page 12 (4) Barron's Diction Non-Medical Reade Chapman, page 91 3. Resident #129 w 4/22/21. Resident were not limited to land COVID-19. Reminimum data set a assessment referer resident's cognition Review of Resident revealed a nurse's documented the reshospital on 9/20/21 temperature, an ele respiratory complication of the Con 10/20/21 at 2:58 conducted with OSI social services mar faxes or emails the resident transfers at | ary of Medical Terms for the er, 5th edition, Rothenberg and 0. ary of Medical Terms for the er, 5th edition, Rothenberg and 8. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er, 5th edition, Rothenberg and 1. ary of Medical Terms for the er | F 6. | 23 | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | , | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | ' | 10/20/2021 |
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| F 623 | Continued From pa | ge 31 | F 62 | 3 | | |
| | staff member) #1 (tl | 2 p.m., ASM (administrative ne executive director) and or of clinical services) were above concern. | | | | |
| | 4. Resident # 45 wa diagnoses included iron, intestinal bleed Resident # 45's moset), a quarterly ass (assessment refere coded Resident # 4 interview for mental | on was presented prior to exit. as admitted to the facility with but were not limited to: low ding and muscle weakness. st recent MDS (minimum data sessment with an ARD noce date) of 09/22/2021, 5 as scoring a 14 on the brief status (BIMS) of a score of 0 nitively intact for making daily | | | | |
| | | l p.m., documented, "resident lame of Hospital] for Gl | | | | |
| | (electronic health re to evidence notifica | al record and the EHR ecord) for Resident # 45 failed tion to the ombudsman for the sfer on 08/05/2021 for | | | | |
| | conducted with OSI social services man faxes or emails the | 5 p.m., an interview was M (other staff member) #4, the lager. OSM #4 stated she ombudsman with notice of nd places the notice in a | | | | |
| | interview was condi | pproximately 4:09 p.m., an ucted with OSM [other staff I services manager. When | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | TIPLE CONSTRUCTION NG | ' ' | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | OODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | OULD BE | (X5) COMPLETION DATE | |
| F 655 SS=D | have evidence of notion of 10/20/2021 at 4:50 staff member] # 1, exidirector of clinical service president of oper nurse, and ASM # 5, in nursing, were made at No further information Reference; [1] GI bleeding is not of a disease. There at GI bleeding, including tears or inflammation diverticulosis and diverticulosis and diverticulosis and diverticulosis and diverticulosis and or information was obtain https://medlineplus.got.ml. Baseline Care Plan CFR(s): 483.21(a)(1)- §483.21 Comprehense Planning §483.21(a) Baseline (§483.21(a)(1) The fact implement a baseline that includes the instreffective and person- | mentation for the on regarding the er of Resident #45 on stated that they did not fication to the ombudsman." O p.m., ASM [administrative ecutive director, ASM # 2, vices, ASM # 3, regional rations, ASM # 4, clinical interim assistant director of aware of the above findings. In was provided prior to exit. a disease, but a symptom re many possible causes of a hemorrhoids, peptic ulcers, in the esophagus, erticulitis, ulcerative colitis colonic polyps, or cancer in resophagus. This ned from the website: by/gastrointestinalbleeding.h (3) Sive Person-Centered Care Care Plans Sility must develop and care plan for each resident uctions needed to provide centered care of the resident al standards of quality care. | | 623 | | 12/1/21 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | | 26/ 2021 | |
| | ROVIDER OR SUPPLIER | OODSTOCK | 1 | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | 1 101 | 20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 655 | admission. (ii) Include the minimus necessary to properly including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommoders. §483.21(a)(2) The fact comprehensive care plan if the comprehensive care plan if the comprehensive care plan if the comprehension. (ii) Meets the requirer (b) of this section (except the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the facon behalf of the faciliti (iv) Any updated infor of the comprehensive This REQUIREMENT by: Based on staff intervand clinical record revents. | in 48 hours of a resident's Im healthcare information or care for a resident ited to- I on admission orders. endation, if applicable. cility may develop a colan in place of the baseline rehensive care plan- in 48 hours of the resident's ments set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary lan that includes but is not if the resident. resident's medications and treatments to be acility and personnel acting y, mation based on the details or care plan, as necessary. I is not met as evidenced iew, facility document review view, it was determined that to develop a baseline care | F | 655 | 1. Baseline care plan completed on residents #130 and #229 by the Reside Assessment Coordinator on 10/21/202 Resident #230 no longer at the facility. | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | L IDENTIFICATION NUMBER: | | X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | | C 0/ 26/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | ST | FREET ADDRESS, CITY, STATE, ZIP CODE | 1 10 | 1/26/2021 | |
| | | | | | 3 SOUTH MAIN ST | | | |
| CONSULA | ATE HEALTH CARE OF W | VOODSTOCK | | | OODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 655 | Continued From page | e 34 | F 6 | 555 | | | | |
| | #230. 1. The facility staff fai | l30, #229 and Resident led to develop a baseline int #130 who was admitted 4/21. | | | 2. Quality review completed on new admissions in the past 2 weeks for baline care plan completion on 11/18/202 Residents identified will have baseline care plan completed. | | | |
| | | led to develop a baseline ent #229 admitted to the | | | 3. Licensed staff re-educated on Basel Care Plan completion per F655 regular 11/18/2021 by DON/designee. | | | |
| | care plan to address statements regarding | iled to develop a baseline Resident #230's mood and self harm. | | | 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete Bed Hold quality monitor for any facility initiated | | | |
| | 10/14/21. Resident # but were not limited to diabetes and chronic #130's admission MD | s admitted to the facility on £130's diagnoses included o congestive heart failure, kidney disease. Resident PS (minimum data set) assessment reference date e resident as being | | | discharges to ensure compliance week for 4 weeks then monthly for 6 months Follow up based on findings and report to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021 | | | |
| | record failed to revea blank baseline care p #130's paper clinical | of Resident #130's clinical I a baseline care plan. A lan was present in Resident record but was not filled out. | | | | | | |
| | conducted with LPN (LPN #1 stated the nu | o.m., an interview was (licensed practical nurse) #1. rses complete assessments on for baseline care plans aseline care plans. | | | | | | |
| | | o.m., an interview was egistered nurse) #1, MDS | | | | | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | | (. | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CO 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | DDE | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIAT | (X5) COMPLETION DATE | |
| F 655 | a resident is suppose on admission. RN # baseline care plan fo within 48 hours of ad On 10/20/21 at 5:12 pstaff member) #1 (the ASM #2 (the director made aware of the all The facility policy title documented, "Develor Individualized Persor care within 48 hours but not limited to, initiadmission orders, phorders, therapy service PASARR (pre-admission review) recommendate areas needed to proversident that meets pocare to ensure that the appropriately until the care is completed." No further information 2. Resident #229 was 10/13/21 with diagnon not limited to: Diabet insulin to function not fracture right fibula (beg) (2), chronic respinability of the heart a adequate level of gas | stated the nurse who admits and to initiate a baseline care a stated there is a blank rm that should be completed mission. D.m., ASM (administrative executive director) and of clinical services) were prove concern. D. Plans of Care" D. Plans of Care" D. Pand implement an and procentered baseline plan of of admission that includes, all goals based on the system orders, dietary cases, social services, soin screening and resident tions, if applicable, and other ride effective care of the rofessional standards of the resident's needs are met as Comprehensive plan of the was presented prior to exit. It is admitted to the facility on the sist that included but were the mellitus (inability of smally in the body) (1), whereas in the outer bone of the irratory failure (chronic and lungs to maintain and the exchange) (3) and epilepsy or characterized by recurrent the seizures) (4). | F 6 | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 405245 | B. WING | | | l | 0 |
| | | 495315 | D. WING | | | 10/ | 26/2021 |
| | ROVIDER OR SUPPLIER | /OODSTOCK | | 8 | STREET ADDRESS, CITY, STATE, ZIP CODE 103 SOUTH MAIN ST VOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 655 | with an ARD (assessi 10/20/21, coded the r of 15 on the BIMS (br status) score, indicati cognitively intact. A re G-functional status or requiring extensive as transfer, hygiene/bath independent for eatin H- Bowel and Bladde always incontinent for Review of Resident # evidence a completed 10/19/21. An interview was con PM with LPN (license asked to review the b Resident #229, LPN #EMR (electronic medino care plan. There is chart." LPN #4 was the Resident #229's paper "Yes, this is the form a came later in the event the purpose of the bastated, "It is to develobased on their individ When asked who is recare plan, LPN #4 staresponsible to developing baseline of the status of the purpose of the bastated, "It is to developing baseline of developing baseline of developing baseline of developing baseline of the purpose of the purpose of the bastated, "It is to developing baseline of developing baseline of developing baseline of developing baseline of the purpose of the purpose of the bastated, "It is to developing baseline of developing baseline of the purpose of the purpose of the bastated, "It is to developing baseline of the purpose of the purpose of the bastated, "It is to developing baseline of the purpose of the purpose of the bastated, "It is to developing baseline of the purpose of the purpose of the bastated, "It is to developing baseline of the purpose of the purpose of the bastated, "It is to developing baseline of the purpose of the purpose of the purpose of the bastated of the purpose of | ay Medicare assessment, ment reference date) of esident as scoring a 15 out ief interview for mental ing the resident was eview of the MDS Section oded the resident as esistance for bed mobility, ning, dressing and as g. A review of MDS Section or coded the resident as rowel and for bladder. 229's clinical record failed to disaseline care plan prior to ducted on 10/19/21 at 2:40 disaseline care plan for the stated, "I will look in the ical record). It says there is may be one in her paper interior in the stated, and it is blank. I believe she ining." When asked about seline care plan, LPN #4 in goals for the resident ual needs, and orders." esponsible for the baseline | F | 655 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | | |
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| | | 495315 | B. WING | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | ' | 10/20/2021 |
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| F 655 | nurse who admits the care plan. The basel within 48 hours of ad progress until the corollar of the director of clinical regional vice preside the regional clinical regional vice preside the regional clinical regional clinical regional vice preside the regional clinical regional clinical regional vice preside the regional clinical regional clinical regional clinical regional clinical regional vice preside the regional clinical regional vice preside the regional clinical regional clinical regional clinical regional clinical regional clinical regional clinical Reader Chapman, page 160 (2) Barron's Dictional Non-Medical Reader Chapman, page 502 (4) Barron's Dictional Non-Medical Reader Chapman, page 199 3. The facility staff facare plan to address statements regarding Resident #230 was a 8/20/21 with diagnos limited to: Diabetes refunction normally in the statements of the progression of the prog | to the comprehensive. The expansion particle patients starts the baseline ine care plan should be done dission but is a work in imprehensive is completed." PM, ASM (administrative executive director, ASM #2, I services, ASM #3 the int of operations and ASM #4 nurse were made aware of in was provided prior to exit in a service of the expansion | F 65 | 55 | | |

| ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | IPLE CONSTRUCTION IG | ` ' | (X3) DATE SURVEY COMPLETED | |
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| F 655 | Continued From page | e 38 | F6 | 555 | | | |
| | disease 'ESRD' (inab waste and to function electrolyte balance in of testis and buttocks testis and buttocks) (| isease) (2), end stage renal illity of the kidneys to excrete in in the maintenance of the body) (3) and abscess (accumulation of pus in the 4). | | | | | |
| | assessment, a five da with an ARD (assess 8/26/21, coded the re 15 on the BIMS (brief score, indicating the intact. A review of M Thoughts that you we hurting yourself in so | ay Medicare assessment ment reference date) of esident as scoring a 15 out of f interview for mental status) resident was cognitively DS Section D-Mood-letter I: ould be better off dead, or of me way coded the resident cy of symptoms coded the | | | | | |
| | This was reviewed as Resident #230. | s part of a complaint for | | | | | |
| | Review of Resident #230's clinical record failed to reveal a baseline care plan addressing Resident #230's expressed thoughts of self- injury documented on the MDS-Section D-Letter I., that was completed on 8/25/21 by the social worker no longer employed at the facility. | | | | | | |
| | documented in part " Psychology as neede clinical record failed t and or psychology vis Resident #230. | cian orders dated 8/20/21, Psychiatry as needed. ed." Further review of the to evidence any psychiatric sits were provided for | | | | | |
| | 2:58 AM, documente | sfer form dated 8/31/21 at d in part, "Suicide attempt. Resident was found with | | | | | |

| , , , , , , , , , , , , , , , , , , , | | 1 ' ' | | (X3) DATE SURVEY COMPLETED | | |
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| SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIVE ACTION | I SHOULD BE | (X5) COMPLETION DATE | |
| light cord wrapped a asked what he was[expletive] hand (Further review of the comprehensive care documented in part, for a decline in moor and current living an INTERVENTIONS-A consult follow up as An interview was co PM with LPN (licens asked about the purplan, LPN #4 stated resident based on thorders." When asked baseline care plan, I responsible to devel An interview was co AM with LPN (licens asked the purpose of LPN #8 stated, "To he resident needs that asked if mood and be included on the base "Yes, they should be An interview was co PM with LPN #6, MI the purpose of the be stated, "The purpose care for the resident | round his neck and when doing he stated, 'trying to f (Sic. [hang]) myself'. e clinical record revealed a plan dated 9/2/21, that "FOCUS-Resident is at risk drelated to medical condition rangements. Arrange for psych [psychiatric] indicated." Inducted on 10/19/21 at 2:40 ed practical nurse) #4. When pose of the baseline care, "It is to develop goals for the derir individual needs, and and who is responsible for the LPN #4 stated, "The nurse is pop the baseline care plan." Inducted on 10/20/21 at 6:55 ed practical nurse) #8. When the base line care plan, have a plan to meet the everyone can see." When the base line care plan, have a plan to meet the eline plan, LPN #8 stated, elincluded." Inducted on 10/20/21 at 2:40 DS coordinator. When asked aseline care plan, LPN #6 elis to develop the plan of to meet their needs." When | F 65 | 55 | | | |
| | ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN' REGULATORY OR Continued From page light cord wrapped a asked what he was of the comprehensive care documented in part, for a decline in mood and current living and INTERVENTIONS-A consult follow up as An interview was co PM with LPN (licens asked about the pur plan, LPN #4 stated resident based on the orders." When asked baseline care plan, I responsible to devel An interview was co AM with LPN (licens asked the purpose of LPN #8 stated, "To he resident needs that of asked if mood and be included on the base "Yes, they should be An interview was co PM with LPN #6, ME the purpose of the be stated, "The purpose care for the resident asked about the MD completed on 8/25/2 plan for Resident #2 | TORRECTION IDENTIFICATION NUMBER: 495315 ROVIDER OR SUPPLIER ATE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL | ROVIDER OR SUPPLIER IDENTIFICATION NUMBER: 495315 ROVIDER OR SUPPLIER ITE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 light cord wrapped around his neck and when asked what he was doing he stated, 'trying to f[expletive] hand (Sic. [hang]) myself. Further review of the clinical record revealed a comprehensive care plan dated 9/2/21, that documented in part, "FOCUS-Resident is at risk for a decline in mood related to medical condition and current living arrangements. INTERVENTIONS-Arrange for psych [psychiatric] consult follow up as indicated." An interview was conducted on 10/19/21 at 2:40 PM with LPN (licensed practical nurse) #4. When asked about the purpose of the baseline care plan, LPN #4 stated, "It is to develop goals for the resident based on their individual needs, and orders." When asked who is responsible for the baseline care plan, LPN #4 stated, "The nurse is responsible to develop the baseline care plan." An interview was conducted on 10/20/21 at 6:55 AM with LPN (licensed practical nurse) #8. When asked the purpose of the base line care plan, LPN #8 stated, "To have a plan to meet the resident needs that everyone can see." When asked if mood and behavior issues should be included on the baseline plan, LPN #8 stated, "Yes, they should be included." An interview was conducted on 10/20/21 at 2:40 PM with LPN #6, MDS coordinator. When asked the purpose of the baseline care plan, LPN #6 stated, "The purpose is to develop the plan of care for the resident to meet their needs." When asked about the MDS Section D Letter I coding completed on 8/25/21 and development of a care plan for Resident #230, LPN #6 stated, "Yes, that | ROVIDER OR SUPPLIER THE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 39 light cord wrapped around his neck and when asked what he was doing he stated, "trying to f | A BUILDING 495315 B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 833 SOUTH MAIN ST WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR I.Sc. IDENTIFYING INFORMATION) Continued From page 39 light cord wrapped around his neck and when asked what he was doing he stated, 'trying to f[expleitve] hand (Sic. [hang]) myself'. Further review of the clinical record revealed a comprehensive care plan dated 9/2/21, that documented in part, "FOCUS-Resident is at risk for a decline in mood related to medical condition and current living arrangements. INTERVENTIONS-Arrange for psych [psychiatric] consult follow up as indicated." An interview was conducted on 10/19/21 at 2:40 PM with LPN (licensed practical nurse) #4. When asked about the purpose of the baseline care plan. LPN #4 stated, "The nurse is responsible to develop the baseline care plan, LPN #4 stated, "The nurse is responsible to develop the baseline care plan, LPN #8 stated, "The nurse is resident based that everyone can see." When asked do in the individual needs, and orders, "When asked thou the purpose of the baseline care plan, LPN #8 stated, "The nurse is resident needs that everyone can see." When asked if mood and behavior issues should be included on the baseline plan, LPN #6 stated, "The purpose is to develop the plan of care for the resident needs that everyone can see." When asked the purpose of the baseline care plan, LPN #6 stated, "The purpose is to develop the plan of care for the resident needs are plan plan of Resident #230, LPN #6 stated, "The stated, "The stated, "Yes, that have purpose of the baseline care plan, LPN #6 stated, "The stated, "Yes, that have purpose of the baseline care plan, LPN #6 stated, "The stated, "The stated, "The stated, "Yes, that have purpose of the baseline care plan, LPN #6 stated, "The stated, "The stated, "The stated, "Yes, that have purpose of the baseline care plan, LPN #6 stated, "Yes, that have purpose of the stated that the stated that the sta | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| F 655 | been developed to a mood and self injury [9/2/21], LPN #6 star On 10/26/21 at 3:52 staff member) #1, the director of clinical regional vice preside aware of the concert. The facility policy titt documented, "Develoumented, "PASARR (pre-admission orders, porders, therapy server PASARR (pre-admission orders, porders, therapy server persident that meets care to ensure that the appropriately until the care is completed." | d if there was any a baseline care plan had address Resident #230's a statements before that date ted, "None that I can see." PM, ASM (administrative the executive director, ASM #2, al services and ASM #3 the tent of operations were made the ent of operations were made to a fine plan of the professional standards of the resident's needs are met the Comprehensive plan of the resident's needs are met the Comprehensive plan of the resident's needs are met the Comprehensive plan of the side of the plan of the resident's needs are met the Comprehensive plan of the ty's "Mental Health Referrals" | F | 655 | DEFICIENCY) | | | |
| | "Resident's behavio nursing home staff r the resident's chart. | | | | | | | |
| | References: (1) Barron's Dictiona | on was provided prior to exit. ary of Medical Terms for the r, 7th edition, Rothenberg and | | | | | | |

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| F 655 | Non-Medical Reader, Chapman, page 120. (3) Barron's Dictionar Non-Medical Reader, Chapman, page 498. (4) Barron's Dictionar | y of Medical Terms for the 7th edition, Rothenberg and y of Medical Terms for the 7th edition, Rothenberg and y of Medical Terms for the 7th edition, Rothenberg and | F | 655 | | |
| | CFR(s): 483.21(b)(1) §483.21(b) Comprehe §483.21(b)(1) The faci implement a compreh care plan for each res- resident rights set for §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identificances as that are identificances are identificances. The con- describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483. provided due to the re under §483.10, include treatment under §483 (iii) Any specialized so rehabilitative services provide as a result of recommendations. If | cility must develop and densive person-centered sident, consistent with the sident set of the sident and psychosocial sident in the comprehensive care plan must prehensive care plan must pre | F | 656 | | 12/1/21 |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION NG | (X3 |) DATE SURVEY COMPLETED |
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| F 656 | resident's representa (A) The resident's go desired outcomes. (B) The resident's pr future discharge. Fac whether the resident community was asse local contact agencie entities, for this purp (C) Discharge plans plan, as appropriate, requirements set fort section. This REQUIREMEN' by: Based on observation interview, staff intervictinical record review complaint investigation the facility staff failed implement the comp of 41 residents in the #53, #26, #33, #8, #2 The findings include: 1.a. The facility staff #53's comprehensive resident a shower, m September 2021. Resident #53 was ac 2/8/21 with diagnose hardening and disint bones, quadriplegia recent MDS (minimu | ent's medical record. th the resident and the ative(s)- pals for admission and eference and potential for cilities must document 's desire to return to the essed and any referrals to es and/or other appropriate ose. in the comprehensive care in accordance with the ch in paragraph (c) of this T is not met as evidenced on, resident interview, family iew, facility document review, or, and in the course of a con, it was determined that it to develop and/or rehensive care plan for eight esurvey sample, Residents 24, #28, #129, and #59. | Fé | 1. Residents #53 plan of care implemented for his showers a administration of Diazepam, #2 preventative pressure ulcer tree of care, laboratory services, fl restriction and dialysis plan of cimplemented, #33 pressure ulcerteatment plan of care bing implemented, #24 plan anticoagulants being implemented plan of care for Foley catheter implemented, #129 weight pla being implemented and #59 pla updated for use of side rails ca updated to accurately reflect received. 2. Quality review of facility resignals for pressure ulcers prevented being in reach, fluid restrictive rails, dialysis, weight monitoring laboratory studies and medicated. | and 26 atment plan uid care being er elemented, an of care of care for ated, #28 being n of care an of care re plan esident. dents care ention, call tions side g, | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| CONSULA | TE HEALTH CARE OF W | OODSTOCK | | | VOODSTOCK, VA 22664 | | |
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| F 656 | Continued From page | e 43 | F | 656 | | | |
| F 656 | date) of 9/6/21, Reside moderately impaired having scored 12 out interview for mental sibeing completely depistaff for personal hygical completely depistaff for personal have a forehead because his greasy. She stated she concerns to both ASM member) #1, the execute DCS (director of completely depistated his personal has been turnor "the facility just cannot with the facility just cannot with the facility just cannot with the facility for his personal has been turnor the facility for his personal has been turnor with the facility for his personal has been turnor with the facility for his personal has been turnor with the facility for his personal has been turnor the facility for his persona | lent #53 was coded as being for making daily decisions, of 15 on the BIMS (brief tatus). He was coded as endent on the assistance of iene and bathing. b.m., Resident #53 and his meet with the survey team. | F | 656 | administration will be reviewed to ensu compliance with regulations and their pof care. 3. Staff re-education on implementation plan of care and timely development arrevisions to the plan of care. 4. Random sample of 10 plans of care weekly for 4 weeks and monthly for 3 months to ensure that plan of care beir implemented, developed and revised timely. Results of finding to QAPI for follow-up. 5. 12/01/2021 | olan n of nd | |
| | A review of Resident plan dated 3/11/21, m 4/30/21, revealed, in ADL self-care perforn | #53's comprehensive care nost recently updated on part: "[Resident #53] has an | | | | | |

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| F 656 | or shower cannot be requires full assistar twice weekly/prn [as A review of Residen revealed no evidence bathed and showered dates: 8/12/21 through 10/6/21; 9/10/21 through 10/6/21. A review of the bath Resident #53 reveal should ordinarily get Mondays and Thurs A review of Residen revealed the following RN (registered nurse motherproceeded early regarding [Resident Hat I had already taken care of the comprehensive of a care plenables the staff to for a resident. She sensure all the reside When asked how shoomprehensive care LPN #1 stated she of the physician's orde | ath day and as sponge bath when a full bath a toleratedthe resident nee by staff with showering a needed]." It #53's bathing records the of the resident being and between the following gh 8/23/21; 9/1/21 through and 9/15/21; 9/17/21 through and 9/15/21; 9/17/21 through as signment sheet for ed documentation stating he a shower or bath on days. It #53's progress notes and note, written on 10/7/21 by the proof of the metabout her calling sident #53] needing a bath. The same about the call and it was not before she called in." In p.m., LPN (licensed practical riewed. When asked the an, she stated a care plan coffer the best possible care stated the care plan helps and she she same a resident's a plan is being implemented, loes her best to follow all of | F | 056 | | | |

| AND DI AN OF CORRECTION INTEREST. | | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| F 656 | showering because to She stated, as far as #5 stated Resident # shower aide, but the work a regular assign RN #5 stated when to not receive a bath or spoken multiple time nursing assistants) a "but they only have send that on mother had called to #53's not having receive a stated she had a about this. She state resident does not gereceive a "wipe down she could not recall at the that Resident is been completed. Who bath records, RN #5 "about right," and she resident had received of blanks on the show purpose of a care plaplan tells the staff whor her care. When as implementing a residuated, "All of us. The On 10/25/21 at 3:42 assistant) #12 was in has worked with Resadmitted to the facilit resident has "for sure time without a shower not usually have the | her that he had not been here was not enough staff. she knew, this was true. RN 53's unit has an assigned aide is most often pulled to ment, due to lack of staff. his happens, residents do shower. She stated she had so to the CNAs (certified bout bathing Resident #53, o much time in their day." 10/7/21, Resident #53's complain about Resident eived a bath/shower recently. Already spoken to the aides do she assumes when the it a shower or bath, they "or bed bath. RN #5 stated a CNA specifically reporting #53's bath or shower had not ten shown Resident #53's stated the records looked be could not verify that the dot a bath during the long gaps wer records. When asked the int, RN #5 stated the care that the resident needs for his sked who is responsible for ent's care plan, RN #5 | F 6 | 56 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | VOODSTOCK | | 803 SOUTH MAIN S | ST | 1 10/ | 20/2021 |
| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFI TAG | (EACH (| | | (X5) COMPLETION DATE |
| on the bath record. Of frequently not enouge give Resident #53 at the purpose of a resist the care plan tells even the resident. When a following a resident's the care plan must be can be their best." On 10/26/21 at 3:50 were informed of the evidence verifying Reshowers or baths durabove, and the care was implemented, was implemented, was implemented, was implemented plan by the interdisciplinar resident and/or resident and/or resident and/or resident's medical, in psychosocial needs to comprehensive asse implement an individual comprehensive plan Interdisciplinary Tear limited to - the attending with responsibility determined by the residentimed by the res | cNA #12 stated there was in staff working the unit to both or shower. When asked dent's care plan, she stated eryone how to take care of sked the importance of care plan, CNA #12 stated er followed "so the resident p.m., ASM #1 and ASM #2 se concerns. Additional esident #53 had received fing the gaps identified plan as documented above as requested. If y policy, "Plans of Care," individualized in of care will be established by team (IDT) with the ent evelop a comprehensive plan dent that includes es and timetables to meet the cursing, mental and that are identified in the sementdevelop and ual person-centered of care by the in that includes, but is not ling physician, a registered ility for the residentas sident's needs." | F | 556 | | | |
| 1. b. The facility staff | failed to implement Resident | | | | | |
| | CORRECTION ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page on the bath record. Of frequently not enough give Resident #53 and the purpose of a resident steem of the care plan tells even the care plan must be can be their best." On 10/26/21 at 3:50 mere widence verifying Residence verifyi | A95315 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 on the bath record. CNA #12 stated there was frequently not enough staff working the unit to give Resident #53 a bath or shower. When asked the purpose of a resident's care plan, she stated the care plan tells everyone how to take care of the resident. When asked the importance of following a resident's care plan, CNA #12 stated the care plan must be followed "so the resident | A BUILDIN B. WING | A BUILDING 495315 ROWIDER OR SUPPLIER TE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 On the bath record. CNA #12 stated there was frequently not enough staff working the unit to give Resident #53 a bath or shower. When asked the purpose of a resident's care plan, she stated the care plan tells everyone how to take care of the resident. When asked the importance of following a resident's care plan, CNA #12 stated the care plan must be followed "so the resident can be their best." On 10/26/21 at 3:50 p.m., ASM #1 and ASM #2 were informed of these concerns. Additional evidence verifying Resident #53 had received showers or baths during the gaps identified above, and the care plan as documented above was implemented, was requested. A review of the facility policy, "Plans of Care," revealed, in part. "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessmentdevelop and implement an individual person-centered comprehensive plan of care by the Interdisciplinary Team that includes, but is not limited to - the attending physician, a registered nurse with responsibility for the resident, an unuse aide with responsibility for the resident, as determined by the resident's needs." No further information was provided prior to exit. | TE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 on the bath record. CNA #12 stated there was frequently not enough staff working the unit to give Resident #53 a bath or shower. When asked the care plan hell everyone how to take care of the resident. When asked the care plan hell everyone how to take care of following a resident's care plan, Stated the care plan the importance of following a resident's care plan as documented above was implemented, was requested. A review of the facility policy, "Plans of Care," revealed, in part: "An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s). Develop a comprehensive plan of care by the interdisciplinary team, mental and psychosocial needs that are identified in the comprehensive plan of care by the interdisciplinary Team that includes, but is not limited to - the attending physician, a registered nurse with responsibility for the resident. as determined by the resident's needs." No further information was provided prior to exit. | A BUILDING 495315 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST EE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 46 on the bath record, CNA #12 stated there was frequently not enough staff working the unit to give Resident #53 a bath or shower. When asked the purpose of a resident's care plan, She stated the care plan lells everyone how to take care of the resident. When asked the importance of following a resident's care plan, CNA #12 stated the care plan must be followed "so the resident can be their best." On 10/26/21 at 3:50 p.m., ASM #1 and ASM #2 were informed of these concerns. Additional evidence verifying Resident #53 had received showers or baths during the gaps identified above, and the care plan as documented above was implemented, was requested. A review of the facility policy, "Plans of Care," revealed, in part." An individualized person-centered plan of care will be established by the interdisciplinary team (ICTT) with the resident and click, provided prior to exit. A review of the facility policy, mental and psychosocial needs that are identified in the comprehensive assessment. develop and implement an individual person-centered comprehensive assessment. develop and implement an individual person-centered comprehensive plan of care by the Interdisciplinary Team that includes, but is not limited to - the attending physician, a registered nurse with responsibility for the resident a nurse add the proposition for the exity. No further information was provided prior to exit. |

| AND DLAN OF CORRECTION IDENTIFICATION NUMBER | | | IPLE CONSTRUCTION NG | (X | COMPLETED | |
|--|---|---|-----------------------|---|-------------|----------------------------|
| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | JE | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE |
| F 656 | #53's comprehensive Diazepam (1), a med physician's order. On 10/24/21 at 4:26 parents requested to Resident #53's mother regarding Resident # medications as order had not received Dia 10/20/21. Resident # statement. Resident "miserable" since that A review of Resident plan dated 3/11/21 re #53] uses anti-anxiety medication physician." A review of Resident revealed, in part, the 5 mg (milligrams. Give bedtimerelated to a A review of Resident (medication administ number 9 in the squa administration on 10/10/23/21. The legent documented: "9 = Other contraction of the square contraction of the square contraction of the square contraction on 10/10/23/21. The legent documented: "9 = Other contraction of the square contraction of the squ | e care plan to administer lication to treat anxiety, per a p.m., Resident #53 and his meet with the survey team. For reported concerns and the stated Resident #53 repam since Wednesday, 53 confirmed his mother's #53 stated he had been at time. #53's comprehensive care evealed, in part: "[Resident reported to the stated had been at time. #53's physician's orders following: "Diazepam Tablet re 2 tablets by mouth at anxiety disorder." #53's October 2021 MAR retion record) revealed the pre for the Diazepam 21/21, 10/22/21, and a for the October 2021 MAR ner/See Nurse Note." | F | 656 | | |
| | A review of Resident revealed, in part: "10/21/2021 11:23 p. Administration Note available." | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT IDENTIFICATION NUMBER: A. BUILDING | | | (X3) DATE COMP | SURVEY LETED | |
|---|--|--|---------|--|---|-----------------|----------------------------|
| | | 495315 | B. WING | | | C 10/26/2021 | |
| | NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | 1 10/ | 20/2021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 656 | Further review of Resrevealed, in part, the (6:00 p.m.) Nursing F calls to [ASM (admini (medical director and physician)] on numer (Diazepam)to be caresident. 1430 (2:30 p.m.), 163 goes to voicemail that The nurse who wrote for interview at the time. On 10/20/21 at 1:44 p. nurse) #1 was interview purpose of a care pla enables the staff to offor a resident. She standard when asked how she care plan is being impless her best to follow orders. On 10/25/21 at 3:23 p. #5 was interviewed. So care of Resident #53 upset because he has the past few nights. Spersonally faxed the fourse practitioner), Assertices and part of the process of the practitioner, Assertices of the practitioner, Assertices of the practitioner, Assertices of the part of the part few nights. Spersonally faxed the fourse practitioner, Assertices of the practitioner, Assertices of the part of the part of the part of the practitioner, Assertices of the part of the | mMedication Fext: medication not Medication Administration in not available." sident #53's progress notes following: "10/23/2021 18:00 Progress Note: Attempted strative staff member) #8 Resident #53's attending ous occasions to get Valium alled to pharmacy for this o.m.), 1450 (2:50 p.m.), 85 (4:35 p.m.) no answer, t says that mailbox is full." this note was unavailable ne of the survey. o.m., LPN (licensed practical ewed. When asked the n, she stated a care plan ffer the best possible care ated the care plan helps it's needs are being met. e makes sure a resident's olemented, she stated she w all of the physician's o.m., RN (registered nurse) She stated she was taking that morning and that he is s not received his Diazepam | F | 656 | | | |

| ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|--|-------------------------------|
| | | 495315 | B. WING | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| F 656 | Resident #53 would Diazepam, and nee because Diazepam refill required the NF contact the pharmar stated she did not with 10/21/21 and that mote had the opportustated when she arr 10/25/21, she discofinally been re-order not been delivered to she had looked for, locate the refill required on 10/21/21. When #53's care plan was not receiving Diazepstated, "No. I don't be contact the refill required on 10/26/21 at 9:34 director and Reside was interviewed. With followed for authorize medications, ASM # should communicate before the medication receives a request felectronic order director can call the pharma when asked what he needed on a weeke at the facility have the phone numbers and they should call asked if he was aware stated was aware as a second call the was a was a second call the was a ware as a second call the was a | d ASM #6 and told her soon be completely out of the ded a refill. She stated is a controlled substance, a or physician to directly by to authorize it. RN #5 work between Thursday, sorning (10/25/21), she had nity follow up on this refill. She ived at work at 7:00 a.m. on wered the medication had red on 10/24/21, but still had to the facility. RN #5 stated but had not been able to ests she had faxed to ASM #6 asked whether Resident being implemented if he was bam as ordered, RN #5 | F 65 | 56 | |
| | | stated his voicemail had not | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | l ` ′ | LE CONSTRUCTION | , , | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|---|----------------------------|----------------------------|--|
| | | 495315 | B. WING | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | ľ | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 656 | Continued From pa | ge 50 | F 65 | 6 | | | |
| | practitioner, was intresident needs a rethe staff prints out the provider to sign on the She stated if the refinary call her, and she electronic refill requistated she had not a faxes from facility not a faxes from fa | 2 p.m., ASM #2, the director of as interviewed. She stated if a argent refill for a controlled sing staff may all a provider vider to transmit the refill ne pharmacy. She stated she by concerns regarding repam. ASM #2 was informed m administration was included | | | | | |
| | director, and ASM # concerns. Additional | p.m., ASM #1, the executive 2 were informed of these all evidence that Resident #53 azepam as ordered was | | | | | |
| | No further information | on was provided prior to exit. | | | | | |
| | control agitation cau is also used along v control muscle spas certain neurological | ed to relieve anxiety and to used by alcohol withdrawal. It with other medications to sms and spasticity caused by disorders such as cerebral t causes difficulty with | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|-----------------------|--|----------------------------|----------------------------|
| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | I | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 656 | move parts of the bo muscle contractions) rare disorder with mu This information is ta https://medlineplus.g tml. | ce), paraplegia (inability to dy), athetosis (abnormal , and stiff-man syndrome (a iscle rigidity and stiffness)." ken from the website ov/druginfo/meds/a682047.h | F 6 | 556 | | |
| | preventative pressure provide treatments for | e ulcer treatments, and to or Resident #26's pressure es in August, September, and | | | | |
| | 6/30/17, and most re with diagnoses include artery disease, and extremely disease, and extremely assessment reference date) of 7/3 coded as being cognidecisions, having see BIMS (brief interview resident was coded a staff for bed mobility, hygiene, and bathing received dialysis semperiod. Resident #26 pressure ulcers (1), but the side of th | surveyor observation of his | | | | |
| | plan dated 7/27/20, a | #26's comprehensive care and most recently updated part: [Resident #26] has | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTII | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|---------------------|---|-----------|----------------------------|
| | | 495315 | B. WING | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | ' | |
| (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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 656 | to lay (sic) side to side ordered and monitor #26] has potential imper order." A review of Resident revealed the following medication administration record "Clean wound to righ Normal saline, pat drabsorbent material) a dressing." This order discontinued 9/6/21. revealed blanks for a 8/9/21 and 8/12/21. "Preventative skin caeach incontinent epis needed to prevent sk was written 12/9/20. revealed blanks for a 8/3/21, 8/4/21, 8/5/21, 9/25/21, 9/27/21, 9/2 | #26's clinical record g physician's orders and ation records, as TARs (treatment ls): t and left buttock with y, apply maxorb (an and cover with foam was written 7/23/21 and Resident #26's TARs dministration of this order on re: apply skin barrier after sode every shift and as in breakdown." This order | F 6 | 56 | | |
| | pat dryApply Silvad with foam dressing. (prn (as needed)." Th and discontinued 10/ revealed blanks for a | ccyx with NS (normal saline), lene (dressing) and cover Change Q (every) day and is order was written 9/18/21 7/21. Resident #26's TARs dministration of this order on 8/21, 10/1/21, 10/3/21, and | | | | |

| ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | L 1 / | | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|---------------------|--|----------|----------------------------|--|--|
| | | 495315 | B. WING | | | C 40/26/2024 | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | I | 10/26/2021 | | |
| (X4) ID PREFIX TAG | / | | ID PREFIX TAG | PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | | |
| F 656 | "Left lower buttock: of apply medihoney (meand cover with dry dresoiled or loosened programs written on 9/18/2 10/7/21. Resident #2 administration of this 9/28/21, 10/1/21, 1 | cleanse area with NS, pat dry, edication to treat wounds) ressing. Change dressing if rn every day shift." This order 21 and discontinued on 26's TARs revealed blanks for order on 9/22/21, 9/27/21, 23/21, and 107/21. It Cleanse area with NS, pat and cover with dry dressing. Coiled or loosened prn every awas written on 9/18/21 and 25/21. Resident #26's TARs administration of this order on 25/21, 9/30/21, 10/1/21, In p.m., LPN (licensed practical dewed. When asked how she are ulcer treatment once she N #1 stated she signs it on all record. She stated her as her initials and a check are specific date and time a sher initials and a check are specific date and time a sher asked how a blank on a coreted, LPN #1 stated: nowing. If it's not bot happen." When shown as for August, September, and sked to interpret the blanks assure ulcer treatments, LPN documented, it was not | F 6 | 56 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|---|----------------------------|--|--|
| | | 495315 | B. WING | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF | D BE COMPLETION | | |
| F 656 | care plan is being in does her best to foll orders. When asked to prevent and treat followed, LPN #1 st. On 10/20/21 at 4:50 staff member) #1, the director of clinical regional vice preside #4, the regional clinical these concerns. A review of the facility Skin & Wound, "revisite would be with the second and intervention monitoring as indicated goals and intervention with the second and inte | inplemented, she stated she ow all of the physician's dif Resident #26's care plan pressure ulcers was being ated it was not. In p.m., ASM (administrative ne executive director, ASM #2, all services, ASM #3, the ent of operations, and ASM ical nurse, were informed of atty policy, "Clinical Guidelines ealed in part: "To provide a gig skin at risk, implementing ons including evaluation and attedDevelop individualized | F 65 | 6 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
|--------------------------|---|--|-----------------------------|--|------------------------------|--|
| | | 495315 | B. WING | | 10/26/2021 | |
| | ROVIDER OR SUPPLIER | - WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE COMPLETION | |
| F 656 | is visible in the ulce epibole (rolled wou Slough and/or esch of tissue damage vareas of significant wounds. Undermin Fascia, muscle, ter and/or bone are no obscures the exten Unstageable Press from the website https://cdn.ymaws.org/online_store/npia 2. b. The facility sta #26's comprehensiservices. A review of Reside plan dated 7/27/20 revealed, in part: "[r/t (related to) renal signs1200 ml/day noncompliant at tim A review of Reside dialysis communica (medication admini September, and Octage PreDialysis assesse every day shift Mor This order was writ clinical record contagre-dialysis assessessessessessessessessessessessesse | of skin, in which adipose (fat) or and granulation tissue and and edges) are often present. The depth aries by anatomical location; adiposity can develop deep ing and tunneling may occur. Indon, ligament, cartilage of exposed. If slough or eschar at of tissue loss this is an eure Injury." This injury is taken com/npiap.com/resource/resm ap_pressure_injury_stages.pdf aff failed to implement Resident are care plan for dialysis Int #26's comprehensive care and updated 8/11/20, Resident #26] needs dialysis are fluid restriction. He is | F 65 | | | |

| . , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | ULTIPLE CONSTRUCTION DING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|---|--|-----|----------------------------|--|
| | | 495315 | B. WING _ | | | 10/ | 26/2021 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | 20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 656 | "PostDialysis assess Monday, Wednesda written 7/7/21. Reside contained no eviden assessment, including access site, on 8/9/210/8/21. Further review of Residen revealed the feem of the review of Residen revealed the feem of the review of Residen revealed the feem of the review of Residen reversible for fluid restriction: 12 Dietary: Breakfast 20 240 ml = 720 with most 7p - 7a = 240 = 480 revery shift for fluid reversible for fluid reversible for fluid reversible for the exact with the review of the exact with the review of a dietary 10/21/21 revealed, in choice1200 ml fluid fluid for 10/20/21 at 1:44 rurse) #1 was intervealed, in choice with medications, or something to drink. It is not the review of the reversible for the review of the reversible fluid f | sment every day shift y and Friday." This order was dent #26's clinical record ace of a post-dialysis and vital signs and dialysis 21, 8/30/21, 10/1/21, and esident #26's physician's collowing order, dated 12/9/20: 00 ml/day (milliliters per day). 40 ml, lunch 240 ml, dinner deals. Nursing 7a - 7p = 240. ml with meds (medications) estriction." It #26's MARs and Point of tober 2021 revealed no cottamount of fluids Resident of shift, or for any 24 hour In instruction slip for dinner on a part: "6 oz (ounce) tea of direstriction." p.m., LPN (licensed practical viewed. When asked how she ent is compliant with a uid restriction, LPN #1 stated is how much fluid she is giving if she is offering the resident when asked who documents | F6 | 556 | | | | |
| | how much fluid a restray, she stated the | When asked who documents sident receives on a meal CNAs document this oint of care records. When | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|--|-------------------------------|----------------------------|
| | | 495315 B. WING | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 656 | amount of fluids con hour period, LPN #1 question." LPN #1 st but she doesn't know When asked why it wexactly how much flustated if the resident could harm their kidr. When asked what as a resident before the LPN #1 stated she of the dialysis access sommunicates this in [laboratory] results, we changes, to the dialy dialysis communicat. "It's a form we all fill in their part and the When shown the gall Resident #26's dialy communication book look like things were asked the purpose of care plan enables the possible care for a replan helps ensure all being met. When as resident's care plan #1 stated she "does physician's orders." On 10/20/21 at 2:26 nurse) #7 was intervithe blanks in dialysis communication book communication book in the proposed in the pro | sible for calculating a total sumed by a resident for a 24 stated, "That's an excellent ated, "Someone should be," who is actually doing it. would be important to know aid a resident is drinking, she is on dialysis, too much fluid neys even more. Seessments she performs on resident goes to dialysis, hecks vital signs, and checks ite. LPN #1 stated, "She information, as well as any lab weights, and medication visic center by way of a iten book." LPN #1 stated, out. The dialysis center fills book comes back to us." Os in documentation for sis assessments and at LPN #1 stated, "It does not done on those days." When for a care plan, she stated a le staff to offer the best lesident. She stated the care at the resident's needs are ked how she makes sure a lis being implemented, LPN her best to follow all of the p.m., LPN (licensed practical iewed. When asked about assessments and dialysis a for Resident #26, she stated then she would have to say | F 6 | 56 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | C 10/26/2021 | |
| | NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | ı | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | | | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 656 | assistant) #2 was interestriction, CNA #2 state documents for restriction, CNA #2 state percentage of a magnetic She stated there is not system to document a resident receives with the comparison of the compari | o.m., CNA (certified nursing erviewed. When asked what sidents who are on a fluid ated she can only document heal the resident has eaten. It is place on the point of care an exact amount of fluid a meals. o.m., ASM (administrative executive director, ASM #2, services, ASM #3, the services, ASM #3, the services, and ASM all nurse, were informed of an was provided prior to exit. failed implement Resident care plan to obtain g on 9/30/21. #26's comprehensive care evealed, in part: "Obtain and cowork as ordered." #26's physician's orders g: "CBC (complete blood entiation), BMP (basic P (C-reactive protein), -dimer (clotting level), ting) one time a day every . Start date 9/23/21." sident #26's September 2021 inistration records) and ealed no results for the | F | 656 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | • | 10/20/2021 |
| (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 CC ((EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 656 | Continued From page | ge 59 | F6 | 956 | | |
| | nurse) #1 was interinformation for lab (in be done is kept in a She stated the nursilab test fills out a rebook. When the out at the facility, they could be specimens as not sure why Reside performed for 9/30/2 evidence that the teresident #26's care regarding laboratory. On 10/21/21 at 8:36 lab tests had not be 9/30/21. She stated responsible for doul requests for a particular the book for the out she could not locate Resident #26 for 9/3 On 10/20/21 at 4:50 staff member) #1, the director of clinical regional vice presiding these concerns. No further information 3. The facility staff for #33's comprehensive at the state of the could not locate for 9/3 at 150 staff member) #1, the director of clinical regional vice presiding #4, the regional clinical for the concerns. | 6 a.m., ASM #2 confirmed the en done for Resident #26 on the night shift nurse is ple checking that all lab cular day are accurate and in side lab company. She stated a lab test request sheet for | | | | |

| I i i | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | (XX | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | C | |
| | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP COI 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | DE | 10/26/2021 | |
| (X4) ID PREFIX TAG | FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 656 | October 2021. Resident #33 was ac 1/6/16, and most rec with diagnoses of dia and dementia. On th (minimum data set), an ARD (assessmen Resident #33 was co cognitively impaired the resident was not BIMS (brief interview #33 was coded as be assistance for all act coded as having a S On 10/21/21 at 10:5 made of RN (register wound care to Resid old dressing from Rechanged gloves, san new gloves. She cleated acid, applied Maxine covered the wound vicessing. She remove her hands. RN #5 me 1.4 cms (centimeters The wound bed was (healing) tissue. No described the side of Resident plan dated 6/9/20, werevealed, in part: [Resident plan dated fine part: [Resident plan dat | Imitted to the facility on ently readmitted on 6/23/20, abetes, history of a stroke, e most recent MDS a quarterly assessment with the reference date) of 9/6/21, aded as being severely for making daily decisions; able to be interviewed for the room of the ro | Fé | 656 | | | |
| | A review of Resident revealed the followin | #33's clinical record g physician's orders and | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | O BE COMPLETION | |
| F 656 | medication administ documented on the administration record and October 2021: "Acetic Acid Solution miscellaneous ever (pressure injury) to to sacrum with 2% acollagen/maxorb (didressing daily and pwas written 3/20/21 revealed blanks for 8/7/21, 9/25/21, 9/2 10/8/21, 10/9/21, 10/18/21. "Cleanse sacral wordry, and apply colla foam dressing ever written on 6/9/21. Riblanks for administr 9/25/21, 9/26/21, 9/10/10/21, 10/15/21, A review of Resider revealed no gaps in of the wound. The word administred the period of | TARs (treatment rds) for August, September, n 2% 10 ml (milliliters) y day shift for Stage 3 Pl sacrum. Cleanse Stage 3 Pl sacetic acid, pat dry, apply ressing), cover with foam orn (as needed)." This order . Resident #33's TARs administration of this order on 6/21, 9/30/21, 10/1/21, 0/10/21, 10/15/21, and und with normal saline, pat gen/maxorb covered by a y day shift." This order was esident #33's TARs revealed ation of this order on 8/7/21, 30/21, 10/1/21, 10/9/21, | F 65 | 6 | | |
| | nurse) #1 was interdocuments a pression has completed it, LI the electronic medical signature shows up | I p.m., LPN (licensed practical viewed. When asked how she ure ulcer treatment once she PN #1 stated she signs it on cal record. She stated her as her initials and a check the specific date and time a | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | OODSTOCK | 1 | STREET ADDRESS, CITY, STATE, ZIP 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | CODE | , | |
| (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 ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BI THE APPROPRIA | | (X5) COMPLETION DATE |
| F 656 | treatment is due. Who TAR should be interp "There's no way of kn documented, it did not Resident #33's TARs October 2021, and as for the resident's pres #1 stated, "If it's not of done." When asked the stated a care plan the best possible care the care plan helps en needs are being met. makes sure a resident implemented, she stated low all of the physic Resident #26's care pressure ulcers was a was not. On 10/20/21 at 2:26 promises and the provide evidence that for pressure ulcers have a stated if there are blassay the treatments were resident #33's care pulcers was being followed to the director of clinical regional vice presider #4, the regional clinic these concerns. The provide evidence that for pressure ulcers have a stated in the provide evidence that for pressure ulcers have a state of t | en asked how a blank on a reted, LPN #1 stated, owing. If it's not thappen." When shown for August, September, and sked to interpret the blanks sure ulcer treatments, LPN ocumented, it was not ne purpose of a care plan, ne enables the staff to offer e for a resident. She stated insure all the resident's When asked how she | F6 | 656 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X: | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN | | LE CONSTRUCTION | COMPLI | (X3) DATE SURVEY COMPLETED C | |
|---|--|--|---------------------|--|---------|---------------------------------------|--|
| | | 495315 | B. WING | B. WING | | 6/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | , ,,,,, | · · · · · · · · · · · · · · · · · · · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | |
| F 656 | Continued From pa | ge 63 | F 65 | 6 | | | |
| | Skin & Wound," rev system for identifyin individual intervention | ity policy, "Clinical Guidelines ealed in part: "To provide a ig skin at risk, implementing ons including evaluation and atedDevelop individualized ons." | | | | | |
| | No further information was provided prior to exit. | | | | | | |
| | loss Full-thickness loss of is visible in the ulce epibole (rolled wour Slough and/or eschoof tissue damage vareas of significant wounds. Undermining Fascia, muscle, tenand/or bone are not obscures the extent Unstageable Pressufrom the website https://cdn.ymaws.com/or visible in the visible | of skin, in which adipose (fat) or and granulation tissue and and edges) are often present. For armay be visible. The depth aries by anatomical location; adiposity can develop deeping and tunneling may occur. In don, ligament, cartilage of exposed. If slough or eschar of tissue loss this is an are Injury." This injury is taken som/npiap.com/resource/resming_pressure_injury_stages.pdf | | | | | |
| | skin and underlying bony prominence of device. The injury copen ulcer and may as a result of intens or pressure in comb tolerance of soft tiss may also be affecte perfusion, co-morbio | ry is localized damage to the soft tissue usually over a related to a medical or other an present as intact skin or an be painful. The injury occurs and/or prolonged pressure bination with shear. The sue for pressure and shear d by microclimate, nutrition, dities and condition of the soft ation is taken from the website | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | | |
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| F 656 | https://cdn.ymaws.cgr/online_store/npia. 4. The facility staff f #8's comprehensive resident's call bell w Resident #8 was ad 8/13/20. Resident # were not limited to r diabetes and muscl annual minimum da assessment referent resident as being cocoded Resident #8 assistance of two on Resident #8's comp 8/26/20 documenter falls r/t (related to) is resident's call light in the resident to use in the resident was ring bell was ring bell was ring bell was ring bell was observe positioned against to the head of Resident On 10/20/21 at 1:41 conducted with LPN LPN #1 stated the poffer a plan of care. | com/npiap.com/resource/resm pp_pressure_injury_stages.pdf ailed to implement Resident ailed to implement Resident accare plan for maintaining the vithin reach. Imitted to the facility on the stage of the second | F 65 | 6 | | | |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | IPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CI 803 SOUTH MAIN ST WOODSTOCK, VA | • | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH C | IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B FERENCED TO THE APPROPRIA DEFICIENCY) | |
| F 656 | stated residents sho bells within reach so get a hold of staff. On 10/20/21 at 2:32 conducted with RN (stated the purpose or resident's plan of cal have access to resident #2 (the director made aware of the all No further informations. 5. The facility staff for #24's comprehensive (blood thinning) medical were not limited to divide and a history of strol minimum data set as assessment reference resident's cognitive sident's comprehensive sident's comprehensive sident's cognitive sident's comprehensive sident's cognitive sident's cognitiv | p.m., an interview was registered nurse) #1. RN #1 if the care plan is to drive the re. RN #1 stated all nurses lents' care plans. p.m., ASM (administrative executive director) and rof clinical services) were above concern. In was presented prior to exit. In was presented prior to exit. | F | 556 | | |
| | | lated 3/12/21 for Eliquis (1) | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDI | TIPLE CONSTRUCTION NG | | DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | OODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | CODE | 10/20/2021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 656 | 2.5 mg (milligrams) - continues a day for peripher Resident #24's July 2 administration record; Eliquis 2.5 mg- one to day. On 7/5/21 at 5:0 p.m., the nurse did not as being administered the code, "9=other/Se note dated 7/5/21 documedication and was redated 7/29/21 documedication and was redated 7/29/21 documedication and to mater a plan of care for that person and to mater a plan of care for that person and to mater a plan of care for that person and to mater a plan of care for that person and to mater a plan of care for the person and the purpose of the computer system. On 10/20/21 at 2:32 producted with RN (restated the purpose of resident's plan of care have access to reside the purpose of the difference of the difference of the above access to the access to th | one tablet by mouth two deral vascular disease (2). O21 MAR (medication of documented the order for ablet by mouth two times a company of p.m. and 7/29/21 at 5:00 of document the medication of the MAR documented of the Nurse Notes." A nurse's cumented, "out of deordered." A nurse's note cented, "not available." O.m., an interview was dicensed practical nurse) #1. The pose of the care plan is to be the best possible care for ake sure all of their needs ded residents' care plans are deference but she had not ent's care plan. LPN #1 medication refill requests to dest a refill directly through of the care plan is to drive the dest of the care plan is to drive the dest of the care plan is to drive the dest of the care plans. O.M., ASM (administrative executive director) and of clinical services) were | F | 656 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED C | | |
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| | | 495315 | B. WING _ | | | 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 656 | medication) is used clots in people who condition in which t increasing the char and possibly causir by heart valve diserobtained from the vhttps://medlineplus.tml (2) Peripheral vasc the blood vessels the blood vessels the this information was https://medlineplus.tml 6.a. The facility stat #28's comprehensithe resident's call be | uis- an anticoagulant I help prevent strokes or blood have atrial fibrillation (a he heart beats irregularly, nce of clots forming in the body ng strokes) that is not caused ase." This information was vebsite: gov/druginfo/meds/a613032.h ular disease is a condition of nat supply the feet and legs. as obtained from the website: gov/ency/article/000170.htm If failed to implement Resident we care plan for maintaining | F 6 | | | | | |
| | 4/21/20. Resident: were not limited to muscle weakness a quarterly minimum assessment referer resident's cognition Section G coded Re extensive assistance mobility. Resident #28's com 4/29/20 documente falls r/t (related to) a his call light is withi | #28's diagnoses included but congestive heart failure, and dementia. Resident #28's data set assessment with an ince date of 8/31/21, coded the as moderately impaired. esident #28 as requiring the of one staff with bed in prehensive care plan dated d, "(Resident #28) is at risk for a h/o (history of) fallsBe sure in reach and encourage him to be as needed. Due to blindness, | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | , , | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | ľ | 10/20/2021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 656 | On 10/19/21 at 8:48 Resident #28 was oresident's call bell wof the resident's bed resident's reach. Robe interviewed during On 10/20/21 at 1:41 conducted with LPN LPN #1 stated the poffer a plan of care that person and to rare met. LPN #1 stavailable for staff to reviewed every resident's stated residents should be staff. On 10/20/21 at 2:32 conducted with RN stated the purpose oresident's plan of cathave access to resident's plan of cathave access t | where the call bell is." a.m. and 11:07 a.m., bserved in bed. The ras on the floor on the left side d and was not within the resident #28 was not able to rig the survey. p.m., an interview was d (licensed practical nurse) #1. rurpose of the care plan is to for the best possible care for make sure all of their needs reference but she had not dent's care plan. LPN #1 rull have call bells or ring they have an easy way to a.p.m., an interview was (registered nurse) #1. RN #1 of the care plan is to drive the re. RN #1 stated all nurses dents' care plans. a.p.m., ASM (administrative re executive director) and re of clinical services) were reabove concern. and the care plan for Foley urinary rent. | F6 | 56 | | | | |
| | Resident #28's com | prehensive care plan dated | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CO 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | DDE | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIA | DATE | |
| F 656 | 3/15/21 documented Indwelling Foley Cat obstructive uropathy tubing below the leve from entrance room Review of Resident: a physician's order of catheter due to urinate to a physician's order of catheter due to urinate to a physician's order of catheter due to urinate to a physician's order of catheter due to urinate to a physician's order of catheter due to urinate to a physician's order of catheter due to urinate to a physician's order of catheter due to urinate was observed in interviewed. The residente was observed attach located on the side of door. The urine in the from the hall. On 10/20/21 at 1:41 conducted with LPN LPN #1 stated the purpose of that person and to make a person and to | I, "(Resident #28) has heter r/t (related to)Position catheter bag and el of the bladder and away door." #28's clinical record revealed lated 3/23/21 for a Foley ary retention. a.m. and 9:49 a.m., Resident a bed and not able to be sident's Foley catheter bag ned to the bed frame and was of the bed that was facing the ne catheter bag was visible p.m., an interview was (licensed practical nurse) #1. urpose of the care plan is to or the best possible care for nake sure all of their needs ated residents' care plans are reference but she had not lent's care plan. p.m., an interview was registered nurse) #1, the mented Resident #28's care she documented to keep eter bag and tubing aware om door for privacy. RN #1 of the care plan is to drive the re. RN #1 stated all nurses | F | 956 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION IG | | COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | I | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE APDEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 656 | made aware of the all No further information Reference: (1) "A urinary cathet to drain and collect information was obtained in the second of | r of clinical services) were above concern. on was presented prior to exit. er is a tube placed in the body urine from the bladder." This ained from the website: gov/ency/article/003981.htm ailed to implement Resident ive care plan for obtaining a n's order. Imprehensive care plan dated d., "(Resident #129) is at risk and altered nutritional/fluid odx (diagnosis) COVID, PNA tory failure, and labs per order/protocol" #129's clinical record n's order dated 6/19/21 for a reday shift every Monday. #129's August 2021 weight I MAR (medication d) revealed the resident's don 8/9/21 and 8/23/21 but my other date during that one dated 8/16/21 documented a unable to obtain Resident at date due to staffing issues. | F6 | 56 | | |
| | (the nurse who docu | (licensed practical nurse) #1 umented the above note). CNAs (certified nursing | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 656 | weights but she trie #1 stated 8/16/21 w lack of staffing and Resident #129's we purpose of the care for the best possible make sure all of the stated residents' ca to reference but she resident's care plan On 10/20/21 at 2:32 conducted with RN stated the purpose resident's plan of ca have access to resi On 10/20/21 at 5:12 staff member) #1 (ti ASM #2 (the director made aware of the No further informati 8. The facility staff of comprehensive care Resident #59. Res with 1/2 upper bedr AM and on 10/19/2 Resident #59 was a 1/29/21 with diagnor limited to: Diabetes function normally in obstructive pulmona non-reversible lung respiratory failure (o | consible for obtaining resident is to help when she can. LPN was a really bad day due to a the staff was unable to obtain eight. LPN #1 stated the plan is to offer a plan of care is care for that person and to be ir needs are met. LPN #1 re plans are available for staff is had not reviewed every and interview was (registered nurse) #1. RN #1 of the care plan is to drive the are. RN #1 stated all nurses dents' care plans. 2 p.m., ASM (administrative the executive director) and for of clinical services) were above concern. 2 plan for bedrails for ident #59 was observed in bed ails up on 10/19/21 at 10:15 | F 6 | 56 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | B. WING | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | 8 | STREET ADDRESS, CITY, STATE, ZIP CODE 103 SOUTH MAIN ST WOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 656 | assessment, a quarte (assessment reference the resident as scoring BIMS (brief interview indicating the resident review of the MDS Seconded the resident as assistance for bed mand total dependence hygiene. A review of bladder coded the refor bowel and for bladder coded the plan failed to evidence plan failed to evidence plan to address the undocuments in part, "For (activities of daily living deficit related to multion of life. INTERVENTI to promote independence asked the purpose of stated, "It is the plan to address the reside When asked if side reformation in the stated of the plan to address the reside when asked if side reformation in the stated of the purpose of stated, "It is the plan to address the reside when asked if side reformation in the state of the plan to address the reside when asked if side reformation in the state of the plan to address the reside when asked if side reformation in the state of the plan to address the reside when asked if side reformation in the plan to address the reside when asked if side reformation in the plan to address the reside when asked if side reformation in the plan to address the reside when asked if side reformation in the plan to a state of the plan to | S (minimum data set) erly assessment with an ARD ce date) of 9/29/21, coded ng a 14 out of 15 on the for mental status) score, nt was cognitively intact. A ection G-functional status is requiring extensive obility, supervision for eating e for dressing, bathing and MDS Section H- bowel and sident as always incontinent dder. cian orders dated 9/14/21, 1/2 side rails to promote ed mobility." #59's comprehensive care se development of a care use of bed rails until prehensive care plan FOCUS-Resident has an ADL ng) self-care performance iple co-morbidities and end ONS- 1/2 bilateral side rails ence and bed mobility." aducted on 10/19/21 at 4:30 ed practical nurse) #5. When if the care plan, LPN #5 of care that everyone sees ent's needs and orders." ails should be included on | F | 656 | | | |
| | | are plan, LPN #5 stated, | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP COE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | DE | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIAT | DATE | |
| F 656 | AM with LPN #8. Who comprehensive care have a plan to meet everyone can see." side rails should be incomprehensive care they should be included on 10/20/21 at 5:10 staff member) #1, the director of clinical regional vice preside the regional clinical regional vice presidents. A review of the facility dated 9/2017, document the resident's repsychosocial needs comprehensive asset A review of the facility policy, dated 4/2018, rail/bed rail may inclurails, bed rails, safety bars. Update the care | anducted on 10/20/21 at 6:55 then asked the purpose of the plan, LPN #8 stated, "To the resident needs that When asked if the use of included on the plan, LPN #8 stated, "Yes, ded." PM, ASM (administrative executive director, ASM #2, all services, ASM #3 the ent of operations and ASM #4 nurse were made aware of a sare plan for Resident #59, rails. DAM, ASM #1 provided a sare plan for Resident #59, rails. Dy's "Plans of Care" policy, mented in part, "Develop a of care for each resident that explications and timetables to medical, nursing, mental and that are identified in the essment." Dy's "Side Rail/Bed Rail", documented in part, "Side ude but not limited to: side y rails, grab bars and assist re plan and kardex." | F6 | | | | |
| | No further informatio | n was provided prior to exit. | | | | | |
| | | ry of Medical Terms for the | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | 1, , | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | B. WING | | C 0/26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | , , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | LD BE | (X5) COMPLETION DATE | |
| F 656 | Chapman, page 160. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 120. (3) Barron's Dictionar Non-Medical Reader, Chapman, page 502. | 7th edition, Rothenberg and y of Medical Terms for the 7th edition, Rothenberg and y of Medical Terms for the 7th edition, Rothenberg and | F | 656 | | | |
| F 657 SS=D | be- (i) Developed within 7 the comprehensive as (ii) Prepared by an initial includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent praction the resident and their and their resident reput for practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by th (iii)Reviewed and rev | ensive Care Plans brehensive care plan must days after completion of sesessment. terdisciplinary team, that hited to dysician. with responsibility for the responsibility for the days after completion of the included in a resident's participation of the resentative is determined to development of the staff or professionals in ined by the resident's needs the resident. seed by the interdisciplinary sesment, including both the | F | 657 | | 12/1/21 | |

| | | ' IDENTIFICATION AND ADED | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|---|--|-------------------------------|----------------------------|
| | | 495315 | 95315 B. WING | | | | C 10/26/2021 |
| NAME OF D | ROVIDER OR SUPPLIER | 40010 | | ٥. | TREET ADDRESS, CITY, STATE, ZIP CODE | 10/ | 26/2021 |
| NAIVIE OF FI | NOVIDER OR SUFFLIER | | | | | | |
| CONSULA | TE HEALTH CARE OF W | OODSTOCK | | | 03 SOUTH MAIN ST | | |
| | | | | V | VOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 657 | Continued From page | e 75 | F 6 | 657 | | | |
| | | is not met as evidenced | | | | | |
| | document review, and was determined that review and revise the for two of 41 resident Residents #331 and # The facility staff failed comprehensive care address a urinary cat and revise Resident #plan for the use of be to the findings include: 1. Resident #331 was 5/26/21, and most recent MDS (minus arm, diabetes, and himost recent MDS (minus assessment with an Adate) of 7/30/21, Resbeing severely cognit daily decisions, havin the BIMS (brief intervone Resident #331 was contacted to the proof of the proof | It to revise the plan for Resident #331 to heter and failed to review #8's comprehensive care d rails. Is admitted to the facility on cently readmitted on ses including a broken right story of a stroke. On the nimum data set), a quarterly ARD (assessment reference ident #331 was coded as ively impaired for making g scored three out of 15 on iew for mental status. oded as not having a dder for urination during the | | | 1. Care Plans for residents #8 updated reflect side rail use and #331 updated Foley catheter. 2. Quality review of residents with side rails and Catheters to ensure that plan care updated 3. RAI re-education provided to RNAC and LPNAC by the Regional Nurse Assessment Coordinator 4. Random sample of 10 plans of care ensure that Quality monitoring weekly 4 weeks and monthly for 3 months to ensure ongoing compliance. Results to QAPI for follow-up. 5. 12/01/2021 | of to for | |
| | rim. | hanging on the wheelchair #331's physician's orders | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | TIPLE CONSTRUCTION NG | ' ' | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZII 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | P CODE | 10,20,2021 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 657 | designating cathete centimeters) balloor 10/13/21, and did not need for the urinary. A review of Resider plan dated 6/9/21 farelated to the reside. On 10/20/21 at 4:50 staff member) #1, the director of clinic regional vice presid #4, the regional clinithese concerns. On 10/20/21 at 2:32 #1, the MDS coording stated she and LPN work together on caup to her and LPN # plans. She stated the resident changes do meetings. RN #1 staupdated to include a A review of the facil revealed no informative revising an existing. No further information. | oley catheter 16 FR (French, r size)/10 cc (cubic n." The order was written of include a diagnosis for the catheter. It #331's comprehensive care filled to reveal any information ent having a urinary catheter. It p.m., ASM (administrative ne executive director, ASM #2, al services, ASM #3, the ent of operations, and ASM ical nurse, were informed of the p.m., RN (registered nurse) anator, was interviewed. RN #1 (licensed practical nurse) #6 are planning. She stated it is the forevise the resident care five team hears updates on the urinary catheter. It policy, "Plans of Care," thion related to reviewing and care plan. In was provided prior to exit. | F | 657 | | | |
| | tube placed in the b from the bladder." T the website | er (brand name Foley) is a ody to drain and collect urine his information is taken from gov/ency/article/003981.htm. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | woodstock | • | STREET ADDRESS, CITY, STATE, ZIP C 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | • | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | - | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 657 | Continued From pa | ge 77 | F | 657 | | | |
| | 8/13/20. Resident # were not limited to rediabetes and muscle annual minimum datassessment referent resident as being concoded Resident #8 assistance of two or Review of Resident plan dated 8/26/20 (to reveal documents On 10/19/21 at 8:56 observed lying in bethe upright position. Review of Resident physician's order dataside rails (bed rails) and bed mobility. On 10/20/21 at 2:32 conducted with RN stated the purpose of plan of care. RN #1 should be reviewed bed rails. On 10/20/21 at 5:12 | admitted to the facility on 8's diagnoses included but hajor depressive disorder, we weakness. Resident #8's ta set assessment with an oce date of 8/2/21, coded the ignitively intact. Section G as requiring extensive more staff with bed mobility. #8's comprehensive care reviewed on 10/19/21) failed ation regarding bed rails. a.m., Resident #8 was d with bilateral 1/2 bed rails in 1/2 bed rail | | | | | |
| | staff member) #1 (th | ne executive director) and r of clinical services) were | | | | | |
| | presented Resident | oximately 7:45 a.m., ASM #1 #8's revised care plan. The ed on 10/20/21 to include bed | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BUI | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|---|----------------------------|--|
| | | 495315 | B. WING | | C 10/26/2021 | |
| | NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | |
| F 657 | documented, "Updat | ed, "Side Rail/Bed Rail" e the care plan and kardex." n was presented prior to exit. | F 65 | 7 | | |
| F 658 SS=D | Services Provided M CFR(s): 483.21(b)(3) §483.21(b)(3) Composition of the services provide as outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on observation document review, and was determined that follow professional stronglicting physician Stage 3 pressure ulcomostic the stronglicti | eet Professional Standards (i) rehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. T is not met as evidenced on, staff interview, facility d clinical record review, it the facility staff failed to candards of practice for one e survey sample, Resident failed to clarify two orders for treatment of a er. Imitted to the facility on ently readmitted on 6/23/20, abetes, history of a stroke, e most recent MDS | F 65 | 1. Resident #33 treatment order clarifi on 10/20/2021. 2. Quality review of residents with pressure ulcer treatments to ensure physician ordered treatments complete as ordered. 3. Licensed staff re-education on professional standards including clarification of pressure ulcer treatmen DON/designee on 11/18/2021. 4. The Administrator is responsible for maintaining compliance. The | ed t by | |
| | an ARD (assessmen Resident #33 was co cognitively impaired the resident was not BIMS (brief interview | a quarterly assessment with treference date) of 9/6/21, ded as being severely for making daily decisions; able to be interviewed for the for mental status). The as being dependent on staff | | DON/designee to complete treatment observations quality monitor weekly fo weeks then monthly for 6 months to ensure compliance maintained. Follow based on findings and reported to the facilities monthly QAPI meeting. Quali Monitoring schedule modified based o | up | |

| ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | MULTIPLE CONSTRUCTION JILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | B. WING | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | 1 10/ | 20/2021 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 658 | assistance for all acticoded as having a St On 10/21/21 at 10:51 made of RN (register wound care to Reside old dressing from Rechanged gloves, saninew gloves. She clear acid, applied Maxine covered the wound with dressing. She remove her hands. RN #5 med 1.4 cms (centimeters. The wound bed was (healing) tissue. No catechnique or treatment administration administration administration record and October 2021: "Acetic Acid Solution miscellaneous every (pressure injury) to sa collagen/maxorb (dredressing daily and prowas written 3/20/21. It revealed nurse signat treatment was admin August, September, a "Cleanse sacral wourdry, and apply collage." | vities of daily living. She was age 3 (1) pressure ulcer (2). a.m., observation was ed nurse) #5 providing ent #33. RN #5 removed the sident #33's sacrum. She tized her hands, and donned insed the wound with acetic Alginate to the wound, and with an adhesive foam ed her gloves and sanitized easured the sacral wound at 1) X (by) 0.8 cms X 0.3 cms. 100% beefy red granulation concerns were identified with ent during the observation. #33's clinical record granulation encerns were identified with ent during the observation. #33's clinical record granulation encerns were identified with ent during the observation. #33's clinical record granulation encerns were identified with ent during the observation. #33's clinical record granulation encerns were identified with ent during the observation. | F | 658 | findings. 5. 12/01/2021. | | | |

| ` ' | | · · · | | | (X3) DATE SURVEY COMPLETED | | |
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| | 495315 | B. WING | | | C 10/26/2021 | | |
| ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 | | |
| (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTION S | SHOULD BE | (X5) COMPLETION DATE | | |
| written on 6/9/21. R nurse signatures in administered on mu September, and Oc A review of Resider plan dated 6/9/20, a in part: [Resident # coccyxAdminister monitor for effective On 10/20/21 at 9:58 staff member) #1, ti the survey team wit uses Lippincott, sex professional standa On 10/21/21 at 11: completed providing was interviewed. W #33's TAR specifica #5 stated she could When shown two o same wound, one f with acetic acid, an cleansed with norm Yes." When asked i on previous shifts, I asked which order s stated, "Well, I just order. You know." S normal saline first, i the wound. Then ap reminded of the obs completed of her ac | dicating this treatment was altiple dates in August, stober, 2021. In #33's comprehensive care and updated 7/7/20, revealed, 33] has pressure injury to her treatments as ordered and eness." In a.m., ASM (administrative the executive director, emailed the evidence that the facility wenth edition, as their and of practice. In a.m., RN #5, who had just the gresident #33's wound care, then asked to review Resident ally for wound treatments, RN and identify any concerns. The fact the wound to be call saline, RN #5 stated, "Oh. If she had signed both orders RN #5 stated she had. When she had followed, RN #5 stated she had. When she had followed, RN #5 stated she used the chen the acetic acid to cleanse oplied the dressing. When servation that had just been diministering Resident #33's | F 68 | 58 | | | | |
| | ROVIDER OR SUPPLIER SUMMARY: (EACH DEFICIEN REGULATORY O Continued From pa written on 6/9/21. R nurse signatures in administered on mu September, and Oc A review of Resider plan dated 6/9/20, a in part: [Resident # coccyxAdminister monitor for effective On 10/20/21 at 9:58 staff member) #1, tl the survey team wit uses Lippincott, sev professional standa On 10/21/21 at 11:1 completed providing was interviewed. W #33's TAR specifica #5 stated she could When shown two or same wound, one fo with acetic acid, and cleansed with norm Yes." When asked if on previous shifts, for asked which order is stated, "Well, I just order. You know." S normal saline first, for the wound. Then ap reminded of the obs completed of her ac wound care, RN #5 both that time." She | A95315 ROVIDER OR SUPPLIER ATE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 80 written on 6/9/21. Resident #33's TARs revealed nurse signatures indicating this treatment was administered on multiple dates in August, September, and October, 2021. A review of Resident #33's comprehensive care plan dated 6/9/20, and updated 7/7/20, revealed, in part: [Resident #33] has pressure injury to her coccyxAdminister treatments as ordered and monitor for effectiveness." On 10/20/21 at 9:55 a.m., ASM (administrative staff member) #1, the executive director, emailed the survey team with evidence that the facility uses Lippincott, seventh edition, as their professional standard of practice. On 10/21/21 at 11:15 a.m., RN #5, who had just completed providing Resident #33's wound care, was interviewed. When asked to review Resident #33's TAR specifically for wound treatments, RN #5 stated she could not identify any concerns. When shown two orders for treatment of the same wound, one for the wound to be cleansed with acetic acid, and the other for the wound to be cleansed with normal saline, RN #5 stated, "Oh. Yes." When asked if she had signed both orders on previous shifts, RN #5 stated she had. When asked which order she had followed, RN #5 stated, "Well, I just looked at them as the same order. You know." She stated she used the normal saline first, then the acetic acid to cleanse the wound. Then applied the dressing. When reminded of the observation that had just been completed of her administering Resident #33's wound care, RN #5 stated, "Well, no. I didn't do both that time." She stated the orders were | A BUILDING 495315 ROVIDER OR SUPPLIER ITE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 80 written on 6/9/21. Resident #33's TARs revealed nurse signatures indicating this treatment was administered on multiple dates in August, September, and October, 2021. A review of Resident #33's comprehensive care plan dated 6/9/20, and updated 7/7/20, revealed, in part: [Resident #33] has pressure injury to her coccyxAdminister treatments as ordered and monitor for effectiveness." On 10/20/21 at 9:55 a.m., ASM (administrative staff member) #1, the executive director, emailed the survey team with evidence that the facility uses Lippincott, seventh edition, as their professional standard of practice. On 10/21/21 at 11:15 a.m., RN #5, who had just completed providing Resident #33's wound care, was interviewed. When asked to review Resident #33's TAR specifically for wound treatments, RN #5 stated she could not identify any concerns. When shown two orders for treatment of the same wound, one for the wound to be cleansed with acetic acid, and the other for the wound to be cleansed with normal saline, RN #5 stated, "Oh. Yes." When asked if she had signed both orders on previous shifts, RN #5 stated she had. When asked which order she had followed, RN #5 stated, "Well, I just looked at them as the same order. You know." She stated she used the normal saline first, then the acetic acid to cleanse the wound. Then applied the dressing. When reminded of the observation that had just been completed of her administering Resident #33's wound care, RN #5 stated, "Well, no. I didn't do both that time." She stated the orders were | ROWDER OR SUPPLIER THE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 80 written on 6/9/21. 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| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | E | 10/20/2021 | |
| (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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 658 | treatments for Residinterview at the time. On 10/21/21 at 12:0 practical nurse) #2 vabout the process s two conflicting order contact the provider. On 10/20/21 at 4:50 staff member) #1, the director of clinic regional vice presiding these concerns. A carrier facility's standard of clarification was required. On 10/26/21 at 2:11 could not locate the Lippincott, seventh clarification. He stat policy. A review of the facil revealed, in part: "T physician orders are documented in the interpretation." | ordered both wound dent #33 was not available for e of the survey. 77 p.m., LPN (licensed was interviewed. When asked staff follows if a resident has rs, LPN #2 stated she would to get a clarification. 7 p.m., ASM (administrative ne executive director, ASM #2, all services, ASM #3, the ent of operations, and ASM ical nurse, were informed of copy of the text from the first practice regarding order quested. p.m., ASM #1 stated he requested information from edition, regarding order and the facility follows their executive will ensure that the appropriately and timely | F6 | 658 | | | |
| | loss Full-thickness loss of | re Injury: Full-thickness skin of skin, in which adipose (fat) r and granulation tissue and | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | C 10/26/2021 | |
| | NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | | DATE | |
| F 658 | Slough and/or eschar of tissue damage variareas of significant ac wounds. Undermining Fascia, muscle, tender and/or bone are not exposed to be cures the extent of Unstageable Pressure from the website https://cdn.ymaws.co.gr/online_store/npiap. | edges) are often present. I may be visible. The depth les by anatomical location; liposity can develop deep ly and tunneling may occur. In, ligament, cartilage exposed. If slough or eschar if tissue loss this is an le Injury." This injury is taken Im/npiap.com/resource/resm Im/npiap.com/res | F6 | 58 | | |
| F 677 | device. The injury car open ulcer and may be as a result of intense or pressure in combination tolerance of soft tissurals of be affected by mergusion, co-morbiditissue." This information that in the store of the | e for pressure, shear may | F€ | 77 | 12/1/21 | |
| SS=D | CFR(s): 483.24(a)(2) §483.24(a)(2) A resid out activities of daily I services to maintain of personal and oral hyo This REQUIREMENT by: | ent who is unable to carry iving receives the necessary good nutrition, grooming, and | | 1. Resident #53 receiving his showers | .2, 112 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | B. WING | | C 10/26/2021 | | |
| NAME OF P | ROVIDER OR SUPPLIER | 1000.10 | | | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 120/2021 | |
| TVAIVIL OF T | TOVIDER OR GOLT EIER | | | | 03 SOUTH MAIN ST | | | |
| CONSULA | TE HEALTH CARE OF W | OODSTOCK | | | | | | |
| | | | | | VOODSTOCK, VA 22664 | | | |
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| F 677 | Continued From page | ≥ 83 | F6 | 677 | | | | |
| | | document review, and , it was determined that the | | | per plan of care. | | | |
| | facility staff failed to p | orovide ADL (activities of stance to one resident r care, (Resident #53), in a | | | 2. Quality review of residents showers ensure showers are given per the plan care on 11/18/2021 | of | | |
| | hygiene and bathing, | sistance of staff for personal was not provided a shower staff on multiple occasions | | | 3. Nursing Staff re-education on provid activities of daily living for dependent residents including showers by DON/designee on 11/18/2021. 4. The Administrator is responsible for maintaining compliance. The | | | |
| | The findings include: | | | | DON/designee to complete quality monitor weekly for 4 weeks and then | | | |
| | 2/8/21 with diagnoses hardening and disinte bones, quadriplegia a recent MDS (minimur assessment with an Adate) of 9/6/21, Resignoderately impaired having scored 12 out | mitted to the facility on sincluding cerebral palsy, egration of the spinal cord and nerve pain. On the most m data set), a quarterly ARD (assessment reference lent #53 was coded as being for making daily decisions, of 15 on the BIMS (brief | | | monthly for 6 months to ensure compliance with showers per plan of c Follow up based on findings and repor to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021 | | | |
| | | tatus). He was coded as endent on the assistance of iene and bathing. | | | | | | |
| | parents requested to Resident #53's mother regarding the staff's laresident, particularly in resident. She stated to week or more without there were times whee the resident's hair for resident would have a | o.m., Resident #53 and his meet with the survey team. For reported concerns ack of ADL care for the n bathing/showering the the resident has gone at showering. She stated for the staff had not washed such a long time that the facue breakouts along his shair was so dirty and | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILD | | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CO 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | DDE | 10/20/2021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREI REGULATORY OR LSC IDENTIFYING INFORMATION) TAG | | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | | |
| F 677 | concerns to both AS member) #1, the ex the DCS (director or there has been turn "the facility just can #53 confirmed these are times when "no Resident #53 stated stretches of more the offered a shower, a He stated he was not assigned bath days was not offered any days, and that he dibed bath." A review of Resider revealed no evidence bathed and shower dates: 8/12/21 through 10/6/21; 9/10/21 through 10/6/21. A review of the bath Resident #53 revealed the state of the bath Resident #53 revealed the state of | she has reported these SM (administrative staff secutive director, and ASM #2, of clinical services). She stated over in the DCS position, and not keep any help." Resident se statements, and stated there body" is working the floor. If that he has gone through nan a week without being and without getting a bed bath, not certain which days were his a Resident #53 stated that he withing the floor in most" if and feel clean with "just a stated that he with the state of the resident being the flowing and between the following and help 15/21; 9/1/21 through and assignment sheet for a shower or bath on | F | 577 | | | | |
| | revealed the followi RN (registered nurs motherproceeded early regarding [Readvised her that I halready taken care A review of Resider | nt #53's progress notes ng note, written on 10/7/21 by ne) #5: "PC (phone call) from to tell me about her calling sident #53] needing a bath. eard about the call and it was of before she called in." nt #53's comprehensive care and most recently updated on | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG | (X: | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | , | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | FIX (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION DATE | | |
| F 677 | ADL self-care perform deficitBathing/Show trim and clean on bath necessaryprovide so or shower cannot be requires full assistant twice weekly/prn [as On 10/25/21 at 3:23 #5 was interviewed. Frecently reported to his showering because the RN #5 stated, as far She stated Resident shower aide, but the work a regular assign RN #5 stated when the receive a bath or show spoken multiple time nursing assistants) a "but they only have so She stated that on 10 mother had called to #53's not having receive a "wipe down she could not recall at the treceive a to her that Resident to been completed. Who bath records, RN #5 | part: "[Resident #53] has an mance vering: Check nail length and th day and as sponge bath when a full bath toleratedthe resident ce by staff with showering needed]." p.m., RN (registered nurse) She stated the resident had her that he had not been here was not enough staff. as she knew, this was true. #53's unit has an assigned aide is most often pulled to hament, due to lack of staff. his happens, residents do not haver. RN #5 stated she had so to the CNAs (certified bout bathing Resident #53, on much time in their day." 10/7/21, Resident #53's complain about Resident eived a bath/shower recently. Already spoken to the aides sted she assumes when the is a shower or bath, they it or bed bath. She stated a CNA specifically reporting #53's bath or shower had not en shown Resident #53's stated the records looked | F | 577 | | | | |
| | resident had received of blanks on the show On 10/25/21 at 3:42 | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | (X | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZI 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | IP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | ACTION SHOULD BE FO THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 677 | facility. CNA #12 state gone for long stretch or bath. She stated stime to give him a be so, she would docum. She stated there was working the unit to gishower. On 10/26/21 at 3:42 staff member) #2, the was interviewed. She shower schedule, bushowers need to be goto either resident or stresidents should be days each week. ASI responsible for giving the baths as given in She stated Resident aide, and the shower giving most of the shistated if showers are should report this to should document this record. She stated shoccasions when the sassigned to other dutadditional staff. On 10/26/21 at 3:50 were informed of the evidence verifying Resident and the shower giving most of the dutadditional staff. | e 86 se was admitted to the ed the resident has "for sure" es of time without a shower he did not usually have the d bath. She stated if she did sent it on the bath record. If frequently not enough staff we Resident #53 a bath or sp.m., ASM (administrative edirector of clinical services, estated all residents have a st sometimes, baths or given on a different day, cue staffing needs. She stated offered a bath or shower two M #2 stated the CNAs are gishowers, and for recording the resident's clinical record. #53's unit has a shower aide is responsible for owers on the unit. ASM #2 not accomplished, the CNA the nurse, and the nurse in the resident's clinical ne was aware of some shower aide had been the shower and the | F | 577 | | | |
| | A review of the facility "Bathing/Showering," | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION NG | , , , | ATE SURVEY OMPLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 684 SS=D | provided at least twice needed) to cleanse a resident shall be ask a frequency schedule will take precedence PRN cleansing." | e 87 wering and bathing will be ce a week and PRN (as and refresh the resident. The ed on admission to establish e for bathing. This schedule over the twice a week and n was provided prior to exit. | | 584 | | 12/1/21 |
| | applies to all treatmet facility residents. Base assessment of a resithat residents received accordance with propractice, the comprescare plan, and the restriction of the resident in the staff interview, facility clinical record review facility staff failed to maintain the highest 41 residents in the stand #129. 1. The facility staff failed to maintain the highest 41 residents in the stand #129. 1. The facility staff failed to maintain the highest 41 residents in the stand #129. | andamental principle that and care provided to sed on the comprehensive dent, the facility must ensure the treatment and care in fessional standards of thensive person-centered sidents' choices. To is not met as evidenced and the evident of the evidence | | 1. The physician was noti 26. Res #129's physician 2. Residents with physicial fluid restrictions were reviewed weekly were resident's obtained per physician administration reviewed to ensure over-the medications are available administered per the physic Follow up based on finding 3. The Director of Nursing designee re-educated the | was notified. n's orders for ewed. Residents re reviewed to ysician's orders. records (MAR) ne counter and ician's orders. gs. | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING_ | | | | C | | |
| NAME OF B | | 493313 | D. WING_ | | TREET ADDRESS SITV STATE ZID SODE | 10 |)/26/2021 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| CONSUL | ATE HEALTH CARE O | F WOODSTOCK | | | 03 SOUTH MAIN ST | | | | |
| | | | | ۷ | VOODSTOCK, VA 22664 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | ' STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | | |
| F 684 | Continued From pa | age 88 | F 6 | 684 | following physician's orders, weighing | | | | |
| | 1 | aff failed to obtain Resident | | | residents, fluid restrictions, and the | | | | |
| | #129's weekly weig 8/16/21. | ght per physician's order on | | | process for obtaining over-the-counter medications. | | | | |
| | The findings include | le: | | | The DON/designee to conduct a random QI (Quality Improvement) | | | | |
| | | as admitted to the facility on | | | monitoring of F684 to ensure care and | | | | |
| | · · | recently readmitted on 8/24/21, | | | services to maintain the highest level o | f | | | |
| | 1 | luding diabetes, peripheral | | | well-being weekly for 4 weeks then | | | | |
| | | d end stage kidney disease. On | | | monthly for 6 months. Findings to be | | | | |
| | | DS (minimum data set), a | | | reviewed via Quality Assurance | | | | |
| | | ent with an ARD (assessment | | | Performance Improvement (QAPI) | | | | |
| | | 7/23/21, Resident #26 was | | | Committee Meeting and updated as indicated. QI schedule modified based | on | | | |
| | 1 | gnitively intact for making daily scored 15 out of 15 on the | | | | OH | | | |
| | | ew for mental status). He was | | | findings. | | | | |
| | , | eceived dialysis services during | | | 5. 12/01/2021 | | | | |
| | the look back perio | | | | 0. 12/01/2021 | | | | |
| | revealed the follow restriction: 1200 m Dietary: Breakfast 240 ml = 720 with | ent #26's physician's orders, ving order, dated 12/9/20: "Fluid Il/day (milliliters per day). 240 ml, lunch 240 ml, dinner meals. Nursing 7a - 7p = 240. 0 ml with meds (medications) restriction." | | | | | | | |
| | administration reco for October 2021 for exact amount of flu | ent #26's MARs [medication ord] and Point of Care records ailed to reveal evidence of the uids Resident #26 received on y 24 hour period in total. | | | | | | | |
| | | ry instruction slip for dinner on , in part: "6 oz (ounce) tea of uid restriction." | | | | | | | |
| | A review of Reside | ent #26's comprehensive care | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONSTRUCT | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | 1 | C 26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRE | | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PREFIX (EACH CORRECTIVE ACTION SHOU | | | (X5) COMPLETION DATE |
| F 684 | r/t (related to) renal (signs1200 ml/day noncompliant at time) On 10/20/21 at 1:44 nurse) #1 was interved calculates if a reside restriction, she state much fluid she is gives he is offering the rewident receives on the CNAs document of care records. When for calculating a total by a resident for a 24 "That's an excellent "someone should be is actually doing it. Wimportant to know expresident is drinking, son dialysis, too much kidneys even more. | esident #26] needs dialysis (kidney) failuremonitor vital fluid restriction. He is es." p.m., LPN (licensed practical iewed. When asked how she nt is compliant with a fluid d she only documents how ing with medications, or if sident something to drink. cuments how much fluid a a meal tray, LPN #1 stated this information on the point en asked who is responsible amount of fluids consumed 4 hour period, LPN #1 stated, question." LPN #1 stated, "but she doesn't know who when asked why it would be eactly how much fluid a she stated if the resident is in fluid could harm their | F | 584 | DEFICIENCY) | | |
| | assistant) #2 was int she documents for re restriction, she state percentage of a mea CNA #2 stated there care system to docu fluid a resident receir On 10/20/21 at 4:50 staff member) #1, the the director of clinical | p.m., CNA (certified nursing erviewed. When asked what esidents who are on a fluid d she can only document the all the resident has eaten. is no place on the point of ment an exact amount of ves with meals. p.m., ASM (administrative e executive director, ASM #2, all services, ASM #3, the ent of operations, and ASM | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | l | C 26/2021 | |
| | ROVIDER OR SUPPLIER | OODSTOCK | | 803 S | ET ADDRESS, CITY, STATE, ZIP CODE OUTH MAIN ST IDSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE | |
| F 684 | these concerns. The provide evidence of Fintake for the gaps ide. A review of the facility revealed, in part: "Refluid intake within the the attending physician notified on limitations. No further information 2. a. Resident #129 w 4/22/21 and readmitte #129's diagnoses inclining blood pressure, Resident #129's quar assessment with an a of 10/3/21, coded the severely impaired. Review of Resident # revealed a physician's guaifenesin liquid 100 (milliliters). Give 10 m for a cough for 15 day. Resident #129's Sept (medication administrate order for guaifenee (milligrams)/5 ml (millimouth every four hou On 9/28/21 at 12:00 p at 4:00 a.m. and 8:00 | al nurse, were informed of facility staff were asked to desident #26's recorded fluid entified above. If policy, "Fluid Restrictions," sidents receive adequate limitations determined by anCaregivers will be anCaregi | F | 684 | | | | |
| | ' | ne nurse did not document ng administered. The MAR e, "9=other/See Nurse | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | 1 | C 0/26/2021 | |
| | ROVIDER OR SUPPLIER | /OODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 0/20/2021 | |
| (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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 684 | order from supply." A 9/28/21 documented, nurse's note dated 9/2 not available." Anoth 9/29/21 documented, nurse's note dated 9/2 not available." Resident #129's com 6/25/21 failed to docu guaifenesin administr On 10/20/21 at 1:41 pconducted with LPN ((the nurse who docur notes). LPN #1 state counter medication the facility. LPN #1 state medication is due for the medication cart the obtained from anothed over the counter medication the available for administ LPN #1 stated Resider readmitted to the faci guaifenesin stocked in was waiting to obtain pharmacy. Review of the facility stock list revealed guain house. | 9/28/21 documented, "on another nurse's note dated "on supply order." A 29/21 documented, "drug er nurse's note dated "drug not available." A 30/21 documented, "drug aprehensive care plan dated ament information regarding ation. o.m., an interview was licensed practical nurse) #1 mented the 9/28/21 nurses' d guaifenesin is an over the last is kept in stock in the dif an over the counter administration and is not on the medication cart or in the ication supply closet. In 129's guaifenesin not being ration in September 2021, ent #129 had been lity and there was no in house at the time so she the medication from the cover the counter medication aifenesin was kept in stock | F 6 | 84 | | | |
| | staff member) #1 (the | a.m., ASM (administrative e executive director) and of clinical services) were pove concern. | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | | OMPLETED |
|--------------------------|--|---|---------------------|--|-----------|----------------------------|
| | | 495315 | B. WING | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | ' | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 684 | Continued From pa | ge 92 | F 68 | 34 | | |
| | failed to document in the counter medical kept in house. | or medication administration instructions for obtaining over tions that are supposed to be on was presented prior to exit. | | | | |
| | Reference: | on was presented pilot to onti- | | | | |
| | This information wa | sed to treat chest congestion. s obtained from the website: gov/druginfo/meds/a682494.h | | | | |
| | revealed a physicia | ident #129's clinical record n's order dated 6/19/21 for a y day shift every Monday. | | | | |
| | 6/25/21 documente for weight changes status r/t (related to (pneumonia, respira | mprehensive care plan dated d, "(Resident #129) is at risk and altered nutritional/fluid) dx (diagnosis) COVID, PNA atory failure, and labs per order/protocol" | | | | |
| | list and August 202 administration reco weight was obtaine | #129's August 2021 weight 1 MAR (medication rd) revealed the resident's d on 8/9/21 and 8/23/21 but any other date during that | | | | |
| | facility staff were ur | d 8/16/21 documented the nable to obtain Resident at date due to staffing issues. | | | | |
| | On 10/20/21 at 1:41 | I p.m., an interview was | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | | 7. BOILD | | | (| с |
| | | 495315 | B. WING | | | 10/ | 26/2021 |
| | ROVIDER OR SUPPLIER | OODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | (X5) COMPLETION DATE |
| F 684 | the nurse who docum #1 stated the CNAs (or are responsible for or she tries to help wher 8/16/21 was a really be staffing and the staff or Resident #129's weig On 10/20/21 at 5:12 properties of the above the staff member) #1 (the ASM #2 (the director made aware of the above the staff or a staff member) #1 (the ASM #2 (the director made aware of the above the staff or a staff member) #1 (the ASM #2 (the director made aware of the above the staff or a staff or | licensed practical nurse) #1, ented the above note. LPN certified nursing assistants) patining resident weights but a she can. LPN #1 stated and day due to a lack of was unable to obtain ht. b.m., ASM (administrative executive director) and of clinical services) were cove concern. d, "Weighing the Resident" ints will be weighed unless the physician: siion x3 days | F | 684 | | | |
| | Treatment/Svcs to Pro CFR(s): 483.25(b)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1) | rity re ulcers. hensive assessment of a nust ensure that- s care, consistent with les of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent | F | 686 | | | 12/1/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | 1 | 26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | 80 | REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MAIN ST OODSTOCK, VA 22664 | 1 10// | 20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 686 | promote healing, previous relief rence date) of 7/2 coded as being cognidecisions, having scc BIMS (brief inderview). | vent infection and prevent sloping. is not met as evidenced n, staff interview, facility declinical record review, it the facility failed to provide the treatment of a pressure sidents in the survey sample, 33. If to provide preventative eents, and failed to provide ent #26's pressure ulcer and ure ulcer on multiple dates | F6 | 586 | 1. The physician was notified for Res at 33. 2. Facility review to identify and address declines in skin integrity was conducted ensure care and services for the treatment of pressure ulcers. 3. Nursing staff were re-educated by the Director of Nursing (DON)/designee on the facility's Clinical Guideline for Skin Wound. 4. The DON/ designee to conduct rand QI monitoring of F686 to ensure preventative pressure ulcer or pressure ulcer treatments, as indicated, are in place weekly for 4 weeks then monthly 6 months. Findings to be reviewed via Quality Assurance Performance Improvement (QAPI) Committee Meeti and updated as indicated. QI schedule modified based on findings. 5. 12/01/2021 | es d to ne & om e | | |
| | staff for bed mobility, hygiene, and bathing received dialysis serv period. He was coded ulcers (1), both at sta | dressing, toileting, personal He was coded as having rices during the look back as having two pressure | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | | 26/ 2021 |
| | ROVIDER OR SUPPLIER | woodstock | • | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 686 | medication administration record administration record "Clean wound to righ Normal saline, pat disposed absorbent material) adressing." This order discontinued 9/6/21. revealed blanks for a treatment order on 8 "Preventative skin cate ach incontinent epis needed to prevent sl was written 12/9/20. revealed blanks for a 8/3/21, 8/4/21, 8/5/2 9/25/21, 9/27/21, 10/19/21, 1 | at #26's clinical record ag physician's orders and ration records, as TARs (treatment ds): at and left buttock with ry, apply maxorb (an and cover with foam r was written 7/23/21 and Resident #26's TARs administration of this r/9/21 and 8/12/21. are: apply skin barrier after sode every shift and as kin breakdown." This order Resident #26's TARs administration of this order on 1, 8/10/21, 8/11/21, 9/14/21, 29/21, 9/30/21, 0/8/21, 0/15/21, 10/18/21, and ccyx with NS (normal saline), dene (dressing) and cover Change Q (every) day and his order was written 9/18/21 17/21. Is revealed blanks for Is order on 9/22/21, 9/27/21, | F | 686 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | CODE | 10/20/2021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE | TION SHOULD BE THE APPROPRIA | | | |
| F 686 | was written on 9/18// 10/7/21. Resident #2 administration of this 9/28/21, 10/1/21, 10// "Right upper buttock dry, apply silvadene, Change dressing if s day shift." This order discontinued on 9/28/revealed blanks for a 9/22/21, 9/27/21. 9/2/ 10/3/21, and 10/7/21 A review of Resident revealed no gaps in of the wound. The w during the period of entrance. No other w this time frame. A review of Resident plan dated 7/27/20, a 9/24/21, revealed, in pressure injuryrela to lay (sic) side to sid ordered and monitor #26] has potential im per order." On 10/20/21 at 1:44 nurse) #1 was interv documents a pressu has completed it, LP the electronic medica signature shows up a mark in the box for the treatment is due. Wh | 21 and discontinued on 26's TARs revealed blanks for 36 order on 9/22/21, 9/27/21, 9/3/21, and 107/21. Cleanse area with NS, pat and cover with dry dressing. Soiled or loosened prn every awas written on 9/18/21 and 3/21. Resident #26's TARs administration of this order on 28/21, 9/30/21, 10/1/21, | Fé | 586 | | | | |

| AND DI AN OF CORRECTION IN INDEST. | | ` ′ | PLE CONSTRUCTION B | COMPL | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | 10/2 | 6/2021 |
| | PROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 1 10/2 | 0/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 686 | "There's no way of k documented, it did not resident #26's TARs October 2021, and a for the resident's pre #6 stated, "If it's not done." On 10/20/21 at 2:26 nurse) #7 was intervite blanks on the TA stated if there are blasay the treatments who is the treatment of the director of clinical regional vice preside #4, the regional clinical these concerns. The provide evidence that for pressure ulcers hordered by the physical above. A review of the facility Skin & Wound," revestigated by the physical concerns are individual intervention monitoring as indicated goals and intervention mo | nowing. If it's not of happen." When shown of for August, September, and sked to interpret the blanks assure ulcer treatments, LPN documented, it was not documented, it was not p.m., LPN (licensed practical lewed. When asked about Rs for Resident #26, LPN #7 anks, then she would have to be executive director, ASM #2, I services, ASM #3, the not of operations, and ASM cal nurse, were informed of facility staff were asked to the Resident #26's treatments and been administered as cian on the dates identified by policy, "Clinical Guidelines aled in part: "To provide a giskin at risk, implementing ins including evaluation and edDevelop individualized | F 68 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | LE CONSTRUCTION | , , | COMPLETED | | |
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| | | 495315 | B. WING | | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | , | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE | | |
| F 686 | as a result of intension pressure in combit tolerance of soft tiss may also be affected perfusion, co-morbit and condition of the is taken from the whittps://cdn.ymaws.cgr/online_store/npia. (2) "Stage 3 Pressure loss Full-thickness loss is visible in the ulce epibole (rolled wour Slough and/or eschof tissue damage vareas of significant wounds. Undermini Fascia, muscle, ten and/or bone are not obscures the extent Unstageable Pressure from the website https://cdn.ymaws.cgr/online_store/npia. | be painful. The injury occurs are and/or prolonged pressure bination with shear. The sue for pressure and shear and by microclimate, nutrition, dities a soft tissue." This information bebsite com/npiap.com/resource/resm ap_pressure_injury_stages.pdf are Injury: Full-thickness skin of skin, in which adipose (fat) are and granulation tissue and and edges) are often present. The depth aries by anatomical location; adiposity can develop deep and tunneling may occur. Indon, ligament, cartilage to exposed. If slough or eschart of tissue loss this is an ure Injury." This injury is taken com/npiap.com/resource/resm ap_pressure_injury_stages.pdf as admitted to the facility on excently readmitted on 6/23/20, | F 68 | | | | | |
| | 1/6/16, and most re with diagnoses of d and dementia. On t (minimum data set) an ARD (assessme Resident #33 was o | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C |
|---|---|--|---------------------|---|------------------------------|
| | | 495315 | B. WING | | 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | , |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETION |
| F 686 | Continued From pa | ge 99 | F 68 | 6 | |
| | BIMS (brief intervieresident was coded assistance for all ad #33 was coded as lulcer (2). | ot able to be interviewed for the w for mental status). The las being dependent on staff ctivities of daily living. Resident having a Stage 3 (1) pressure | | | |
| | On 10/21/21 at 10:51 a.m., observation was made of RN (registered nurse) #5 providing wound care to Resident #33. RN #5 removed the old dressing from Resident #33's sacrum. She changed gloves, sanitized her hands, and donned new gloves. She cleansed the wound with acetic acid, applied Maxine Alginate to the wound, and covered the wound with an adhesive foam | | | | |
| | her hands. RN #5 r 1.4 cms (centimete The wound bed wa (healing) tissue. No | neasured the sacral wound at rs) X (by) 0.8 cms X 0.3 cms. s 100% beefy red granulation concerns were identified with the tent during the observation. | | | |
| | A review of Resident #33's clinical record revealed the following physician's orders and medication administration records, as documented on the TARs (treatment administration records) for August, September, and October 2021: | | | | |
| | miscellaneous ever (pressure injury) to to sacrum with 2% collagen/maxorb (d dressing daily and p was written 3/20/21 revealed blanks for 8/7/21, 9/25/21, 9/2 | on 2% 10 ml (milliliters) by day shift for Stage 3 Pl sacrum. Cleanse Stage 3 Pl acetic acid, pat dry, apply ressing), cover with foam prn (as needed)." This order . Resident #33's TARs administration of this order on 16/21, 9/30/21, 10/1/21, 10/10/21, 10/15/21, and | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | ZIP CODE | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY) | |
| F 686 | dry, and apply collage foam dressing every written on 6/9/21. Resolvants for administration 9/25/21, 9/26/21, 9/3 10/10/21, 10/15/21, and a review of Resident revealed no gaps in of the wound. The weather during the period of the entrance. No other weather that the period of the entrance of the entrance. A review of Resident plan dated 6/9/20, and in part: [Resident #33 coccyxAdminister that the monitor for effectiver on 10/20/21 at 1:44 nurse) #1 was interved ocuments a pressure has completed it, LP the electronic medical signature shows up a mark in the box for the treatment is due. When TAR should be interpreted in the president #33's TARS october 2021, and a for the resident's president's president | nd with normal saline, pat en/maxorb covered by a day shift." This order was esident #33's TARs revealed ation of this order on 8/7/21, 0/21, 10/1/21, 10/9/21, and 10/18/21. #33's wound tracking measurements and staging ound had not worsened August 2021 through survey younds had developed during #33's comprehensive care and updated 7/7/20, revealed, 3] has pressure injury to her treatments as ordered and ness. p.m., LPN (licensed practical fewed. When asked how she re ulcer treatment once she N #1 stated she signs it on all record. She stated her as her initials and a check ne specific date and time a nereted, LPN #1 stated, | F | 586 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
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| | | 495315 | B. WING | | 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 1 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE COMPLETION | |
| F 686 | Continued From pa | ige 101 | F 68 | 6 | | |
| | nurse) #7 was inter the blanks in TARs stated if there are be say the treatments On 10/20/21 at 4:50 staff member) #1, the director of clinic regional vice presion #4, the regional clir these concerns. The provide evidence the for pressure ulcers | 5 p.m., LPN (licensed practical viewed. When asked about for Resident #33, LPN #7 planks, then she would have to were not done. 5 p.m., ASM (administrative he executive director, ASM #2, cal services, ASM #3, the lent of operations, and ASM nical nurse, were informed of the facility staff were asked to nat Resident #33's treatments had been administered as sician on the dates identified | | | | |
| | Skin & Wound," rev system for identifyii individual interventimonitoring as indicagoals and intervent. No further information in the local system for identifying as indicagoals and intervent. REFERENCES (1) "Stage 3 Pressuloss Full-thickness loss is visible in the ulcal epibole (rolled wound Slough and/or eschof tissue damage vareas of significant wounds. Underminity Fascia, muscle, terminity individuals in the local epibole (rolled wounds) and the local epibole (rolled wounds) are epibole (rolled wounds). | lity policy, "Clinical Guidelines realed in part: "To provide a ng skin at risk, implementing ons including evaluation and atedDevelop individualized ions." ion was provided prior to exit. are Injury: Full-thickness skin of skin, in which adipose (fat) er and granulation tissue and nd edges) are often present. har may be visible. The depth aries by anatomical location; adiposity can develop deep ing and tunneling may occur. Indon, ligament, cartilage t exposed. If slough or eschar | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | | | _ | | | С |
| NAME OF D | | 495315 | B. WING | | TREET ARRESTON OF THE TIP CORE | 10/ | 26/2021 |
| | ROVIDER OR SUPPLIER | /OODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST //OODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 686 | Unstageable Pressure from the website https://cdn.ymaws.co.gr/online_store/npiap. (2) "A pressure injury skin and underlying sbony prominence or r device. The injury car open ulcer and may bas a result of intense prolonged pressure owith shear. The tolera pressure and shear microclimate, nutritior and condition of the sis taken from the web https://cdn.ymaws.co. | of tissue loss this is an e Injury." This injury is taken m/npiap.com/resource/resm_pressure_injury_stages.pdf is localized damage to the oft tissue usually over a elated to a medical or other in present as intact skin or an one painful. The injury occurs and/or in pressure in combination ance of soft tissue for may also be affected by in, perfusion, co-morbidities oft tissue." This information | F | 686 | | | |
| F 690 SS=D | admission receives so maintain continence used condition is or become not possible to maintain §483.25(e)(2)For a reincontinence, based of comprehensive assessensure that- | nce. cility must ensure that the sent of bladder and bowel on the ervices and assistance to surless his or her clinical the es such that continence is the sain. | F | 690 | | | 12/1/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | 495315 | B. WING | | C 10/26/2021 | |
| NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF W | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY) | BE COMPLETION | |
| resident's clinical concatheterization was no (ii) A resident who en indwelling catheter or is assessed for removas possible unless the demonstrates that call and (iii) A resident who is receives appropriate prevent urinary tract is continence to the extension of the extension | not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's esment, the facility must to who is incontinent of bowel treatment and services to hal bowel function as is not met as evidenced in, staff interview and clinical determined that the facility care and services for a conference of 41 residents in the dents #28 and #331. Iled to maintain Resident eatheter (1) tubing and bag in infections. The resident's observed directly touching | F 69 | 1. Res #28 suffered no apparent har from catheter tubing and bag directly touching the floor. The physician wa notified for Res # 331 and consult wi urology ordered. 2. Facility review of residents with a catheter was conducted to ensure me justification and catheters are in a mato prevent infections. 3. The DON/designee re-educated the nursing staff on obtaining medical justification for Foley catheters and to maintain catheters in a manner to preinfections. | s ith Foley edical anner | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | 10 | C 0/26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 3/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| F 690 | 4/21/20. Resident #2 were not limited to comuscle weakness an quarterly minimum da assessment reference resident's cognition at Review of Resident #2 a physician's order data theter due to urinate Resident #28's comp 3/15/21 documented, Indwelling Foley Cathobstructive uropathy. Indwelling Foley Cathobstructive uropathy. Indwelling and bag position of 10/20/21 at 11:29 observed in a low beautioning and bag was composed on 10/20/21 at 1:41 pronducted with LPN producted with LPN produc | admitted to the facility on 88's diagnoses included but ingestive heart failure, didementia. Resident #28's at a set assessment with an ele date of 8/31/21, coded the sign moderately impaired. 28's clinical record revealed ated 3/23/21 for a Foley retention. The care plan dated "(Resident #28) has neter r/t (related to) Position catheter bag and of the bladder and away door." The care plan did not in regarding the catheter on in relation to the floor. A.m., Resident #28 was did. The resident's catheter lirectly touching the floor. D.m., an interview was (licensed practical nurse) #1. dent's catheter tubing and the floor because of one and it is a tripping of chinical services) were | F 69 | 4. The DON/ designee to corr QI monitoring of F690 to ensign justification and catheters are to prevent infections weekly in then monthly for 6 months. Freviewed via Quality Assurant Performance Improvement (Committee Meeting and updaindicated. QI schedule modification of the provential schedule indicated. Section 12/01/2021 | ure medical e in a manner for 4 weeks Findings to be nce QAPI) ated as | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C | | |
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| | | 495315 | B. WING | | 1 | 0/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | - | | | |
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| F 690 | Continued From pa | ge 105 | F 69 | 0 | | | | |
| | | egarding urinary catheter care specific information regarding | | | | | | |
| | No further informati | on was presented prior to exit. | | | | | | |
| | Reference: | | | | | | | |
| | to drain and collect information was ob https://medlineplus. 2. Resident #331 w 5/26/21, and most recent MDS (rassessment with ar date) of 7/30/21, Rebeing severely coglidaily decisions, have the BIMS (brief inter Resident #331 was catheter in her blad look back period. Sincontinent of urine On 10/19/21 at 11:10bserved as she was wheelchair down the catheter collection of the solution of the sol | ter is a tube placed in the body urine from the bladder." This tained from the website: gov/ency/article/003981.htm as admitted to the facility on recently readmitted on loses including a broken right history of a stroke. On the minimum data set), a quarterly a ARD (assessment reference resident #331 was coded as nitively impaired for making ring scored three out of 15 on review for mental status. coded as not having a der for urination during the he was coded as always during the look back period. 15 a.m., Resident #331 was as being pushed in her he hall by a staff member. A bag, covered with a privacy and hanging on the wheelchair | | | | | | |
| | revealed, in part: "F designating cathete | nt #331's physician's orders Foley catheter 16 FR (French, er size)/10 cc (cubic n." The order was written | | | | | | |

| OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | | (X3) DATE SURVEY COMPLETED | |
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| | 495315 | B. WING _ | | | C 10/26/2021 | |
| | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP COI 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | • | 10/20/2021 | |
| (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | ID PREFIX TAG | (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE | |
| 10/13/21, and did not need for the urinary A review of Resider plan dated 6/9/21 farelated to the resided On 10/20/21 at 4:50 staff member) #1, the director of clinic regional vice presid #4, the regional clinic these concerns. On 10/21/21 at 8:30 staff member) #2, the was interviewed. We to have a diagnosis a urinary catheter, a risk of causing urinesidents. She state readmitted from the the facility staff should agnosis. ASM #2 was discharged to the she did not have a discharged to the the facility staff should in the second from the facility catheter in practitioner looks the catheter. If there is the catheter should On 10/21/21 at 10:1 practitioner, was intitle use of a urinary | ot include a diagnosis for the catheter. In #331's comprehensive care alled to reveal any information ent having a urinary catheter. In p.m., ASM (administrative the executive director, ASM #2, all services, ASM #3, the ent of operations, and ASM ical nurse, were informed of the director of clinical services, then asked why it is important that would indicate a need for the ASM #2 stated catheters carry the navitation of the director of clinical services, then asked why it is important that would indicate a need for the ASM #2 stated catheters carry the navitation of the director of clinical services, then asked why it is important that would indicate a need for the ASM #2 stated catheters carry the navitation of the director of clinical services, then asked when a resident is thospital with a new catheter, all look for an appropriate stated when Resident #331 the hospital from the facility, the proposition of the complete of the not an appropriate diagnosis, the removed. In a.m., ASM #6, the nurse erviewed. When asked about catheter, ASM #6 stated, "I | F | 690 | | | |
| | ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIEN REGULATORY OF Continued From particular and did not need for the urinary A review of Resider plan dated 6/9/21 farelated to the resided On 10/20/21 at 4:50 staff member) #1, the director of clinic regional vice presid #4, the regional clin these concerns. On 10/21/21 at 8:36 staff member) #2, the was interviewed. We to have a diagnosis a urinary catheter, a risk of causing urinary catheter, a risk of causing urinary catheter, a risk of causing urinary catheter and the facility staff should agnosis. ASM #2 was discharged to the she did not have a treturned from the hurinary catheter in practitioner looks the the resident for the catheter. If there is the catheter should On 10/21/21 at 10:1 practitioner, was interviewed in the use of a urinary know what the regulated the use of the stated the use o | ATE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 10/13/21, and did not include a diagnosis for the need for the urinary catheter. A review of Resident #331's comprehensive care plan dated 6/9/21 failed to reveal any information related to the resident having a urinary catheter. On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of | ROVIDER OR SUPPLIER ATE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 10/13/21, and did not include a diagnosis for the need for the urinary catheter. A review of Resident #331's comprehensive care plan dated 6/9/21 failed to reveal any information related to the resident having a urinary catheter. On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns. On 10/21/21 at 8:36 a.m., ASM (administrative staff member) #2, the director of clinical services, was interviewed. When asked why it is important to have a diagnosis that would indicate a need for a urinary catheter, ASM #2 stated catheters carry a risk of causing urinary tract infections for residents. She stated when a resident is readmitted from the hospital with a new catheter, the facility staff should look for an appropriate diagnosis. ASM #2 stated when Resident #331 was discharged to the hospital from the facility, she did not have a urinary catheter. When she returned from the hospital on 10/13/21, she had a urinary catheter in place. She stated the nurse practitioner looks through the chart and assesses the resident for the appropriate use of the catheter. If there is not an appropriate diagnosis, the catheter should be removed. On 10/21/21 at 10:10 a.m., ASM #6, the nurse practitioner, was interviewed. When asked about the use of a urinary catheter, ASM #6 stated, "I know what the regulations say about that." She stated the use of the catheter is dependent on the | ROYLOR OR SUPPLIER ATE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 10/13/21, and did not include a diagnosis for the need for the urinary catheter. A review of Resident #331's comprehensive care plan dated 6/9/21 failed to reveal any information related to the resident having a urinary catheter. On 10/20/21 at 4:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns. On 10/21/21 at 8:36 a.m., ASM (administrative staff member) #2, the director of clinical services, was interviewed. When asked why it is important to have a diagnosis that would indicate a need for a urinary catheter, ASM #2 stated catheters carry a risk of causing urinary tract infections for residents. She stated when a resident is readmitted from the hospital with a new catheter, the facility staff should look for an appropriate diagnosis. Sh #3 stated when Resident #331 was discharged to the hospital from the facility, she did not have a urinary catheter. When she returned from the hospital on 10/13/21, she had a urinary catheter in place. She stated the nurse practitioner looks through the chart and assesses the resident for the appropriate use of the catheter. If there is not an appropriate diagnosis, the catheter is of an appropriate diagnosis, the catheter serious what the regulations say about that. 'She had sated the use of a urinary catheter, ASM #6 stated, "I know what the regulations say about that.' She stated the use of the catheter is dependent on the best atted the use of the catheter is dependent on the | A BUILDING BY WIND STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK SUMMERY STATEMENT OF DEFICIENCIES 102 SOUTH MAIN ST WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES 12 SOUTH MAIN ST WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES 12 SOUTH MAIN ST WOODSTOCK, VA 22664 SUMMARY STATEMENT OF DEFICIENCIES 12 SOUTH MAIN ST WOODSTOCK, VA 22664 Continued From page 106 F 690 Tol/3/21, and did not include a diagnosis for the need for the urinary catheter. A review of Resident #331's comprehensive care plan dated 6/9/21 failed to reveal any information related to the resident thaving a urinary catheter. ASM #3, the regional vice president of operations, and ASM #4, the regional clinical nurse, were informed of these concerns. On 10/21/21 at 4:50 p.m., ASM (administrative staff member) #2, the director of clinical services, was interviewed. When asked why it is important to have a diagnosis that would indicate a need for a urinary catheter, ASM #2 stated catheters carry a risk of causing urinary tract infections for residents. She stated when resident is readmitted from the hospital with a new catheter, the facility staff should look for an appropriate diagnosis. ASM #2 stated when Resident #331 was discharged to the hospital from the facility, she did not have a urinary catheter. When she returned from the hospital on 10/13/21, she had a urinary catheter in place. She stated the nurse practitioner was interviewed. When asked about the use of a urinary catheter, ASM #6 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | C 26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 695 SS=D | She stated she had re clinical record, and di qualifying diagnosis fe stated the catheter sh removed. A review of the facility Urinary," revealed no qualifying diagnoses urinary catheter. No further information REFERENCES 1. "A urinary catheter tube placed in the bod from the bladder." The the website https://medlineplus.go. Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and tracheal succare, consistent with practice, the comprehear and 483.65 of this sul This REQUIREMENT by: Based on observation document review and determined that the face in the care plan is the face of the component review and determined that the face of the care plan is the face of the component review and determined that the face of the care plan is the face of the care plan is the review and determined that the face of the care plan is the face of the care plan is the review and determined that the face of the care plan is the face of the care plan is the face of the care plan is the | n readmission to the facility. eviewed Resident #331's d not see any evidence of a for the urinary catheter. She hould have already been of policy, "Catheter Care, information related to for residents to utilize a n was provided prior to exit. (brand name Foley) is a dy to drain and collect urine is information is taken from ov/ency/article/003981.htm. stomy Care and Suctioning or care, including and tracheal suctioning. ure that a resident who e, including tracheostomy etioning, is provided such professional standards of nensive person-centered ats' goals and preferences, | F6 | | | 12/1/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION (X | |) DATE SURVEY COMPLETED |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | E, ZIP CODE | 10/20/2021 |
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| F 695 | sample, Resident #1 The facility staff adm #129 without a phys The findings include Resident #129 was 4/22/21. Resident # were not limited to h and COVID-19. Res minimum data set as assessment referencesident's cognition Review of Resident orders failed to reve oxygen. Resident #129's con 6/25/21 failed to reve oxygen administration On 10/19/21 at 8:52 Resident #129 was receiving oxygen at cannula connected to that was running. On 10/20/21 at 1:41 conducted with LPN LPN #1 stated nurse oxygen administration medication that enter On 10/20/21 at 5:12 staff member) #1 (the | 41 residents in the survey 129. Ininistered oxygen to Resident icians order. : admitted to the facility on 129's diagnoses included but igh blood pressure, diabetes sident #129's quarterly seessment with an ce date of 10/3/21, coded the as severely impaired. #129's current physician al a physician's order for on prehensive care plan dated eal documentation regarding on. a.m. and 10:09 a.m., observed in their room, 1.5 liters per minute via nasal o an oxygen concentrator p.m., an interview was (licensed practical nurse) #1. es must obtain an order for on because oxygen is a | F | oxygen was conducterespiratory services of professional standard identified were correct. 3. The DON/designee nursing staff on the fatherapy policy. 4. The DON/ designee QI monitoring of F695 respiratory services of professional standard weeks then monthly for Findings to be review. Assurance Performant (QAPI) Committee Meas indicated. QI sched on findings. 5. 12/01/2021 | onsistent with Is. Any issues sted immediately. e re-educated the acility's oxygen e to conduct random to to ensure onsistent with Is weekly for 4 or 6 months. ed via Quality nce Improvement eeting and updated | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 1 10/20/2021 |
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| F 695 | made aware of the all The facility policy title of Practice" document treatments shall be g order." The facility policy title documented, "Physic therapy shall include: -Administration moda -FiO2 (fraction of insp -Continuous or PRN | d, "Medical Care/Standards ated, "No medications or iven without a doctor's d, "Oxygen Therapy" ian's order for oxygen lity bired oxygen) or liter flow (as needed) clude specific guidelines as | F 6 | 95 | |
| F 697 SS=D | Pain Management CFR(s): 483.25(k) §483.25(k) Pain Man The facility must ensu provided to residents consistent with profest the comprehensive pand the residents' go. This REQUIREMENT by: Based on resident in facility document revireview, it was determ failed to implement a program for one of 4' sample, Resident #70. The facility staff failed non-pharmacological | ure that pain management is who require such services, esional standards of practice, erson-centered care plan, als and preferences. is not met as evidenced terview, staff interview, ew and clinical record ined that the facility staff complete pain management I residents in the survey of the services. | F 6 | 1. Res #70 was administered pain medication as ordered by the physici 2. Facility review of residents receiving pain medications was conducted to ensure implementation of non-pharmacological interventions. Follow up based on findings. 3. The DON/designee re-educated the | ng |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | | 495315 | B. WING _ | | | | 26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST /OODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 697 | The findings include: Resident #70 was ad 4/9/21. Resident #70 were not limited to his and chronic pain synquarterly minimum da assessment reference the resident as being 15 on a scale from 0 for mental status. See Resident #70 reporter Review of Resident #4 a physician's order for (milligrams) - one tab as needed for pain. Review of Resident #0 October 2021 MARs records) revealed the as needed acetaming 10/12/21 and 10/16/2 Further review of Residence the and October 2021 MARs records) revealed the as needed acetaming 10/12/21 and 10/16/2 Further review of Residence the non-pharmacological administration of as in the above dates. Resident #70's comp 4/22/21 documented, | mitted to the facility on l's diagnoses included but gh blood pressure, diabetes drome. Resident #70's ata set assessment with an e date of 10/10/21, coded cognitively intact, scoring a to 15 on the brief interview action J documented doccasional pain. 70's clinical record revealed ar acetaminophen 500 mg let by mouth every six hours 70's September 2021 and (medication administration aresident was administered by and phen on 9/19/21, 10/6/21, 1. Sident #70's September 2021 ARs and nurses' notes failed at the facility staff attempted interventions prior to the needed acetaminophen on erehensive care plan dated "(Resident #70) has chronic europathy. Encourage LE (lower extremity) | F | 597 | licensed nurses on the facility's pain management policy. 4. The DON/ designee to conduct rand QI monitoring of F697 to ensure complepain management program with non-pharmacological interventions were for 4 weeks then monthly for 6 months. Findings to be reviewed via Quality Assurance Performance Improvement (QAPI) Committee Meeting and update as indicated. QI schedule modified bas on findings. 5. 12/01/2021 | ete ekly ed | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | | | DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | B. WING | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | OODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 |
| (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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 697 | conducted with Resid stated a CNA (certifier massaged her leg on offer non-pharmacolot the administration of a COn 10/20/21 at 1:41 pconducted with LPN (a nurse who administ acetaminophen to Reabove dates. When a prior to administering medication, LPN #1 srepositioning and a lot the resident. LPN #1 offers snacks to Resident. LPN #1 offers snacks to Resident and prior to the administration of the resident. LPN #1 offers snacks to Resident and prior to the administration of the could not recall if non-pharmacological #70 prior to the administration of the administration of the difference of the administration | a.m., an interview was ent #70. Resident #70 d nursing assistant) et time but the nurses do not gical interventions prior to as needed acetaminophen. a.m., an interview was licensed practical nurse) #1, ered as needed sident #70 on one of the asked what should be done an as needed pain tated she encourages to fit has to do with knowing stated she sometimes dent #70. LPN #1 stated she attempted interventions with Resident aistration of as needed 2021 or October 2021. a.m., ASM (administrative executive director) and of clinical services) were cove concern. d, "Pain Management ed, "Treatment: Develop ventions (pharmacologic | F 6 | 97 | | |
| F 698 SS=E | No further information Dialysis | was presented prior to exit. | F 6 | 98 | | 12/1/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | \ ' ' | PLE CONSTRUCTION G | (X3) |) DATE SURVEY COMPLETED | |
|--|--|---------------------|---|--|----------------------------|--|
| | 495315 | B. WING _ | | | C 10/26/2021 | |
| NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE (| | | STREET ADDRESS, CITY, STATE, ZIP C 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | CODE | | |
| PREFIX (EACH DEFIC | RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL / OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| require dialysis re with professional comprehensive p the residents' goa This REQUIREM by: Based on staff in review, and clinic determined that the care and services with the plan of comprehensive sample, Resident #26 price appointments as communicate with occasions during October 2021. The findings inclusive sample in artery disease, and the most recent in quarterly assessing reference date) of coded as being the decisions, having BIMS (brief interversides and the most coded as services during the comprehensive side in the code of the code of the code of the comprehensive side in the code of the c | ensure that residents who eceive such services, consistent standards of practice, the erson-centered care plan, and als and preferences. ENT is not met as evidenced exerview, facility document all record review, it was the facility staff failed to provide a related to dialysis consistent are for one of 41 residents in the desident #26. Called to ensure assessments of or to, and post dialysis ordered, and failed to the the dialysis center on multiple August, September, and | F 6 | 1. Resident #26's physicial 2. Facility review of resider services was conducted to communication with dialyst as resident assessment prappointment. 3. The DON/designee re-elicensed nurses on the fact coordination policy. The dommunication forms to be member of the IDT (Interditem) during morning clinitem) during morning clinitem) during of F698 to elassessment pre/post appoas communication with the weekly for 4 weeks then months. Findings to be requality Assurance Perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. Findings to be requality Assurance Perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. Findings to be requality Assurance Perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. Findings to be requality Assurance Perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. Findings to be residually assurance perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. Findings to be residually assurance perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. Findings to be residually assurance perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. Findings to be residually assurance perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. Findings to be residually assurance perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. Findings to be residually assurance perform Improvement (QAPI) Communication with the weekly for 4 weeks then months. | nts with dialysis ensure is center as well e/post dialysis educated the ility's dialysis ialysis e reviewed by a isciplinary ical meeting. conduct random nsure resident intment as well edialysis center ionthly for 6 viewed via nance mittee Meeting QI schedule | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | DATE SURVEY COMPLETED | |
|--------------------------|---|---|-------------------------|---|--|----------------------------|--|
| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 698 | A physician order for prior to appointment Wednesday and Frid 7/7/21. Resident #26 no evidence of a preincluding vital signs a communication to the 10/1/21, 10/8/21, and A physician order for every day shift Mond This order was writte clinical record contain post-dialysis assess and dialysis access s 10/1/21, and 10/8/21 A review of Resident plan dated 7/27/20 arevealed, in part: "[Ror/t (related to) renal (lisigns1200 ml/day finoncompliant at time) On 10/20/21 at 1:44 nurse) #1 was interviassessments she per the resident goes to checks vital signs, ar site. She stated she conformation, as well aresults, weights, and dialysis center by was communication book we all fill out. The dial and the book comes | ci "PreDialysis assessment every day shift Monday, ay." This order was written 's clinical record contained dialysis assessment, and dialysis access site, or edialysis center on 8/30/21, if 10/11/21. ci "PostDialysis assessment ay, Wednesday and Friday." in 7/7/21. Resident #26's ned no evidence of a ment, including vital signs site, on 8/9/21, 8/30/21, #26's comprehensive care nd updated 8/11/20, esident #26] needs dialysis kidney) failuremonitor vital luid restriction. He is s." p.m., LPN (licensed practical ewed. When asked what rforms on a resident before dialysis, LPN #1 stated she and checks the dialysis access communicates this is any lab [laboratory test] medication changes, to the | F | 598 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|----------------------|--|---------|----------------------------|
| | | 495315 | B. WING _ | | l | C / 26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 1 10 | 720/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 698 | LPN #1 stated, "It do done on those days." On 10/20/21 at 2:26 nurse) #7 was interv the blanks in dialysis communication book stated if there are blasay the assessments. On 10/20/21 at 4:50 staff member) #1, the director of clinical regional vice preside #4, the regional clinical these concerns. The provide evidence the assessments were pidentified above. A review of the facilith Hemodialysis Service dialysis Communicate the facility for any received the stage renal dial hemodialysisNursing the ESRD centerU the facility, nursing we Communication form by the dialysis center post dialysis information regards. | p.m., LPN (licensed practical lewed. When asked about assessments and dialysis for Resident #26, LPN #7 anks, then she would have to swere not done. p.m., ASM (administrative executive director, ASM #2, I services, ASM #3, the nt of operations, and ASM cal nurse, were informed of facility staff were asked to it Resident #26's dialysis erformed for the gaps by policy, "Coordination of es," revealed, in part: "The ion form will be initiated by sident going to an ESRD ysis) facility for ng will collect and complete reding the resident to send to pon the resident's return to will review the Dialysis and information completed rNursing will complete the tion on the Dialysis and file the completed form | F 6 | 98 | | |
| F 725 SS=D | No further informatio Sufficient Nursing St | n was provided prior to exit. aff | F 7 | 25 | | 12/1/21 |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION IG | | E SURVEY IPLETED |
|--------------------------|--|--|---------------------|--|---|----------------------------|
| | | 495315 | B. WING _ | | 1 | C 0/26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 3/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 725 | the appropriate comprovide nursing and resident safety and a practicable physical, well-being of each reresident assessment and considering the resident assessment and considering the resident accordance with the at §483.70(e). §483.35(a)(1) The fact by sufficient numbers types of personnel or nursing care to all respect to the section, licensed (ii) Other nursing persimited to nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on resident in staff interview, facility clinical record review facility staff failed to present the needs of two survey sample, Resident resident resident resident resident review facility staff failed to present the needs of two survey sample, Resident resid | Staff. e sufficient nursing staff with betencies and skills sets to related services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and lity's resident population in facility assessment required cility must provide services of each of the following a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and sonnel, including but not s. t when waived under section, the facility must nurse to serve as a charge f duty. T is not met as evidenced atterview, family interview, or document review, and t, it was determined that the provide sufficient staffing to o of 41 residents in the | F 7 | 1. Resident #53 has been pr shower as of 11/15/2021 and to receive showers as outline of care. Resident #129 has a weight and will be weighed in with MD orders. 2. Residents in the facility has | will continue d in the plan current accordance | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | (X3) DATE SURVE COMPLETED | (X3) DATE SURVEY COMPLETED | |
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| | | | | С | | |
| | 495315 | B. WING _ | | 10/26/20 | 21 | |
| NAME OF PROVIDER OR SUPPLIES | ۲ | | STREET ADDRESS, CITY, STATE, ZIP COL |)E | | |
| | 07.W0000000 | | 803 SOUTH MAIN ST | | | |
| CONSULATE HEALTH CARE | OF WOODSTOCK | | WOODSTOCK, VA 22664 | | | |
| PREFIX (EACH DEFIC | RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE COMP E APPROPRIATE | (X5) PLETION OATE | |
| F 725 Continued From | page 116 | F 7 | 25 | | | |
| ensure a shower occasions in Aug Resident #53, whice dependent on the hygiene and bath. 2. The facility state staffing to obtain physician's order. The findings included in the findings included in the findings included in the finding in the fi | //bath was provided on multiple just and September 2021, to no was assessed as being e assistance of staff for personal ning. If failed to provide sufficient Resident #129's weight per the ron 8/16/21. | F 7 | potential to be affected. A quescheduled showers will be controlled the Director of Clinical service designee to ensure complian resident not provided a show completed immediately. A question of residents will be conducted or designee to ensure weights obtained as per MD order, an issues will be corrected immediately as will be corrected immediately. The DCS or designee will certified nursing staff and lice staff completing task as orde MD to include obtaining weights providing ADL care to include showers, noting any refusals services will require follow upfor a reattempt with documer clinical record. The clinical tereview the shower scheduled clinical review meeting as we with orders for daily, weekly a weights to ensure task have completed and are document clinical record. This will be convected and are document clinical record. This will be convected and are document clinical record. The quality in the reviewed at the monthly of the reviewed at | enducted by es or ce. Any er will be ality review d by the DCS s have been ny identified ediately. educate the ensed nursing red by the hts and on e offering of of care and b by the nurse atation in the eam will during the ell residents and monthly been ted in the ompleted ally x 6 | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
|---|---|--|---------------------|--|-----------------|--|
| | | 495315 | B. WING | | 10/26/2021 | |
| | PROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION | |
| F 725 | the DCS (director of there has been turnous "the facility just cannous the facility just cannot be facility just cannot be facility just cannot be required the following the facility just cannot be required facility just cannot be required full assistant twice weekly/prn [assistant facility just cannot be required full assistant full full full full full full full ful | clinical services). She stated over in the DCS position, and not keep any help." Resident a statements, and stated there ody" is working the floor. That he has gone through an a week without being not without getting a bed bath. Of certain which days were his at #53's bathing records the effect of the resident being and between the following gh 8/23/21; 9/1/21 through and help a | F 725 | | | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ` ′ | TIPLE CONSTRUCTION | | TE SURVEY MPLETED |
|---|--|--|--------------------|--|---|----------------------------|
| | | 495315 | B. WING | | 1 | C 0/26/2021 |
| | ROVIDER OR SUPPLIER | F WOODSTOCK | | STREET ADDRESS, CITY, STATE, 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 0/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICI | Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIVI CROSS-REFERENCED | AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY) | (X5) COMPLETION DATE |
| F 725 | showering because She stated, as far #5 stated Resident shower aide, but the work a regular assent RN #5 stated when not receive a bath residents to get bath least three CNAs. multiple times to the assistants of a bath shown about 10/7/21, Route to complain about received a bath/shown Resident # the records looked not verify that the during the long garecords. On 10/25/21 at 32 interviewed. She shown Resident #53 since facility. CNA #12 stated the time to give him a so, she would doc CNA #12 stated the staff working the Lor shower. She stated the staff working the Lor shower. | age 118 To her that he had not been the there was not enough staff. The as she knew, this was true. RN It #53's unit has an assigned the aide is most often pulled to signment, due to lack of staff. In this happens, residents do To shower. She stated for The asic care, the unit requires at The RN #5 stated she had spoken The CNAs (certified nursing The bathing Resident #53, "but they The time in their day." She stated The aides about this. When The aides about this. When The aides about this. When The aides about this The aides about this when The aides about this when The aides about | F | 725 | | |
| | #12 stated resider "assigned" showe Resident #53's sh | nts are not limited to only their r days, and, after reviewing ower records, stated he had | | | | |

| | DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | | DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|--|---------|----------------------------|
| | | 495315 | B. WING | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 725 | #12 stated there is all the showers, but "pulled" to do "regu on the facility's other A review of the as-w #53's unit during Aurevealed, in part: On 8/16/21, only cassistant) was docu #53's unit, and this 7:00 am just until 12 documented as word p.m. and 3:00 p.m. On 9/18/21, only cassistant) was docu #53's unit on all three On 10/26/21 at 3:42 interviewed. She standard showers need to be to either resident or residents should be days each week. As responsible for giving the baths as given in the standard should be the standard should be the standard should be days each week. As responsible for giving the baths as given in the standard should be standard should be standard should be should be standard should be should be standard should be | regular shower days. CNA CNA who is tasked with giving that CNA is most often lar" CNA duties on her unit, or er unit because of low staffing. vorked schedule for Resident ligust and September 2021 one CNA (certified nursing limented working Resident staff member worked from 2:45 p.m. No CNA was rking the unit between 12:45 one CNA (certified nursing limented as working Resident lies shifts. 2 p.m., ASM #2 was lated all residents have a lut sometimes, baths or le given on a different day, cue staffing needs. She stated offered a bath or shower two SM #2 stated the CNAs are ling showers, and for recording in the resident's clinical record. | F 7: | 25 | | |
| | aide, and the shows giving most of the s stated if showers ar should report this to should document the record. She stated so occasions when the assigned to other d additional staff. ASI | at #53's unit has a shower er aide is responsible for howers on the unit. ASM #2 the not accomplished, the CNA to the nurse, and the nurse his in the resident's clinical she was aware of some a shower aide had been uties because of the need for M #2 stated she could not add in what was documented in the | | | | |

| . , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , <i>'</i> | LE CONSTRUCTION | | COMPLETED | | |
|--------------------------|--|---|---|---|-----------|----------------------------|--|--|
| | | 495315 | B. WING | | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 725 | Continued From pa | ge 120 on the as worked schedules. | F 72 | 5 | | | | |
| | were informed of the evidence verifying t | p.m., ASM #1 and ASM #2 ese concerns. Additional he facility had provided meet Resident #53's as requested. | | | | | | |
| | provide a policy rela | p.m., ASM #1 was asked to ated to sufficient staffing to esidents. On 10/26/21 at 2:11 d the facility did not have such | | | | | | |
| | 2. Resident #129 w. 4/22/21. Resident # were not limited to h and COVID-19. Re minimum data set a assessment referen | on was provided prior to exit. as admitted to the facility on #129's diagnoses included but high blood pressure, diabetes sident #129's quarterly ssessment with an lice date of 10/3/21, coded the as severely impaired. | | | | | | |
| | revealed a physicia | #129's clinical record n's order dated 6/19/21 for a y day shift every Monday. | | | | | | |
| | 6/25/21 documenter for weight changes status r/t (related to (pneumonia, respira diabetesWeights a | mprehensive care plan dated d, "(Resident #129) is at risk and altered nutritional/fluid) dx (diagnosis) COVID, PNA atory failure, and labs per order/protocol" | | | | | | |
| | list and August 202 administration recoruseight was obtained | • | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---------------------|--|-------------------------------|----------------------------|--|
| | | 495315 | B. WING | | , | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEI | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 725 | facility staff were ur #129's weight on the 129's weight on the 129's weight on the 129's weight on the 139's weight who docu #1 stated 8/16/21 weight was not obtain the staff could do weight was not obtain the staff could do we got their meals, we the floor. Review of the facility 8/16/21 revealed not and CNAs worked hour shifts. Further staff schedule for 8 worked from 7:00 a worked from 7:00 a worked from 3:00 p worked from 6:45 p worked from 6:45 p worked from 6:45 p worked from 1:00 | d 8/16/21 documented the nable to obtain Resident lat date due to staffing issues. 1 p.m., an interview was N (licensed practical nurse) #1, umented the above note. LPN was a really bad day. LPN #1 ertified nursing assistants) are an ining residents' weights but len she can. LPN #1 stated if e above note then there was or two CNAs either on the unit LPN #1 stated Resident #129's ained due to staffing and all leas to make sure the residents are clean and dry, and not on the interview of the facility nursing had all leas to make sure the residents are clean and dry, and not on the interview of the facility nursing had | F 72 | | | | |
| | worked from 11:00 On 10/20/21 at 5:10 conducted with ASI | p.m. to 7:00 a.m. and one CNA p.m. to 7:00 a.m. D p.m., an interview was (administrative staff eccutive director). ASM #1 | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|--|-----|---|------------|----------------------------|
| | | 495315 | B. WING _ | | | l | C 26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST //OODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 730 SS=D | or three nurses should night shift, four CNAs shift, three CNAs sho shift and two CNAs shift. On 10/20/21 at 5:12 pstaff member) #1 (the ASM #2 (the director made aware of the above the shift) which was a shift. No further information Nurse Aide Peform R CFR(s): 483.35(d)(7) Regular The facility must common of every nurse aide at months, and must proceducation based on the treviews. In-service the trequirements of §483. This REQUIREMENT by: Based on staff interviewiew, it was determined to complete an nursing aide) perform CNA record reviews, The facility staff failed performance review for the findings include: CNA #6 was hired on | g on the facility census, four d work during the day and a should work during the evening should work during the evening should work during the night of clinical services) were cove concern. In was presented prior to exit. eview-12 hr/yr In-Service ar in-service education. plete a performance review the least once every 12 covide regular in-service she outcome of these raining must comply with the exposing must comply with the exposing must decide the evidenced siew and facility document ined that the facility staff annual CNA (certified sance review for one of three (CNA #6) If to complete an annual or CNA #6. | | 725 | 1. Employee CNA#6 has a completed annual performance review as of 11/18/2021. 2. Human Resource Manager or Designee will review all actively employ nurse aides to ensure that an annual performance review was conducted with the last year and in-service education we provided based on the outcome. Follow ups will be done based on findings. | hin vas | 12/1/21 |
| | record revealed the la | ast performance review was | | | 3. Human Resources Manager will be | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WO | | | 80 | REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MAIN ST OODSTOCK, VA 22664 | 1 10/ | 20/2021 |
| PREFIX (EACH DEFICIENCY I | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTTED TAG CROSS-REFERENCED TO THE APPROPRIED TO THE APPRO | | | (X5) COMPLETION DATE |
| human resources coord performance reviews a annually. OSM #3 state on 5/31/21 or 6/1/21. On the state of the | m., an interview was other staff member) #3 (the dinator). OSM #3 stated re supposed to be done ed she began employment DSM #3 stated she audited deed performance reviews SM #3 stated she has not action for this but there er things to do. m., ASM (administrative executive director) and folinical services) were executive director) and folinical services were executive director and folinical services were executive director and formation are continual and executive and ormance on a continual and executive and ormance prior to the oductory Period and executive director and director and executive director and execut | F 7 | | educated on ensuring that the facility completes a performance review of evenurse aide once every 12 months and provide regular in-service education based on the outcomes by Executive Director or Designee. Human Resource Manager or Designee to review all nursuides to ensure performance review was completed on an annual basis and in-service education provided monthly Months. 4. The results of the Quality Monitoring be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, a further recommendations. 5. 12/01/2021 | esse as x 6 | 12/1/21 |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION | |
| F 732 | by the following cate unlicensed nursing s resident care per sh (A) Registered nurse (B) Licensed practic vocational nurses (a (C) Certified nurse a (iv) Resident census §483.35(g)(2) Postir (i) The facility must p specified in paragral daily basis at the be (ii) Data must be pos (A) Clear and readal (B) In a prominent p residents and visitor §483.35(g)(3) Public staffing data. The fa written request, make | egories of licensed and staff directly responsible for lift: les. al nurses or licensed as defined under State law). lides. by grequirements. by grequiremen | F 73 | 2 | | |
| | posted daily nurse s 18 months, or as red is greater. This REQUIREMEN by: Based on observati determined that the current nurse staffin information for 10/19 | acility must maintain the taffing data for a minimum of quired by State law, whichever T is not met as evidenced on and staff interview, it was facility staff failed to post g information. Nurse staffing 0/21 was not posted on nurse staffing information for | | The facility corrected the daily staff sheet during survey. The daily staffing sheet is current and reflects the corredate and census. No residents were affected. A qualicative will be completed by the DON designee the daily staffing sheet is | g ct | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | IULTIPLE CONSTRUCTION LDING | | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|--|------------------------------|--|-------------------------|-------------------------------|--|
| | | 495315 | B. WING _ | | | l | C 26/2021 | |
| NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 ID PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SH | | ECTION (X5) HOULD BE COMPLETION | | | |
| F 732 | Continued From page On 10/19/21 at 9:26 a nurse staff posting wa outside of the lobby. dated 10/8/21 and co for that date. On 10/19/21 at 3:57 p conducted with ASM member) #2 (the dire ASM #2 stated the so document and post th the facility did not cur ASM #2 stated the hu had recently been po information and she (human resources em stated the nurse staff posted this morning v current nurse staffing posted because the fa a scheduler. On 10/20/21 at 5:12 p staff member) #1 (the ASM #2 were made a On 10/20/21 at 5:30 p provide a policy regar On 10/26/21 at 2:11 p facility did not have the | a.m, observation of the as conducted in the hall The nurse staff posting was intained staffing information a.m., an interview was (administrative staff ctor of clinical services). Heduler is supposed to be nurse staff information but rently employ a scheduler. In an resources employee sting the nurse staffing ASM #2) tries to help the ployee with this task. ASM ang information that was was dated 10/8/21 and information had not been accility did not currently have a executive director) and aware of the above concern. a.m., ASM (administrative executive director) and aware of the above concern. a.m., ASM #1 was asked to reding the nurse staff posting. a.m., ASM #1 stated the are requested policy. | F 7 | 732 | accurately reflected. Any issues will be corrected immediately. 3. The Executive Director and DON will educated by the Regional Director of Clinical Services on the regulation for daily posting requirements for nursing information. The DON or designee will conduct quality review of daily staff posting weekly x 4 weeks and monthly months to ensure continued compliance. 4. The results of the Quality Monitoring be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, a further recommendations. 5. 12/01/2021 | I be x 6 e. to | 12/1/21 | |
| | CFR(s): 483.40 §483.40 Behavioral h | | | .0 | | | | |

| | OF DEFICIENCIES CORRECTION | S (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING | | COMPLET | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|--|--|----------------------------|
| | | 495315 | B. WING _ | | 10/26/ | /2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | , 10/20/ | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOOT CORRECTIVE ACTION SHOOT CORRECTIVE ACTION SHOOT CORRECTIVE ACTION SHOOT CORRECTION SHOT CORRECTION SHOT CORRECTION SHOT CORRECTION SHOUT CORRECTION SHO | OULD BE | (X5) COMPLETION DATE |
| F 740 | provide the necessar services to attain or repracticable physical, well-being, in accord assessment and plarencompasses a resignmental well-being, wel | eceive and the facility must by behavioral health care and maintain the highest mental, and psychosocial ance with the comprehensive of care. Behavioral health dent's whole emotional and nich includes, but is not tion and treatment of mental isorders. To is not met as evidenced on, staff interview, facility nical record review, and a complaint investigation, it the facility staff failed to ealth services such as ized assessments and aning, related to residents rexpressed suicidal ideation, in the survey sample, dent #59, Resident #20, ent #61 and Resident #13. It #230 expressed thoughts of the don'the MDS-Section not further assessed by interventions and behavioral | F 7 | 1. The facility failed to implement behavioral health services for residentified with feelings of self-injurecorded on PHQ-9 for residents #61, #59, #24, #13, and #20. Residents #61, #59, #24, #13, and were evaluated by Psych service deemed to be safe and not at risk endangering themselves or other 2 Residents in the facility have the potential to be affected. The Direcompleted PHQ-9 assessments for residents completed within the paweeks for thoughts of self-injury of present symptoms. Residents identification and propriate interventions in placed plan of care updated. 3. A) DON or designee will educated staff on identifying changes in psychosocial behavior to include | idents ry as #230, sident d #20 s and c for s. e ctor of eviewed or all ist 2 or other entified rded on review and and tte all | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | 1, , | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|--|--|-------------------------------|--|
| | | | | | | С | |
| | | 495315 | B. WING _ | | 10 | /26/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP | • | | |
| | | - W0000000 | | 803 SOUTH MAIN ST | | | |
| CONSULA | TE HEALTH CARE O | FWOODSTOCK | | WOODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | 'STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 740 | Continued From page | age 127 | F7 | 740 | | | |
| 1 740 | facility, and no car ideation developed 1:10 PM a request (administrative sta director for a list of services, and a list expressed thought the MDS-Section I residents were ide been assessed on as having express of the seven, (Reshad no further imminterventions and / provided resulting Jeopardy on 10/21/2 abated on 10/22/2 to an E. The findings included 1. Resident #230 v 8/20/21 with diagn limited to: Diabete function normally in obstructive pulmor non-reversible lung disease 'ESRD' (in waste and to funct electrolyte balance of testis and buttooks.) The most recent Massessment, a five with an ARD (asses | e plan addressing suicidal d'until 9/2/21. On 10/21/21 at a was made to ASM iff member) #1, the executive for residents receiving psychiatric de of residents who had as of self- injury documented on D-Letter I. Seven other intified by the facility as having the MDS-Section D-Letter I., ed thoughts of self- injury. Five idents # 59, 20, 24 61 and 13), inediate assessments, safety for behavioral health services in the findings of Immediate 1/21 at 4:28 p.m. The IJ was 1021 at 6:37 p.m. and lowered de: Was admitted to the facility on oses that included but were not is mellitus (inability of insulin to in the body) (1), chronic mary disease 'COPD' (chronic gray disease) (2), end stage renal mability of the kidneys to excrete ion in the maintenance of the in the body) (3) and abscess cks (accumulation of pus in the | | completion of PHQ9 that resident expressing the d themselves education will following: Staff to remain until evaluated by a nurse qualified psychologist and the resident is not suicidal harming self or until the retransferred to a higher level. IDT will review 24 hour resolved to a higher level. IDT will review 24 hour resolved and any other symptom puthe morning clinical meeting appropriate interventions MD/NP/RP notification and reflect appropriate interventions MD/NP/RP notification and reflect appropriate interventions appropriate intervention and reflect appropriate intervention and reflect appropriate intervention. Friday. Weekend staff idea residents who express the themselves will follow the policy. This will be an ong intervention. 4. The results of the Qual be reviewed at the month Assurance Performance I (QAPI) meetings for review further recommendations. 5. 12/01/2021 | esire to harm I also include the with resident e, Physician or a d documents that al or at risk of esident is yel of care. B) eport and nurse ing for self-injury eresence during ing to ensure are in place, ad care plans entions. C) completed lents who may ury during Monday through entifying e desire to harm e suicidal ideation going ity Monitoring to ly Quality Improvement ew, analysis, and | | |
| | assessment, a five with an ARD (asse 8/26/21, coded Re of 15 on the BIMS | e day Medicare assessment essment reference date) of | | 5. 12/01/2021 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|-----|---|-------------------------------|----------------------------|
| | | 495315 | B. WING | | | l | 26/2024 |
| NAME OF P | ROVIDER OR SUPPLIER | 1000.0 | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 10/ | 26/2021 |
| | TE HEALTH CARE OF W | OODSTOCK | | 8 | 103 SOUTH MAIN ST NOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 740 | cognitively intact. A re D-Mood-letter I: Thou better off dead or of h coded Resident #230 questions and coded for the resident as "2-Resident #230 was re complaint regarding a suicide. A review of the physic documented in part "Psychology as neede Resident #230's clinic any evidence psychia were provided. A review of Resident to evidence the devel plan to address psychincluding thoughts of On 9/2/21, the compredocumented in part, "for a decline in mood and current living arra INTERVENTIONS-Ar consult follow up as in A review of the nursin documented in part the 8/24/21 at 1:11 PM, noted as oriented to poriented to time. Moo smilling. Behavioral principles in the second principles and second principles are second principles. | eview of MDS Section ghts that you would be jurting yourself in some way as "Yes" for these the frequency of symptoms 6 days". eviewed as part of a a concern of attempted cian orders dated 8/20/21, Psychiatry as needed. d." Further review of cal record failed to reveal attric consults or services #230's clinical record failed opment of a baseline care nosocial needs and mood, self injury/suicide. ehensive care plan FOCUS-Resident is at risk related to medical condition angements. range for psych [psychiatric] indicated." | F | 740 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|---|-------------------------------|----------------------------|--|
| | | 495315 | B. WING | | | C 1 0/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 740 | problems are not not 8/27/21 at 8:49 AM, noted as oriented to oriented to time. Me happy pleasant smi affect. Behavioral pleas | "Level of consciousness of person oriented to place ood status is depressed ling negative statements flat roblems are not noted." all services progress note of PM, documented in part, diges to thoughts of hurting dent is [Sic.] he had any plans of stated he was in a bad lique interview." Insfer form dated 8/31/21 at led in part, "Suicide attempt. Resident was found with around his neck and when doing he stated, 'trying to f (Sic. [hang]) myself'. The ency department physician are exam dated 8/31/21 at 3:55 part, "Chief complaint: on. Context: Resident is an one presents from nursing uicidal ideations. The patient with the nursing home and cal care to the point that he to be put out of his misery. In a service in nurses if they could shoot | F 74 | | | | |
| | around his neck. The would like to be put Systems: Psychiatr suicidal ideas. Neu | o wrap a small piece of string ne patient tells me that he out of is misery. Review of ric/Behavioral: positive for ro/Psych: Normal affect and ient is alert, and oriented to | | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
|--|--|---|----------------------------|--|-----------|----------------------------|
| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | /OODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 |
| (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 ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 740 | Continued From page | | F 7 | 740 | | |
| | | ntial diagnosis considered anxiety/frustration versus a s." | | | | |
| | dated 8/31/21, docum Case discussed with | department nursing note nented in part, "Disposition: patient, daughter and are: discharge with safety | | | | |
| | 8/31/21 at 4:24 PM, or returned from the hos accompanied by 2 EN technicians], patient rall morning meds [meat the hospital, new or done while at the hospital pressure 145/83, respectively temperature 97.6. Pa monitored for suicidal | MT [emergency medical eturned with no new order, edications] was administered atheter and wound dress pital. Vital signs: blood birations 16, pulse 76, | | | | |
| | | #230's medical record failed rety plan was initiated for the to the facility. | | | | |
| | social services managedischarge plan for Restated, "We had a prenot a care plan meetidischarged on Tuesda | PM, an interview was (other staff member) #4, the ger. When asked about the sident #230, OSM #4 e-discharge meeting. It was ng. The resident was to be ay 9/7. The daughter saident home on 9/3/21, a | | | | |

| STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | FIPLE CONSTRUCTION NG | (XS | (X3) DATE SURVEY COMPLETED | |
|---|--|--|------------------------|--|--|-------------------------------|--|
| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| NAME OF PI | ROVIDER OR SUPPLIER | I | | STREET ADDRESS, CITY, STATE, Z | IP CODE | | |
| CONSULA | TE HEALTH CARE OF V | VOODSTOCK | | 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | |
| (V4) ID | SLIMMADV ST | ATEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN | OF CORRECTION | (X5) | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFI TAG | | ACTION SHOULD BE TO THE APPROPRIATE | COMPLETION DATE | |
| F 740 | Continued From page | e 131 | F | 740 | | | |
| | An interview was con PM with Resident #23 about the discharge of #230's daughter state I could not leave him weekend. I met with took notes on all kind talked with the admin home and he told me on this one including administrator said the their wound vacuum shall. I could not wait before something else. An interview was con PM with ASM (adminithe director of clinical nursing]. When asked done if a resident and they would be better themselves in some would remove everytle could do harm, give the paper plates or Styrow would take away wrapped around his round to the hospital. When asked suicidal attempt by Restated, "No, I was mostate and don't remer." | ducted on 10/21/21 at 2:46 30's daughter. When asked date for her father, Resident ed, "After his suicide attempt, in the facility over another he social worker and she s of scrap pieces of paper. I istrator about taking my dad 'we really dropped the ball administration'. The ey would release my dad with since they had dropped the to get him out of there happened to him." ducted on 10/20/21 at 1:15 istrative staff member) #2, services [director of d what actions would be swered yes to thoughts that off dead, or of hurting way, ASM #2 stated, "We hing out of room that they hem plastic silverware, foam containers for food. anything that could be neck. We would put them on ated, we would send them we would document full this information on in if she remembered the hesident #230, ASM #2 wing from another part of the mber being informed." | | | | | |
| | services manager. W | staff member) #4, the social /hen asked what process ent answers yes to thoughts | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|---------|--|-------------------------------|----------------------------|
| | | 495315 | B. WING _ | | | | C 26/2021 |
| | ROVIDER OR SUPPLIER | OODSTOCK | | 803 SOL | ADDRESS, CITY, STATE, ZIP CODE JTH MAIN ST STOCK, VA 22664 | 1 10/ | 20/2021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | (| PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 740 | that they would be be themselves in some wasn't aware of the athe director of clinical ask the resident if the notify the nurse. We alone and would pull resident could harm to the conducted with OSM social services manage the process followed thoughts of self-harm week, OSM #4 stated week, I would just information was conducted with OSM #4 stated week, normally I would leave a note immediate this information was conducted with the nursing direct resident and do not leave a note immediate this information was conducted with the conducted with the stated, "For any documentation of the week, normally I would leave a note immediate this information was conducted with LPN (license asked if she remember asked if she remember asked if she had been verbalized thoughts of stated, "No, I never kind himself and that there when asked what actions in the conducted with the stated with the state | tter off dead, or of hurting vay, OSM #4 stated, "I nswer until 8/27. I would call services and alert them. I y have a plan in place and would not leave the resident any items from the room the nemselves with." PM, another interview was (other staff member) #4, the ger. When asked the about if a resident verbalized, prior to education last orm the MDS coordinator for. Now we stay with the eave them. Before last d follow up immediately and tely." When asked where locumented and evidenced, Resident #230, I don't have revidence." ducted on 10/21/21 at 6:47 d practical nurse) #8. When ered Resident #230, she acture and then LPN #8 ber caring for him." When in informed that he had f harm to himself, LPN #8 new that he was a risk to a was behavior issues." ions would be taken if a oughts of harm to himself, all have them 1:1 and | F | 740 | | | |

| STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | ' ' | (X3) DATE SURVEY COMPLETED | |
|--|---|--|---------------------|--|-----------------------------------|-------------------------------|--|
| | | 495315 | B. WING _ | | | C 0/26/2021 | |
| | NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | STREET ADDRESS, CITY, STATE, ZIP 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 0/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 740 | AM with LPN #5. Wiremembered Reside I remember the reside where they sent him think he had a cord to remember that he was protocol is to put the what interventions wore turn from the hosp believe anything new. An interview was con 10/21/21 at 8:48 AM duty 8/31/21, night so When asked to desc stated, "I found him [AM. He knew what he cord wrapped around I had the CNA (certification outside of his door a frequent checks. Not the administrator and were changing nursifitime. I know the DO the administrator knet alked with me the new had been informed the thoughts of harming I knew nothing about this took me by surplat risk." An interview was con AM with ASM #6, the asked if she was informed the verbalized though #6 stated, "No, I did with Image of the stated in the | nducted on 10/21/21 at 7:27 hen asked if she nt #230, LPN #5 stated, "Yes lent and there was an issue out to the hospital because I ied around his neck. I do not as put on 1:1. Normally our m on 1:1." When asked ere put in place upon his ital, LPN #5 stated, "I don't v was put in place." | F7 | 740 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | MULTIPLE CONSTRUCTION UILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|--------------------|-------------------------------|---|-------|-------------------------------|--|
| | | 495315 | B. WING | | | | 26/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | 100010 | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 20/2021 | |
| CONSULA | TE HEALTH CARE OF W | VOODSTOCK | | | 03 SOUTH MAIN ST /OODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | | | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 740 | F 740 Continued From page 134 | | F | 740 | | | | |
| | orders to have him ta and seen by psychiat | ken to the hospital if needed ry." | | | | | | |
| | 12:11 PM, with Resid asked if her father ha verbalizing thoughts of #230's daughter state harm himself. That mad my phone number had to call me to inford dad to the emergency see him, my dad said days and I couldn't skaid I can wrap this of turn over in bed a few enough. It's better the | as conducted 10/21/21 at ent #230's daughter. When d any history of self-harm or of self-harm, the Resident ed, "No, he has never tried to norning (8/31/21), the facility er wrong and my nephew rm me that had taken my y room. When I went into , "Sis, I was in pain for two eep. So I see that cord and ord around my neck and y times it just might get tight an being here in this place." | | | | | | |
| | what he remembered suicide attempt, ASM | administrator. When asked about Resident #230's #1 stated, "I would have to I remember being told that | | | | | | |
| | around his neck." Will the interview conduct that her recollection a medical record were a "Resident was found around his neck and doing he stated, 'tryin [hang]) myself'." ASM remember that." Whe were initiated upon R | cross his neck, not wrapped hen ASM #1 was informed of ed with the night nurse and and the documentation in the consistent and documented, with light cord wrapped when asked what he was g to f[expletive] hand (Sic. I #1 stated, "I don't en asked if any interventions esident #230's return from tment and if an investigation | | | | | | |
| | | SM #1 stated, "I don't think | | | | | | |
| | A review of the facility | 's "Resident Expressing | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDI | IPLE CONSTR | UCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|------------------------|-------------|--|----------------------------|----------------------------|
| | | 495315 | B. WING _ | | | | C 26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | 803 SOUT | DDRESS, CITY, STATE, ZIP CODE H MAIN ST FOCK, VA 22664 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 740 | resident that expres themselves. The Di and the Executive D | oolicy dated 8/2017, "To ensure the safety of any ses the desire to harm rector of Clinical Services irector are to be notified | F | 740 | | | |
| | desire to harm them expresses the desire do the following: sta until a physician or a evaluates the resideresident is not suicided self-OR until the reshigher level of care, immediately, the nurresponsible party of nurse to notify the D and the Executive D | resident that expresses the selves. Once a resident to to harm themselves, staff to aff to remain with resident a qualified psychologist and documents that the lall or at risk of harming ident is transferred to a the nurse to be notified se to notify the physician and the resident's condition, the irector of Clinical Services irector, the nurse to prepare of the selves of the s | | | | | |
| | A review of the facili policy dated 11/2014 "Mental Health refer facility when a residuappears disturbed on Resident's behavior nursing home staff resident's chart." | gency room if ordered." ty's "Mental Health Referrals" d, documented in part, rals will be utilized by the ent's behavior and affect r indicates distress. and affect are observed by nembers and documented in sidents who had verbalized | | | | | |
| | [administrative staff administrator, on 10 p.m. On 10/21/21 a a resident list based "Thoughts that you whurting yourself in so | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---------------------|--|-------------------------------|--|
| | | 495315 | B. WING | | C 10/26/2021 | |
| | NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETION | |
| F 740 | of these additional s 10, 50, 59, 20, 24, 6 record review reveal (Resident #'s 59, 20 evidence any impler assessments, safety behavioral health se five residents with dethe MDS question all of hurting themselve situation for serious injury, serious harm, to occur. On 10/21/21 at 3:41 supervisor, was noti implement immediat safety interventions, services for these addocumented above. supervisor consulted Term Care supervisor and the team was not findings. On 10/21/2 team met with the exclinical services and operations, and informediate Jeopardy On 10/21/21, the fact plan of correction the approximately 8:05 processions of the services of the services and operations of the services of | ey team reviewed the records even residents, (Resident #'s 1 and 13). The resident ed five of the seven, 24, 61 and 13), failed to mentation of further interventions, and rvices for these additional ocumented 'yes' answers to cout being better off dead or s. This resulted in a likely psychosocial harm, serious serious impairment, or death PM, the Long Term Care fied of the facility's failure to be further assessments, and behavioral health editional five residents as the Long Term Care is with three additional Long for sand the Division director of the vice president of the vice president of the vice president of the concern for the vice president of the concern for the vice president at was accepted at was accepted at | F 740 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|---|----------------------------|--|--|
| | | 495315 | B. WING | | C 10/26/2021 | | |
| | NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | 10/20/2021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION | | |
| F 740 | room. The facility fa health services for #59, #24, #10, #13, 2021, it was identifi #24, #10, #13, and the PHQ-9. Residents # and #20 had call be plastic silverware in a Registered Nurse 2. The Director of I complete PHQ-9 fo of 8 and above. Rebelow will have nur documentation revithoughts of self-inju Residents identified recorded on PHQ-9 review will have MI appropriate intervercare updated. MD/I appropriate immedi [psychiatric] service transferred to a hig appropriate. Plan olicensed nurse. 3. Regional Vice POperations/Regions will re-educate Soc Coordinators, and Nand procedures related the RAI Manual Guidentifying thoughts addressing change | ailed to implement behavioral Residents #230, #61, #50, and #20. On October 21, ed residents #61, #50, #59, #20 triggered for self-injury on the #230 was discharged on #61, #50, #59, #24, #10, #13, ells removed from their room, inplemented until assessed by e on 10/21/21. Nursing (DON) or designee will residents with BIM score esidents with a BIMS of 7 or sing and social services ewed for the last 30 days for any or other present symptoms. If with feelings of self-injury as the or through documentation D/NP/RP notification and entions in place and plan of NP will be consulted on atteinterventions until psyches can be rendered in house or ther level of care as a f care will be updated by resident of all Director of Clinical Services and Services Director, MDS wires Management on policy atted to completing PHQ-9 per idelines and correctly of self-injury and policy for in condition. Correctly of self-injury include a | F 740 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|-------------------------|---|-------------|-------------------------------|--|
| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | E | 10/20/2021 | |
| (X4) ID PREFIX TAG | EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFI) TAG | PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 740 | Continued From pag | ne 138 | F 7 | 740 | | | |
| | 2. Thoughts that you of hurting yourself in Addressing a change identifying a resident mental, or psychoso DON [director of nurre-educate all staff of psychosocial behavior identifying a resident harm themselves and 1. Staff to remain wor a qualified psychologor and documents that at risk of harming settransferred to a high 2. The nurse to be responsible party of 4. The nurse to noting Services and the Extension of the staff of th | e in condition is done by t's change in their physical, cial status. sing] or designee will in identifying changes in or. Staff education to include t expressing the desire to d completing the following: ith resident until a physician ologist evaluates the resident the resident is not suicidal or lif or until the resident is er level of care. notified immediately fy the physician and the resident's condition. fy the Director of Clinical | | | | | |
| | No staff will be allow completed. | ed to work until education is | | | | | |
| | report and nurse not self-injury and any o during the morning of appropriate interven [medical doctor/nurs party] notification an appropriate interven review completed PI | team] will review 24 hour es of residents triggering for ther symptom presence clinical meeting to ensure tions are in place, MD/NP/RP e practitioner/ responsible d care plans reflect tions. DON/designee to HQ-9's to identify residents ered for self-injury during | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|---------------------|--|------------------------|--|
| | | 495315 | B. WING | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETION | |
| F 740 | morning clinical me Weekend staff iden the desire to harm to suicidal ideation poli intervention. 4. DON to report fir improvement] monity meeting monthly for compliance and/or in 5. Date of complian On 10/23/21 from 8 plan of correction we following: 1. Review of the all documentation of Mappropriate interver 2. Review of all psy residents who were themselves as code 3. Review of all res a revision/update re 4. Review of all res a revision/update re 4. Review of all cre provided, education sheets for all shifts 5. Interviews, in-pe numerous facility st from varying shifts a identifying changes behavior or express themselves and the a. Staff to remain w or a qualified psych and documents that | eting Monday through Friday. tifying residents who express hemselves will follow the licy. This will be an ongoing andings from QI [quality toring at the QI committee of 12 months for further revision. Ince 10/22/21 at 3:00pm. Ince 10/22/21 at 3:00pm | F 74 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | 10 | C / 26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | 803 SOUTH | DRESS, CITY, STATE, ZIP CODE MAIN ST DCK, VA 22664 | , 10 | 720/2021 |
| (X4) ID PREFIX TAG | | | ID PREFII TAG | | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 740 | d. The nurse to noting Services and the Extended The nurse to prepare to prepare to the control of the control | y the physician and the resident's condition. fy the Director of Clinical | F7 | 740 | | | |
| | identified, the facility residents as wanting residents were also review. All ten resid psychiatric services | ren resident's originally identified three additional to harm themselves. These included in the verification ent were evaluated by and deemed safe before the abatement on 10/22/21 at | | | | | |
| | No further informatio | n was provided prior to exit. | | | | | |
| | stated he had though dead, or of hurting he quarterly MDS (mining with an ARD (assess 9/29/21. The facility behavioral health se | illed to assess and care for Resident #59 who has that he would be better off imself in some way on a mum data set) assessment ment reference date) of staff failed to evidence that rvices were offered to en 9/29/21 and 10/21/21. | | | | | |
| | 1/29/21 with diagnos limited to: Diabetes i | ry disease 'COPD' (2) and | | | | | |
| | assessment, a quart | S (minimum data set) erly assessment with an ARD ce date) of 9/29/21, coded | | | | | |

| ` ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | IPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIA | DATE | | |
| F 740 | BIMS (brief interview indicating the reside review of MDS Section that you would be be yourself in some was and frequency of syras "2-6 days." A review of the company 7/8/21, documented has a decline in moor prognosis. INTERV consults as needed, services (initiated 10 to provide emotional Review of the physic evidence any current needed or Psycholochad a discontinuation A review of the social dated 9/29/21 at 11: "On PHQ9 resident about being dead/has no plan in place go." There was no evider additional monitoring There was no evider the resident #59, prior to jeopardy on 10/21/21 at 4:28 staff member) #1, the | ing a 14 out of 15 on the v for mental status) score, int was cognitively intact. A sion D-Mood-letter I: Thoughts etter off dead, or of hurting y coded the resident as "Yes" imptoms coded the resident or prehensive care plan dated in part, "FOCUS-Resident or problem related to terminal ENTIONS-Behavioral health Seen by psych [psychiatric] 0/22/21). Facility/hospice staff I support as needed." | F7 | 740 | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|---------------------|---|-------------------------------|----------------------------|--|
| | | 495315 | B. WING_ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 740 | Continued From pa | • | F 74 | 40 | | | |
| | | lent of operations were nediate Jeopardy findings at | | | | | |
| | | dent safety check form dated hrough 10/21/21 6:45 PM 15 minute checks. | | | | | |
| | conducted with Res remembered being self-harm, Residen the conversation ar | DPM an interview was sident #59. When asked if he asked about thoughts of t #59 stated, "Yes, I remember nd remember saying that. een done, I have not talked | | | | | |
| | dated 10/22/21 at 1 "Suicide screening: judgement. Mental abnormal affect, ha oriented to time, pla recent memory abn abnormal. Patient | se practitioner progress note 0:30 AM, documented in part, Psychiatric: Insight: good status: confused and illucinations. Orientation: not ace and person. Memory: iormal and remote memory with no voiced suicidal ts per staff. Psych uate patient as well." | | | | | |
| | conducted with OS social services mar any information reg Director of Clinical #59's assessed tho stated, "I'm not sure back with you." What staff follows if a resself-harm, prior to estated, "Prior to educated, "Prior to educated" | 7 PM, an interview was M (other staff member) #4, the nager. When asked to provide arding notification to the Services regarding Resident ughts of self-harm, OSM #4 e, I will have to check and get nen asked about the process ident verbalized thoughts of education last week, OSM #4 ucation last week, I would just ordinator and the nursing | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | I ' ' | | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|---------------------|---|-----------|----------------------------|--|--|
| | | 495315 | B. WING | | | C 40/26/2024 | | |
| | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | · | 10/26/2021 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | | |
| F 740 | director. Now we stall leave them. Before I follow up immediately: immediately: immediately: immediately: On 10/25/21 at 4:06 conducted with ASM member) #2, the director of nursing. In the social services of the social services, which is social services of the second second services of the second | py with the resident and don't ast week, normally I would by and leave a note PM, an interview was (administrative staff actor of clinical services) When asked the process assessment identifies an, ASM #2 stated, "Normally anager reports it to me prior ek." When asked what the aded, ASM #2 stated, "We and put them on every 15 the physician can see them. The ell out of room and put them as was started last week. We all services that was not attion to us. That person is no have been here (8/26/21 as ermanent), I have never had dent with thoughts of AM, OSM #4 provided email of AM to the ASM member) #2, the director of and coumented in part, inswered yes to having any himself or being better off and no plan in place. He and now that he is in isolation, seems to have a hard time | F 7- | 40 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | C 10/26/2021 | |
| NAME OF PROVIDER OR S CONSULATE HEALTH | | WOODSTOCK | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | |
| PREFIX (EAC | H DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| normally in Medical Te edition, Ro (2) Chroni 'COPD' (ch Barron's D Non-Medical Te edition, Ro (3) Chronio the heart a level of gas Medical Te edition, Ro (3) The faci implement stated he hadead, or of quarterly N with an AR 8/19/21. The behavioral Resident # Resident # Resident # 3/30/21 will limited to: disease (diffequently cerebrovas blockage of to lack of communication of the most in assessment. | es mellitus the body rms for th thenberg c obstruct ironic non ictionary c al Readel page 120 c respirate nd lungs i s exchang rms for th thenberg lity staff fa a plan of had though hurting h IDS (minin D (assess he facility health se 20 between 20 was ac h diagnos Diabetes i ecreased as a comp scular acc f the bloo xygen and ecent MD nt, a quart | inability of insulin to function . Barron's Dictionary of e Non-Medical Reader, 7th and Chapman, page 160. tive pulmonary disease -reversible lung disease. of Medical Terms for the r, 7th edition, Rothenberg and | F 74 | 40 | | |

| NAME OF PROVIDER OR SUPPLIER 495315 B. WING | 6/2021 |
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| | 0/2021 |
| CONSULATE HEALTH CARE OF WOODSTOCK 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 740 Continued From page 145 indicating the resident was severely cognitively impaired. A review of MDS Section D-Mood-letter I: Thoughts that you would be better off dead, or of hurting yourself in some way coded Resident #20 he resident as "Yes" and frequency of symptoms coded the resident as "2-6 days". A review of the comprehensive care plan dated 8/23/21, documented in part, "FOCUS-Potential for psychosocial well-being. INTERVENTIONS-Observe for psychosocial and mental status changes. Document and social work report as indicated. Provide emotional support and allow residents to express feelings, fears and concerns." A review of the physician orders dated 3/16/21, documented in part "Psychiatry as needed. Psychology as needed." A review of the MDS coordinator note dated 8/23/21 at 1:17 PM, documented in part, "MDS 8/13 Mood interviews. Mood is fluctuating daily. Recent SCIC (significant change in condition) due to coming off hospice." There was no evidence in the medical record of additional monitoring or notification of nursing regarding Resident #20's 8/19/21, assessment for thoughts of being better off dead, or of hurting yourself in some way. There was no documented evidence of removing items from the resident's room or of psychiatric consult, prior to the identification of immediate jeopardy on 10/21/21, at 4:28 PM, ASM (administrative staff member) #1, the executive director, ASM #2, | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | B. WING | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRES 803 SOUTH MAI WOODSTOCK | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AT REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO | | PROVIDER'S PLAN OF CORRECTION ICH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 740 | Continued From page regional vice preside informed of the Imme this time. A review of the reside 10/21/21 11:00 PM to documented every 1 On 10/21/21 at 5:00 attempted with Reside completed. A review of the nurse dated 10/22/21 at 12 "Suicide screening: insight. Mental status abnormal affect, hall oriented to time, place recent memory abnormal. Patient derespond to provider, ideations or thoughts evaluate patient as we on 10/25/21 at 3:57 conducted with OSM social services manaprovide any informat the Director of Clinic #20's, 8/19/21, asset | e 146 Int of operations were ediate Jeopardy findings at ent safety check form dated arough 10/22/21 11:45 AM 5 minute checks. PM, an interview was lent #20, but was not e practitioner progress note:00 PM, documented in part, Psychiatric: Insight: poor s: lethargic, confused and ucinations. Orientation: not be and person. Memory: rmal and remote memory ones not answer questions or staff report no suicidal s. Psych [psychiatric] to well." PM, an interview was (other staff member) #4, the ager. OSM #4 was asked to ion regarding notification to al Services for Resident | | 740 | | | |
| | have to check and gasked about the proceed verbalized thoughts education provided tated, "Prior to education the MDS cool | 4 stated, "I'm not sure, I will et back with you." When cess staff follows if a resident of self-harm, prior to o staff last week, OSM #4 cation last week, I would just dinator and the nursing by with the resident and don't | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ` ′ | PLE CONSTRUCTION G | , , | COMPLETED | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 740 | follow up immediate immediately." On 10/25/21 at 4:00 conducted with ASI member) #2, the di When asked about mood assessment self-harm, ASM #2 services manager reducation last weel revised process included assess the residen minute checks until suicidal, take call boon 1:1. This proceshad someone in so reporting this inform longer here. Since interim, 9/16/21 as | e last week, normally I would ely and leave a note 6 PM, an interview was M (administrative staff rector of clinical services. the process staff follows if the identifies thoughts of stated, "Normally the social reports it to me prior to k." When asked what the cluded, ASM #2 stated, "We that and put them on every 15 physician can see them. If ell out of room and put them as was started last week. We cial services that was not mation to us. That person is no I have been here (8/26/21 as permanent), I have never had sident with thoughts of | F 7 | , | | |
| | AM, with OSM #4, When asked how F the mood assessm #4 stated, "I don't k be honest with you here then and I do the resident had had No further informat References: (1) Barron's Diction | conducted on 10/26/21 at 8:25 the social services manager. Resident #20 was scored on ent as her BIMS was 03, OSM now what she was asking to . The other social worker was not know how she determined armful ideas for self." ion was provided prior to exit. hary of Medical Terms for the er, 7th edition, Rothenberg and 0. | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | B. WING | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | /OODSTOCK | 1 | 8 | STREET ADDRESS, CITY, STATE, ZIP CODE 103 SOUTH MAIN ST VOODSTOCK, VA 22664 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 740 | Non-Medical Reader, Chapman, page 119. (3) Barron's Dictionar Non-Medical Reader, Chapman, page 111. 4. The facility staff fai implement a plan of c stated he had though dead, or of hurting hir quarterly MDS (minim with an ARD (assessi 8/27/21. The facility s behavioral health sen Resident #24 was add 3/29/20. Resident #24 were not limited to distroke. Resident #24 set assessment with a date of 8/27/21, code skills for daily decision independence (some only). Further review of Resassessment revealed interview. This section stated he had though dead, or of hurting hir days during the 14 days dur | y of Medical Terms for the 7th edition, Rothenberg and y of Medical Terms for the 7th edition, Rothenberg and led to assess and are for Resident #24 who ts that he would be better off mself in some way on a num data set) assessment ment reference date) of taff failed to evidence that vices were provided to n 8/27/21 and 10/21/21. mitted to the facility on 4's diagnoses included but abetes and a history of 's quarterly minimum data an assessment reference d the resident's cognitive in making as modified difficulty in new situations section D, the PHQ-9 mood on revealed Resident #24 ts that he would be better off mself in some way two to six ay look back period. | F | 740 | | | |
| | reveal the resident was the above statement. | , | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---------------------|--|----------------------------|----------------------------|
| | | 495315 | B. WING | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | = WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | IOULD BE | (X5) COMPLETION DATE |
| F 740 | Continued From particles psychiatric consult identification of immas documented about the social services section D of Reside assessment was not facility. On 10/21/21 at 1:3 conducted with OS social services man a resident states the or she would be himself or herself winterview then she place, documents a nurse, unit manage on 10/25/21 at 3:5 conducted with OS social services ass | age 149 for Resident 24, prior to the nediate jeopardy on 10/21/21, | F 74 | DEFICIENCY) | | |
| | a few weeks. OSM Resident #24 state would be better off On 10/25/21 at 4:0 conducted with ASI member) #2 (the di director of nursing) states that he or sh would be better off be placed on 15 mi | nly employed at the facility for #4 stated she was not aware d he had thoughts that he dead or of hurting himself. 6 p.m., an interview as M (administrative staff irector of clinical services. ASM #2 stated if a resident he has thoughts that he or she dead then the resident should inutes checks until evaluated SM #2 further stated that if a | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | E SURVEY PLETED | |
|--|--|--|---|--------|---|--------------------|----------------------------|
| | | 495315 | B. WING _ | | | 1 | C / 26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | 803 \$ | SOUTH MAIN ST DDSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 740 | F 740 Continued From page 150 | | F | 740 | | | |
| | resident should be p supervision until eva | he or she is suicidal then the placed on one to one aluated by the physician. | | | | | |
| | | p.m., ASM #1 (the executive 2 were made aware of the | | | | | |
| | 5. The facility staff faimplement safety/ps Resident #61, who she would be better of in some way on an adata set) assessme reference date) of 9 to evidence that better the safety assessment in the safety assessment in the safety as the safety as set in the safety as t | on was presented prior to exit. ailed to assess and sychosocial interventions for stated she had thoughts that off dead, or of hurting herself admission MDS (minimum nt with an ARD (assessment /30/21. The facility staff failed navioral health services were #61 between 9/30/21 and | | | | | |
| | 9/24/21, and most rewith diagnoses includiabetes. On the modata set), an admission (assessment referent #61 was coded as beimpaired for making | dmitted to the facility on ecently readmitted on 9/27/21, uding Alzheimer's disease and est recent MDS (minimum sion assessment with an ARD nace date) of 9/30/21, Resident being moderately cognitively daily decisions, having 15 on the BIMS (brief status). | | | | | |
| | ARD of 9/30/21 reversions answered yet feelings that she work hurting herself for two back period in sections. | at #61's quarterly MDS with an ealed she was coded as as to the question of having huld be better off dead or of two to six days during the look on D200I. The assessment d by OSM (other staff | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495315 | | (X2) MULTIF | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---------------------|---|-----------|----------------------------|
| | | 495315 B. WING | | | 1 | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 740 | Continued From pag | e 151 | F 74 | 10 | | |
| | member) #4, the soc 9/30/21 at 4:51 p.m. | ial services manager) on | | | | |
| | revealed the followin | #61's physician's orders g orders, dated 9/24/21: ledPsychiatry as needed." | | | | |
| | interventions addres | e of staff assessment or sing Resident #61's until 10/4/21, when OSM #4 | | | | |
| | about wishing she w Stated she had no p of the clinical record | ered yes to having thoughts as dead/harming herself. an in place." Further review failed to reveal a safety plan | | | | |
| | was implemented an assessment was cor provided prior to the jeopardy on 10/21/2 | npleted and services identification of immediate | | | | |
| | conducted with OSM social services mana a resident states that he or she would be thimself or herself whinterview then she as place, documents a | p.m., an interview was (other staff member) #4 (the ager). OSM #4 stated that if the or she has thoughts that better off dead, or of hurting ile completing the mood sks if he or she has a plan in note and notifies the floor or director of nursing. | | | | |
| | conducted with ASM member) #2 (the director of nursing). states that he or she would be better off d be placed on 15 min | p.m., an interview was (administrative staff ector of clinical services- ASM #2 stated if a resident has thoughts that he or she ead then the resident should utes checks until evaluated 1 #2 further stated that if a | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | FIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|------------------------|--|-----------------------------------|----------------------------|
| | | 495315 | B. WING _ | | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | CODE | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE |
| F 740 | resident should be p supervision until eval. On 10/26/21 at 8:25 could not find any eval. notified any other statement of question [I having thoughts about dead/harming herse! On 10/26/21 at 3:50 staff member) #1, the director of clinical regional vice preside informed of these council No further information 6. The facility staff for the supervision of | ne or she is suicidal then the laced on one to one luated by the physician. a.m., OSM #4 stated she vidence verifying that she had aff member of Resident #61's D200I documenting yes to ut wishing she was lf. p.m., ASM (administrative e executive director, ASM #2, al services, and ASM #3, the ent of operations, were incerns. | F | 740 | | |
| | Resident #13, who see would be better off doin some way on a quest) assessment on no evidence of remoresident's room or the were provided to Reand 10/21/21. Resident # 13 was a diagnoses that inclustraumatic brain injury syndromes associated disturbances and phand muscle weaknesset), a quarterly asset), a quarterly asset | dmitted to the facility with ded but were not limited to: y [1], unspecified behavioral ed with physiological ysical factors, epilepsy [2] | | | | |

| l' ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|---------|---|-------------------------------|----------------------------|
| | | 495315 | B. WING | B. WING | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | 1 | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | 100 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 740 | brief interview for me of 0 - 15, three [3] - b cognition for making 13 was coded as req of one staff member Section D "Mood" are Interview (PHQ-9)" c "Symptom Presence' you would be better of yourself in some way Frequency" it docum Signed by RN [regist MDS supervisor, "Au The POS [physician's October 2021 failed to behavioral health ser Review of the facility 08/02/2021 through assessment of Resident themselves, rotification to the phy assessment of Resident to evidence do psychology or psychial The comprehensive dated 05/20/2021 with 11/01/2021 failed to evidence do psychology or psychial themselves. On 10/21/21 at 1:39 conducted with OSM | as scoring a three [3] on the ental status (BIMS) of a score peing severely impaired of daily decisions. Resident # uiring extensive assistance for activities of daily living. Pea "D0200 Resident Mood coded Resident # 3 under " as "Yes" for "Thoughts that off dead, or of hurting "." Under "Symptom ented "2-6 [two to six] days." ered nurse] # 3, previous gust 2, 2021 at 12:52 p.m." es order summary] dated to evidence an order for vices. Is nursing notes dated 10/21/2021 failed to evidence sident # 13's statement of monitoring of Resident # 13, visician and/or an lent # 13's mental health. Is sident # 13's progress notes cumentation from fatric services providers. | F | 740 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | 1 ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---------------------|--|-----------------|--|
| | | 495315 | B. WING | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION | |
| F 740 | he or she would be himself or herself w interview then she a place, documents a nurse, unit manage On 10/25/2021 at 4 conducted with OSI social services mar was any follow-up t hurting themselves. Resident # 13 maki was determined Re wanted to hurt them being severely impage. | he or she has thoughts that better off dead, or of hurting hile completing the mood asks if he or she has a plan in note and notifies the floor or or director of nursing. 100 p.m., an interview was M [other staff member] # 4, hager. When asked if there or Resident # 13's statement of if they were aware of they were aware of the statement and how it sident # 13 indicate they have mental they have a sired of cognition for making M # 4 stated they would look | F 740 | | | |
| | conducted with ASI member] # 2, direct asked to describe the resident indicate the themselves in some them on Q15 [every document it until the resident, if suicidal remove the call bell tap bell." On 10/26/2021 at 8 conducted with OSI social services man 10/25/2021 as state there was no evider interventions related of thoughts of hurting resident the services in the conducted with OSI social services man 10/25/2021 as state the conducted with 10/25/2021 as state the conducted with 10/25/2021 as state the conducted with 10/25/20 | 25 a.m., an interview was M [other staff member] # 4, agger in regard to questions on ed above. OSM # 4 stated that nee of any follow-up or d to Resident # 13's statement ng themselves. In regard to N # 3 determined services. When he process they follow when a rey want to harm/hurt way ASM # 2 stated, "We put way ASM # 4 stated that nee of any follow-up or d to Resident # 13's statement ng themselves. In regard to N # 3 determined Resident # | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | IPLE CONSTRUCTION IG | (X3 | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|----------------------|--|----------------------------------|----------------------------|--|
| | | 495315 | B. WING | | | C 10/26/2021 | |
| NAME OF PR | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP C | ODE | 10/20/2021 | |
| CONSULA | TE HEALTH CARE OF W | OODSTOCK | | 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | |
| (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 ((EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 740 | Continued From page | ÷ 155 | F 7 | 40 | | | |
| | 13 indicated that they OSM # 4 stated, "I do | wanted to hurt themselves n't know." | | | | | |
| | staff member] # 1, ex director of clinical ser | 0 p.m., ASM [administrative ecutive director, ASM # 2, vices, ASM # 3, regional rations, were made aware of | | | | | |
| | No further information | n was provided prior to exit. | | | | | |
| | head injury causes da Symptoms of a TBI m weeks following the ir mildest type. It can ca pain, nausea, ringing tiredness. People with may have those, plus headache that gets w repeated vomiting or seizures, Inability to a speech, Weakness or legs, dilated eye pupi obtained from the we | nay not appear until days or njury. A concussion is the ause a headache or neck in the ears, dizziness, and a moderate or severe TBI other symptoms: A corse or does not go away, nausea, Convulsions or waken from sleep, Slurred r numbness in the arms and ls. This information was | | | | | |
| F 755 | recurring seizures. The clusters of nerve cells send out the wrong silviolent muscle spasm. This information was https://medlineplus.go/Pharmacy Srvcs/Prod | edures/Pharmacist/Records | F 7 | ·55 | | 12/1/21 | |
| SS=D | CFR(s): 483.45(a)(b) | (1)-(3) | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---------------------|---|--|-------------------------------|--|
| | | 495315 | B. WING _ | | | C 0/26/2021 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 0/20/2021 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHO | | (X5) COMPLETION DATE | |
| F 755 | drugs and biologicals them under an agree §483.70(g). The faci personnel to adminis permits, but only und a licensed nurse. §483.45(a) Procedur pharmaceutical servithat assure the accur dispensing, and adm biologicals) to meet t §483.45(b) Service C must employ or obtain pharmacist who- §483.45(b)(1) Providing aspects of the provision the facility. §483.45(b)(2) Establication facility. §483.45(b)(3) Determined and design and that an accis maintained and permits REQUIREMENT by: Based on staff interview, it was determined to provide pharmacides. | dervices vide routine and emergency to its residents, or obtain ment described in lity may permit unlicensed ter drugs if State law er the general supervision of es. A facility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and the needs of each resident. Consultation. The facility in the services of a licensed es consultation on all ion of pharmacy services in ishes a system of records of on of all controlled drugs in able an accurate nines that drug records are in count of all controlled drugs | F 7 | 1. The MD was notified or omission for resident #24 10/25/2021. The resident Eliquis as per MD order wadverse effects. The MD the medication omission f | Eliquis on s is receiving vithout any was notified of | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
|--------------------------|---|---|--------------------|--|--|-------|---|
| | | | A. BUILDI | _ | | , | С |
| | | 495315 | B. WING | | | | /26/2021 |
| NAME OF PI | ROVIDER OR SUPPLIER | | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| CONSULA | TE HEALTH CARE OF V | WOODSTOCK | 803 SOUTH MAIN ST | | | | |
| CONCOLA | TE TIEAETH OAKE OF | WOODO TOOK | | WOODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 755 | Continued From pag | e 157 | | 755 | | | |
| | The facility staff facility sta | | | 100 | Diazepam on 10/25/202. The resident | ie | |
| | medication Eliquis (1 | | | | receiving Diazepam as per MD order | 13 | |
| | | sident #24 on 7/5/21 and | | | without any adverse effects. | | |
| | 7/29/21. | | | | | | |
| | | | | | 2. Residents that reside in the facility h | ave | |
| | 2. The facility staff fa | ailed to assure the | | | the potential to be affected. A quality | | |
| | medication Diazepar | n was acquired, and received | | | review will be conducted by the Directo | or of | |
| | | Resident #53, per the | | | Clinical Services for missed medication | | |
| | physician order on 1 | 0/21/21 through 10/23/21. | | | administration over the past 2 weeks a | nd | |
| | | | | | Physician and RP's will be notified as | | |
| | The finalizate in alreda. | | | | indicated and follow up based on findir | ıgs. | |
| | The findings include: | | | | 3.The Director of Nursing or designee | will | |
| | Resident #24 was ac | dmitted to the facility on | | | educate licensed nursing staff on | WIII | |
| | | 24's diagnoses included but | | | following the six rights of medication | | |
| | | abetes, atrial fibrillation (1) | | | administration, following MD orders for | | |
| | | ke. Resident #24's quarterly | | | administering medications and the | | |
| | minimum data set as | | | | process for refilling prescriptions along | | |
| | assessment reference | ce date of 8/27/21, coded the | | | with use of emergency medication sup | | |
| | resident's cognitive s | skills for daily decision | | | A) Unit Managers and or designee will | | |
| | making as modified i | ndependence. | | | conduct medication administration | | |
| | | | | | observations weekly x 4 weeks then | | |
| | | orehensive care plan dated | | | monthly x 6 months to ensure medicat | | |
| | 8/2/20 documented, | ` , | | | are administered per physician order. I review of the missed medication | 3) A | |
| | | ease. Give medications for | | | | .~ | |
| | improved blood flow ordered" | or anticoagularits as | | | administration report will be done during daily clinical meeting and variances wi | | |
| | ordered | | | | addressed, and corrective action and | | |
| | Review of Resident | #24's clinical record revealed | | | education will be provided. Provider wi | | |
| | | ated 3/12/21 for Eliquis 2.5 | | | notified when medications were not | | |
| | | ng (milligrams) - one tablet by mouth two times a | | | administered. This will continue for 6 | | |
| | | scular disease (2). Resident | | | months to ensure ongoing compliance | | |
| | | R (medication administration | | | | | |
| | record) documented the order for Eliquis 2.5 mg- one tablet by mouth two times a day. On 7/5/21 | | | 4. The results of the Quality Monitoring | , to | | |
| | | | | be reviewed at the monthly Quality | | | |
| | | 9/21 at 5:00 p.m., the nurse | | | Assurance Performance Improvement | | |
| | | he medication as being | | | (QAPI) meetings for review, analysis, a | and | |
| | | MAR documented the code, | | | further recommendations. | | |
| | U OTDOT/SOO NIIIROO | NOISE " A DURGE POIS ASISA | 1 | | l | | i contract of the contract of |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | | |
|---|---|--|-------------------------|-----------------------------------|---|------------------------------|----------------------------|--|
| | | 495315 | B. WING _ | | | | /26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | 1 10 | 20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SH | | | (X5) COMPLETION DATE | |
| F 755 | reordered." A nurse documented, "not a On 10/20/21 at 1:41 conducted with LPN LPN #1 stated nurse requests to the phal directly through the stated if a medication then she calls the p medication from the various medications STAT box. Review of the list for during July 2021 fair contained in the box On 10/20/21 at 5:12 staff member) #1 (the ASM #2 (the director made aware of the stated aware of the stated in the box of the stated in the box of the stated in the box in the facility pharmace of the stated in the box of the stated in the stated in the box of the stated in | p.m., an interview was I (licensed practical nurse) #1. es can fax medication refill rmacy or request a refill computer system. LPN #1 on is needed and not available harmacy or obtains the e STAT box (a box containing e) if the medication is in the rthe STAT box in the facility led to reveal Eliquis was c. 2 p.m., ASM (administrative ne executive director) and or of clinical services) were above concern. | F | 755 | 5. 12/01/2021 | | | |
| | fibrillation (a condition irregularly, increasing | on in which the heart beats ng the chance of clots forming sibly causing strokes) that is | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | _ | (X3) DATE SURVEY COMPLETED | |
|---|--|--|--------------------|---|---|-------------------------------|----------------------------|
| | | 495315 | B. WING _ | | | | 26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, S 803 SOUTH MAIN ST WOODSTOCK, VA 226 | , i | 101 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORR | R'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 755 | https://medlineplus.go tml (2) Peripheral vascula the blood vessels tha This information was https://medlineplus.go 2. Resident #53 was 2/8/21 with diagnoses hardening and disinter bones, quadriplegia a recent MDS (minimur assessment with an Adate) of 9/6/21, the remoderately impaired having scored 12 out interview for mental serceiving a medication seven days of the loo On 10/24/21 at 4:26 parents requested to Resident #53's mother regarding Resident #medications as order had not received Diagrams. He stated since that time. A review of Resident revealed, in part, the 5 mg (milligrams. Giv bedtimerelated to a A review of Resident | ralve disease." This ned from the website: by/druginfo/meds/a613032.h or disease is a condition of t supply the feet and legs. obtained from the website: by/ency/article/000170.htm admitted to the facility on sincluding cerebral palsy, egration of the spinal cord and nerve pain. On the most m data set), a quarterly ARD (assessment reference esident was coded as being for making daily decisions, of 15 on the BIMS (brief tatus). He was coded as n to treat anxiety on all k back period. b.m., Resident #53 and his meet with the survey team. For reported concerns and receiving his ed. She stated Resident #53 are pam since Wednesday, and sonfirmed his mother's he had been "miserable" #53's physician's orders following: "Diazepam Tablet e 2 tablets by mouth at | F | 755 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|--------------------|-----|--|-------------------------------|----------------------------|
| | | 495315 | B. WING | | | | 26/2021 |
| | ROVIDER OR SUPPLIER | | | 8 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | 10/2 | 20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 755 | documented: "9 =Oth A review of Resident revealed, in part: "10/21/2021 11:23 p.t Administration Note Tavailable." "10/22/2021 10:47 p.t Administration Note Tavailable." "10/23/21 10:11 p.m Note Text: medication Further review of Reservealed, in part, the (6:00 p.m.) Nursing P calls to [ASM (admini (medical director and physician)] on numero (Diazepam)to be caresident. 1430 (2:30 1530 (3:30 p.m.), 163 goes to voicemail tha The nurse who wrote for interview at the tin A review of Resident plan dated 3/11/21 re #53] uses anti-anxiety anti-anxiety medication physician." | re for the Diazepam 21/21, 10/22/21, and for the October 2021 MAR er/See Nurse Note." #53's progress notes mMedication Text: medication not Medication Administration In not available." sident #53's progress notes following: "10/23/2021 18:00 Progress Note: Attempted strative staff member) #8 Resident #53's attending ous occasions to get Valium alled to pharmacy for this p.m.), 1450 (2:50 p.m.), 55 (4:35 p.m.) no answer, at says that mailbox is full." this note was unavailable ane of the survey. #53's comprehensive care vealed, in part: "[Resident y medicationsAdminister | F | 755 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | ···· | | C 1 0/26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | • | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | I SHOULD BE | (X5) COMPLETION DATE |
| F 755 | care of Resident #53 upset because he had the past few nights. So personally faxed the (nurse practitioner), a member) #6, on Thu she had called ASM would soon be comp and needed a refill. So Diazepam is a contro required the NP or p the pharmacy to auth not work between Th morning (10/25/21), opportunity follow up when she arrived at 10/25/21, she discove finally been re-ordere not been delivered to she had looked for, it locate the refill reque on 10/21/21. Review of the facility revealed that Diazep the box for administr On 10/26/21 at 9:34 director and Resider was interviewed. Wh authorizing refills for stated the facility nur refill needs a week b out. He stated if he re he can send an elect pharmacy, or he can | She stated she was taking at that morning and that he is as not received his Diazepam She stated she had refill request to the NP ASM (administrative staff rsday, 10/21/21. She stated #6 and told her Resident #53 eletely out of the Diazepam, She stated because blled substance, a refill hysician to directly contact norize it. She stated she did nursday, 10/21/21 and that she had not had the on this refill. She stated work at 7:00 a.m. on rered the medication had ed on 10/24/21, but still had be the facility. RN #5 stated but had not been able to ests she had faxed to ASM #6 | F 7 | 55 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF A. BUILDING | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C | |
|---|--|---|---|---|----------|------------------------------|--|
| | | 495315 | B. WING | | | 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 755 | the nurses at the far as well as the phonopractitioners, and the providers. When as facility staff had attended voicemail had not be to the voicemail had not be to the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the provider to sign on the staff prints out the staff prints out the provider to sign of the provider to sign of the staff prints out the staff prints out the staff prints out the provider to sign out the staff prints out the staff pr | cility have his phone number, enumbers for both nurse ey should call one of the ked if he was aware that empted to call him over the he was not. He stated his een full over the weekend. 9 p.m., ASM #6, the nurse erviewed. She stated if a fill for a controlled medication, he paper prescription for the cheir next visit to the facility. It is needed urgently, the staff he can directly transmit an est to the pharmacy. She received any phone calls or curses regarding Resident escription. 2 p.m., ASM #2, the director of is interviewed. She stated if a largent refill for a controlled ing staff may all a provider vider to transmit the refill he pharmacy. She stated she by concerns regarding | F 75 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | | 495315 | B. WING | | | l | C |
| | ROVIDER OR SUPPLIER | | | 80 | REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MAIN ST OODSTOCK, VA 22664 | 10/ | 26/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | X | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 755 | states he/she was nerefill. No further information REFERENCES (1) "Diazepam is used control agitation caus is also used along wit control muscle spasm certain neurological dipalsy (condition that comovement and baland move parts of the boomuscle contractions), rare disorder with must his information is taken and the control muscle contractions. | ance refill while the provider ver contacted about the a was provided prior to exit. If to relieve anxiety and to ed by alcohol withdrawal. It hother medications to as and spasticity caused by isorders such as cerebral causes difficulty with ce), paraplegia (inability to ly), athetosis (abnormal and stiff-man syndrome (a scle rigidity and stiffness)." | F 7 | 755 | | | |
| F 760 SS=D | CFR(s): 483.45(f)(2) The facility must ensu §483.45(f)(2) Resider medication errors. This REQUIREMENT by: Based on staff intervireview, it was determ failed to ensure a resisignificant medication residents in the surve | its are free of any significant is not met as evidenced iew and clinical record ined that the facility staff dent was free from a | F7 | 760 | 1. The MD was notified of the medicatiomission for resident #24 Eliquis on 10/25/2021. The residents is receiving Eliquis as per MD order without any adverse effects. 2. Residents that reside in the facility has the potential to be affected. A quality review will be conducted by the Director Clinical Services for residents with order. | ave r of | 12/1/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | 1 | C 0/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCE | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | EFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE | |
| F 760 | 3/29/20. Resident # were not limited to d and a history of strol minimum data set as assessment reference resident's cognitive s making as modified Resident #24's comp 8/2/20 documented, Peripheral Artery Dis improved blood flow ordered" Review of Resident a physician's order of mg (milligrams) - one day for peripheral va Resident #24's July administration record | dmitted to the facility on 24's diagnoses included but liabetes, atrial fibrillation (1) are. Resident #24's quarterly esessment with an ce date of 8/27/21, coded the skills for daily decision independence. The ending of the endications for or anticoagulants as #24's clinical record revealed lated 3/12/21 for Eliquis 2.5 er tablet by mouth two times a escular disease (2). | F7 | 760 | for blood thinning medications to ensure medication is being administered as per MD order. Any abnormal findings will be reported to the MD and follow up base on orders. 3. The Director of Nursing or designed educate licensed nursing staff on following the six rights of medication administration, following MD orders for administering medications and the process for refilling prescriptions along with use of emergency medication sup A) Unit Managers and or designee will conduct medication administration observations weekly x 4 weeks then monthly x 6 months to ensure medication administration report will be done durin daily clinical meeting and variances will addressed, and corrective action and of education will be provided. Provider will notified when medications were not | er be d will ply. | | |
| | day. On 7/5/21 at 5: p.m., the nurse did nas being administered the code, "9=other/S A nurse's note dated medication and was dated 7/29/21 document of 10/20/21 at 1:41 conducted with LPN LPN #1 stated nurse requests to the pharman stated in the conducted with LPN LPN #1 stated nurse requests to the pharman stated nurse requests to the pharma | rablet by mouth two times a 00 p.m. and 7/29/21 at 5:00 of document the medication ed. The MAR documented ee Nurse Notes." \ 7/5/21 documented, "out of reordered." A nurse's note mented, "not available." p.m., an interview was (licensed practical nurse) #1. es can fax medication refill macy or request a refill computer system. LPN #1 | | | administered. This will continue for 6 months to ensure ongoing compliance 4. The results of the Quality Monitoring be reviewed at the monthly Quality Assurance Performance Improvement (QAPI) meetings for review, analysis, a further recommendations. 5. 12/01/2021 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|--|--|---------------------|--|-------------------------------|
| | | 495315 | B. WING | | C 10/26/2021 |
| | ROVIDER OR SUPPLIER | 1 | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION |
| F 760 | then she calls the predication from the containing various mis in the STAT box. Review of the list for during July 2021 fail contained in the box On 10/20/21 at 4:02 conducted with LPN a blood thinning mere prescribed for atrial important to administ the physician because a blood clot or put a On 10/20/21 at 5:12 staff member) #1 (th ASM #2 (the director made aware of the amount of the contained in the provide a policy regarderors. On 10/20/21 at 5:30 provide a policy regarderors. On 10/26/21 at 2:11 facility did not have the contained in the prescribed for a facility did not have the contained in the prescribed for the prescri | n is needed and not available harmacy or obtains the STAT [immediate] box (a box hedications) if the medication of the STAT box in the facility ed to reveal Eliquis was . p.m., an interview was #2. LPN #2 stated Eliquis is dication that is usually fibrillation. LPN #2 stated it is ter Eliquis as prescribed by se a missed dose can cause resident at risk for a stroke. p.m., ASM (administrative e executive director) and of clinical services) were above concern. p.m., ASM #1 was asked to arding significant medication p.m., ASM #1 stated the | F 766 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | | C 26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 760 | strokes or blood clots fibrillation (a condition irregularly, increasing in the body and possi not caused by heart v information was obtain https://medlineplus.go tml (2) Peripheral vascula | s) is used help prevent s in people who have atrial n in which the heart beats g the chance of clots forming libly causing strokes) that is | F | 7760 | DEFICIENCY) | | |
| F 770 SS=D | https://medlineplus.gd Laboratory Services CFR(s): 483.50(a)(1) §483.50(a) Laborator §483.50(a)(1) The facility and timeliness of the (i) If the facility provid services, the services requirements for labor of this chapter. This REQUIREMENT by: Based on staff intervices review, and clinical redetermined that the fallaboratory testing for survey sample, Resident | ry Services. cility must provide or obtain or meet the needs of its responsible for the quality services. Ides its own laboratory or must meet the applicable or atories specified in part 493 To is not met as evidenced review, facility document ecord review, it was acility staff failed to provide one of 41 residents in the dent #26. The facility staff ratory testing ordered for | F | 770 | Physician notified and declined to he additional labs for resident #26. Quality review completed for labs and diagnostics ordered since 10/20/21 to identify any other residents affected by this practice. Physician notification for | ıd | 12/1/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING _ | | | | C / 26/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | 1000.10 | <u> </u> | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 12012021 | |
| | 10115211 011 001 1 21211 | | | | 03 SOUTH MAIN ST | | | |
| CONSULA | TE HEALTH CARE OF W | VOODSTOCK | | | VOODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | EFIX (EACH CORRECTIVE ACTION SHOULD | | | (X5) COMPLETION DATE | |
| F 770 | 6/30/17, and most red with diagnoses includ artery disease, and end the most recent MDS quarterly assessment reference date) of 7/2 coded as being cognidecisions, having scool BIMS (brief interview resident was coded a staff for bed mobility, hygiene, and bathing received dialysis service period. A review of Resident revealed the following count) with diff (different metabolic panel), CR Ferritin (Iron level), D | mitted to the facility on cently readmitted on 8/24/21, ling diabetes, peripheral and stage kidney disease. On (minimum data set), a with an ARD (assessment 23/21, Resident #26 was tively intact for making daily ared 15 out of 15 on the for mental status). The s requiring the assistance of dressing, toileting, personal. He was coded as having rices during the look back #26's physician's orders g: "CBC (complete blood entiation), BMP (basic P (C-reactive protein), -dimer (clotting level), tting) one time a day every | F 7 | 7770 | other residents with this deficient practions. 3. Licensed staff re-education on obtaining labs and diagnostics per the physician order by the DON/designee. 4. The Administrator is responsible for maintaining compliance. The DON/designee will quality monitor labs and diagnostics 3 times weekly for 4 weeks and then monthly for 6 months. Follow up based on findings and report to the facilities monthly QAPI meeting. Quality Monitoring schedule modified based on findings. 5. 12/01/2021. | ; | | |
| | TARs (treatment adm | sident #26's September 2021 inistration records) and ealed no results for the ordered for 9/30/21. | | | | | | |
| | | #26's comprehensive care vealed, in part: "Obtain and c work as ordered." | | | | | | |
| | nurse) #1 was intervi | o.m., LPN (licensed practical ewed. She stated the boratory) tests that need to | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | /OODSTOCK | | STREET ADDRESS, CITY, STATE, ZI 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | IP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI) TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | |
| F 770 | LPN #1 stated the nut for a lab test fills out at the book. When the carrive at the facility, the obtain blood specime she is not sure why R not performed for 9/3 any evidence that the On 10/21/21 at 8:36 a staff member) #2, the confirmed the lab test Resident #26 on 9/30 shift nurse is respons all lab requests for a land in the book for the ASM #2 stated she correquest sheet for Resident with the director of clinical regional vice presider #4, the regional clinic these concerns. A review of the facility Diagnostic and X-ray, physician's order for I testing, and X-ray. Correquisition form (s). Sindicated." | rook at the nurses' desk. rse who receives an order a request slip, and puts in outside lab company staff ney check the book and ns as ordered. She stated desident #26's lab tests were 0/21, but she could not find of tests were done. a.m., ASM (administrative of director of clinical services, as had not been done for of labeled the night ible for double checking that coarticular day are accurate of outside lab company. Ould not locate a lab test ordered the hight of the stated the hight of the stated the hight ordered the hight of the stated the night | F | 770 | | | |
| F 842 SS=D | No further information Resident Records - Io CFR(s): 483.20(f)(5), | | F 8 | 342 | | 12/1/21 | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | l | 26/ 2021 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | 10/ | 20/2021 |
| CONSULA | TE HEALTH CARE OF W | OODSTOCK | | 8 | 03 SOUTH MAIN ST WOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX (EACH CORRECTIVE ACTION SHOULD | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 842 | §483.20(f)(5) Resider (i) A facility may not re- resident-identifiable to (ii) The facility may re- resident-identifiable to accordance with a co- agrees not to use or of except to the extent the to do so. §483.70(i) Medical re- §483.70(i) Medical re- §483.70(i) (1) In accordance professional standard must maintain medical that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The fact all information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permit with 45 CFR 164.506 (iv) For public health a neglect, or domestic of activities, judicial and law enforcement purp purposes, research p medical examiners, for a serious threat to he | nt-identifiable information. elease information that is to the public. lease information that is to an agent only in intract under which the agent disclose the information the facility itself is permitted cords. dance with accepted as and practices, the facility al records on each resident ented; e; and ganized dility must keep confidential thed in the resident's records, an or storage method of the release is- release | F | 842 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | 1 | C 0/26/2021 | |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | 80 | TREET ADDRESS, CITY, STATE, ZIP CODE 03 SOUTH MAIN ST VOODSTOCK, VA 22664 | | ·· | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF REGULATORY OR LSC IDENTIFYING INFORMATION) TAG | | х | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 842 | Continued From page | e 170 | F | 842 | | | | |
| | record information agunauthorized use. | ility must safeguard medical gainst loss, destruction, or | | | | | | |
| | §483.70(i)(4) Medical records must be retained for- | | | | | | | |
| | | required by State law; or ne date of discharge when ent 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; | | | | | | | |
| | | | | | | | | |
| | · | | | | | | | |
| | (v) Physician's, nurse professional's progre | e's, and other licensed ss notes; and | | | | | | |
| | services reports as re | logy and other diagnostic equired under §483.50. Γ is not met as evidenced | | | | | | |
| | and clinical record re facility staff failed to e accurate medical rec | view, facility document review view, it was determined the ensure a complete and ord for two of forty-one ey sample, Resident #230 | | | Resident #230 no longer at facility. Resident #2 pain level is documented prior to pain medication administration of 11/20/2021. | as | | |
| | and Resident #2. 1. The facility failed to provide a complete and accurate medical record for Resident #230, for documentation on the TAR (treatment | | | | 2. Quality review of documentation records completed since 11/1/2021 to | | | |
| | | | | | ensure records are complete and accurate. | | | |
| | administration record |) for the wound vacuum as ordered on 8/24/21 night | | | Nursing staff re-educated on providicomplete and accurate records on | ng | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | C 10/26/2021 | |
| NAME OF P | ROVIDER OR SUPPLIER | 100010 | | S | TREET ADDRESS, CITY, STATE, ZIP CODE | 1 10/ | 26/2021 |
| NAME OF T | TOVIDER OR SOLT LIER | | | | | | |
| CONSULA | TE HEALTH CARE OF W | VOODSTOCK | | | 03 SOUTH MAIN ST | | |
| | | | | V | VOODSTOCK, VA 22664 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 842 | Continued From page | e 171 | F8 | 342 | | | |
| | shift and 8/30/21 day | shift, and ostomy care every | | | 11/20/2021 by DON/designee | | |
| | shift as ordered on 8/ | 24/21, 8/25/21 and 8/26/21 | | | | | |
| | as well as day shift or | n 8/30/21. | | | 4. The Administrator is responsible for | | |
| | | | | | maintaining compliance. The | | |
| | | provide a complete and | | | DON/designee to quality monitor | | |
| | | ord for the documentation of | | | medication and treatment administration | n | |
| | 1 5 | e administration of pain | | | records weekly for 4 weeks and then | | |
| | medication on the MA | | | | monthly for 6 months to ensure | | |
| | administration record |) for Resident #2. | | | compliance. Follow up based on findir and reported to the facilities monthly Q | | |
| | | | | | meeting. Quality Monitoring schedule | AFI | |
| | The findings include: | | | | modified based on findings. | | |
| | The illiangs illolade. | | | | modified based on infamigs. | | |
| | 8/20/21 with diagnose limited to: Diabetes m function normally in the obstructive pulmonary non-reversible lung d disease 'ESRD' (inabwaste and to function electrolyte balance in | y disease 'COPD' (chronic isease) (2), end stage renal ility of the kidneys to excrete in the maintenance of the body) (3) and abscess (accumulation of pus in the | | | 5. 12/01/2021. | | |
| | with an ARD (assessi 8/26/21, coded Resid of 15 on the BIMS (br status) score, indicati | my Medicare assessment ment reference date) of lent #230 as scoring a 15 out rief interview for mental | | | | | |
| | G-functional status co | | | | | | |
| | | ssistance for bed mobility, | | | | | |
| | | and dressing and bathing; | | | | | |
| | | hygiene and supervision for | | | | | |
| | eating. A review of MDS Section H- bowel and | | | | | | |
| | | sident as having an ostomy | | | | | |
| | for bowel and an indv | velling catheter for bladder. | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | PLE CONSTRUCTION G | (X3 | (X3) DATE SURVEY COMPLETED | | |
|--|--|--|---|-----|--------------------------------------|----------------------------|--|
| | | 495315 | B. WING_ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | 10/20/2021 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX | | RRECTION SHOULD BE APPROPRIATE | (X5) COMPLETION DATE | |
| F 842 | A review of Resident plan dated 9/2/21, the documents in part, "I and right gluteal abs ADL (activities of dai INTERVENTIONS-Tuse: He is not toilete colostomy and is depthese devices." A review of the physical documented in part, continuously running every shift and as new administration record documentation of working every shift of 8/30/21 day shift. A review of Resident evidence documentation of working every shift of 8/30/21 day shift. A review of Resident evidence documentation as needed 8/24/21, 8/25/21 and on 8/30/21. An interview was con AM with LPN (license asked what blanks of stated, "Well, it could charting." When asked when asked when asked charting." | #230's comprehensive care e comprehensive care plan FOCUS-Resident has scrotal cess. Decline in mobility and ly living). reatment per order. Toilet ed. He has a catheter and bendent on staff for care of cian orders dated 8/20/21, "Wound vacuum every shift. Colostomy care ededd. #230's TAR (treatment | F8 | 42 | | | |
| | remember missing a | ring for him and I don't ny treatments." nducted on 10/26/21 at 9:46 | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|-----------------------|--|-------------------------------|----------------------------|--|
| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | DE | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR | | ID PREFIX TAG | PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 842 | the TAR indicates, L means we didn't get he remembered cari #10 stated, "Yes, I d blanks on the TAR, s LPN #10 stated, "I b A review of the facili Records" policy, dat part, "Clinical Recor accordance with pro to provide complete each resident for co On 10/26/21 at 3:52 staff member) #1, th the director of clinica regional vice preside aware of the concer No further information References: (1) Barron's Dictiona Non-Medical Reade Chapman, page 120 (3) Barron's Dictiona Non-Medical Reade Chapman, page 498 (4) Barron's Dictiona (4) Barron's Dictiona Non-Medical Reade Chapman, page 498 (4) Barron's Dictiona | When asked what blanks on PN #10 stated, "Usually it it charted." When asked if ng for Resident #230, LPN o." When asked what the shown to LPN #10 meant, elieve it is charting error." ty's "Clinical/Medical ed 8/2017, documented in ds are maintained in fessional practice standards and accurate information on intinuity of care." PM, ASM (administrative e executive director, ASM #2, al services and ASM #3 the ent of operations were made ins. on was provided prior to exit. ary of Medical Terms for the r, 7th edition, Rothenberg and other, 7th edition, Rothenberg and | F 8 | 42 | | | |
| | 2. Resident #2 was | admitted to the facility on | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--|---|------------------------------|-------------------------------|----------------------------|--|
| | | 495315 | B. WING _ | | | C 10/26/2021 | | |
| NAME OF PI | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | 10/20 | 0/2021 | |
| CONSULA | TE HEALTH CARE OF V | /OODSTOCK | | WOODSTOCK, VA 22664 | | | | |
| (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 C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BI IE APPROPRIA | | (X5) COMPLETION DATE | |
| F 842 | limited to: Diabetes m function normally in the disease (decreased for frequently as a comparight below the kneed removal of right leg by the most recent MDS assessment, a quarter (assessment reference the resident as scorin BIMS (brief interview indicating the resident review of the MDS Seconded the resident as assistance for hygien and dressing and indimobility and transfers A review of MDS Seconded the resident as and for bladder. On 7/27/21 the compitation of chronic back pain. [medications] per ord A review of the physical documented in part 100. | es that included but were not delitus (inability of insulin to the litus (inability of insulin to the body) (1), chronic kidney function of the kidneys ication of diabetes) (2) and camputation 'RBKA' (surgical felow the knee) (3). So (minimum data set) for insuling assessment with an ARD for date) of 10/19/21, coded of a 13 out of 15 on the for mental status) score, at was cognitively intact. A fection G-functional status is requiring extensive for eating, bed for all and bladder is always continent for bowel for the bowel and bladder is always continent for bowel for the side of the care plan ocus. The care plan ocus always continent for bowel in the care plan ocu | F | 342 | | | | |
| | following: | #2's MAR revealed the | | | | | | |
| | | MAR evidenced /codone 5 milligram tablet ocumented pain level of '0' | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY | |
|--|---|---|---|--------|---|--------|----------------------------|
| | | 495315 | B. WING | | | | C / 26/2021 |
| | ROVIDER OR SUPPLIER | WOODSTOCK | • | 803 SO | TADDRESS, CITY, STATE, ZIP CODE UTH MAIN ST OSTOCK, VA 22664 | 1 10 | 20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 842 | The October 2021 Mocumentation of Oadministration for the on 10/2/21 4:12 AM 10:08 PM, 10/15/21 AM, 10/17/21 at 12:10/19/21 at 8:44 PM 10/21/21 at 12:18 AM An interview was concent of O-10, or their faction review the document Resident #2, LPN stated, "I was the of O-10, or their faction review the document Resident #2, LPN stated, "I was the of O-10, or their faction willigram would be guent LPN #8 stated, "I was malligram would be guent level of 0." When the MAR, LPN #1 LPN #8 pulled up has showed that on one was documenting the medication. His pair was never lower that Oxycodone, a narcount when asked if this of since the 'O' appears stated, "No, this is not an interview was concent of the was documenting the oxycodone, and with LPN #5, the When asked about the MAR for pain medical MAR for pain medical management of the was concentrated." | PM, 9/26/21 at 5:34 AM. MAR evidenced xycodone 5 milligram tablet e documented pain level of '0', 10/3/21 9:01 PM, 10/7/21 at at 11:51 PM, 10/16/21 at 5:52 05 AM, 10/18/21 at 5:55 AM, 1, 10/20/21 at 6:08 AM and | F | 342 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | | | | | (| С |
| | | 495315 | B. WING _ | | | 10/ | 26/2021 |
| | ROVIDER OR SUPPLIER | VOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CO 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | DE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | N SHOULD BE E APPROPRIA | | (X5) COMPLETION DATE |
| F 842 | Continued From page | ∍ 176 | F | 842 | | | |
| | staff member) #1, the the director of clinical regional vice presider aware of the concerns | | | | | | |
| F 886 SS=E | References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 160. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 119. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 29. (4) 2019 Lippincott Drug Guide for Nurses, Wolters Kluwer, page 283. COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not | | F | 886 | | | 12/1/21 |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIF | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
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| | | 495315 | B. WING | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | <u>'</u> | 0/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 886 | this paragraph diagn COVID-19 in the faci (iii) The identification this paragraph with s consistent with COV suspected exposure (iv) The criteria for coasymptomatic individual paragraph, such as t COVID-19 in a count (v) The response time (vi) Other factors specified in the factors of COVID-19 in a count (v) The response time (vi) Other factors specified in the paragraph (iii) COVID-10 (ii) COVID-10 (iii) COVID-10 (iii) COVID-10 (iiii) COVID-19, take a transmission of COVID-19, take a transmission of COVID-19, take a transmission of COVID-19 (iiii) COVID-19 (iiiiiii) COVID-19 (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii | of any individual specified in osed with lity; of any individual specified in symptoms ID-19 or with known or to COVID-19; onducting testing of luals specified in this he positivity rate of ty; e for test results; and ecified by the Secretary that went the IID-19. Stuct testing in a manner that trent standards of practice for 9 tests; each instance of testing: sting was completed and the test; and resident records that testing ted (as appropriate ang status), and the results of in the identification of an in this paragraph with ID-19, or who tests positive actions to prevent the | F 88 | 36 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | | 26/ 2021 |
| | ROVIDER OR SUPPLIER | | | 80 | REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MAIN ST OODSTOCK, VA 22664 | 10/ | 20/2021 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE | |
| F 886 | substitute testing or are substitute to the substitute testing or are substitute to the contact state and local health departments, such as obtain processing test result. This REQUIREMENT by: Based on staff intervive review, it was determined to evidence do testing was complete employee reviews. The facility staff failed that COVID-19 testing results of each staff to September 2021 and the substitute that the substitute | gement and volunteers, who unable to be tested. In necessary, such as in esting supply shortages, artments to assist in testing ning testing supplies or its. To is not met as evidenced liew and facility document ined that the facility staff cumentation that COVID-19 d for fourteen of 45. If to evidence documentation g was completed and the est for multiple employees in October 2021. Unumentation revealed the 19 outbreak status on ew of facility documentation nice that the facility staff DVID-19 testing from 8/26/21 urvey (10/19/21). Review of ests revealed the following: Dorary nurse aide) hired on taff failed to evidence inpleted testing for the weeks | F | 386 | 1. Staff identified during survey have been tested for COVID per CMS guidar and testing is ongoing based on guidar 2. Quality review of residents and staff ensure that all tested per the Center for Medicare and Medicaid by DON/design by 11/18/2021. 3. Staff re-educated on COVID-19 testing per the county transmission and outbreak testing by the DON/designee 11/18/2021 4. The Administrator is responsible for maintaining compliance. The DON/designee to complete weekly revi of testing and random observation wee for 4 weeks then monthly for 6 months ensure compliance maintained. Follow based on findings and reported to the facilities monthly QAPI meeting. Qualit Monitoring schedule modified based or findings. 5. 12/01/2021 | ew kly to up | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ' | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 886 | 10/16/21. -For RN #2 hired or failed to evidence detecting for the week -For CNA #15 hired | on 9/21/21, the facility staff ocumentation of completed ending 10/2/21. on 4/19/21, the facility staff ocumentation of completed | F 8 | 36 | | | |
| | -For ASM #7 (nurse practitioner) hired on 8/31/20, the facility staff failed evidence documentation of completed testing for the weeks ending 9/18/21, 9/25/21, 10/2/21, 10/9/21 and 10/16/21. -For CNA #1 hired on 8/25/21, the facility staff failed to evidence documentation of completed testing for the weeks ending 9/11/21 and 9/25/21. -For OSM #21 (dietary supervisor) hired on 4/6/20, the facility staff failed to evidence documentation of completed testing for the weeks ending 9/11/21, 9/18/21, 9/25/21, 10/2/21 and 10/16/21. | | | | | | |
| | on 5/12/20, the faci documentation of co ending 10/2/21 and -For RN #4 hired or failed to evidence of testing for the week 10/16/21. | on 9/14/21, the facility staff ocumentation of completed as ending 9/25/21, 10/9/21 and on 3/2/21, the facility staff ocumentation of completed | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING | | C 10/26/2021 | | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETIO | | |
| F 886 | Continued From pa | ge 180 | F 886 | 5 | | | |
| | failed to evidence of testing for the weel 9/25/21, 10/2/21, 1 -For CNA #9 hired failed to evidence of testing for the weel 9/25/21, 10/2/21, 1 -For CNA #23 hired failed to evidence of testing for the weel testing for the weel of th | 6 a.m., an interview was M #21. OSM #21 stated she 0-19 every Tuesday and | | | | | |
| | On 10/26/21 at 8:4 conducted with CN been tested twice a nurses or someone. On 10/26/21 at 8:5 conducted with #9. the survey, staff we testing. OSM #9 st the tests were posiforms and gave the staff member) #1 (t asked who was trainensure required testions.) | 9 a.m., an interview was A #9. CNA #9 stated she had a week for COVID-19 by a | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | B. WING | | | | 26/ 2021 |
| NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | | 8 | STREET ADDRESS, CITY, STATE, ZIP CODE 103 SOUTH MAIN ST WOODSTOCK, VA 22664 | - | |
| | ACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY) | | (X5) COMPLETION DATE |
| responsite On 10/26 conducte services a stated in tested po tested an ASM #1 s based test were kep On 10/26 conducte testing re would go employee learned th On 10/26 why there employee The facili documen Federal a and resid Investigar -Date cas -Date all -Results a -Outbreal (contact t F 919 SS=E CFR(s): 4 | d with ASM and infection August 2021 sitive, she to d would nee stated the fasting. ASM at in a book in 421 at 9:04 at d with ASM accords were atthrough the eroster. AS the employee was no trace testing. ASM at COVID-19 ted, "Testing and State regentsDocur ion includes se was ident other residents and of all test k Testing strategistrates. | as a tracking roster. a.m., an interview was #2 (the director of clinical a preventionist). ASM #2 I when the first resident old ASM #1 all staff had to be d to be tested twice weekly. cility was conducting broad #1 stated all testing records in ASM #1's office. a.m., an interview was #1. ASM #1 stated the kept in his office and he test results based on an M #1 stated he had now e roster was not complete. b.m., ASM #2 was asked cking for COVID-19 SM #2 shook her head. b) pandemic plan g: 1. Centers will follow gulations for testing of staff mentation: Outbreak i: ified ints and staff were tested d staff were retested ategy used and rational pad-based testing)" | | 919 | | | 12/1/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | | 495315 | 495315 B. WING | | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COD 803 SOUTH MAIN ST | | 10/20/2021 | |
| | | | WOODSTOCK, VA 22664 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETION DATE | |
| F 919 | Continued From page | e 182 | F 9 | 19 | | | |
| | residents to call for st communication syste | dequately equipped to allow aff assistance through a m which relays the call nber or to a centralized staff | | | | | |
| | by: Based on observation interview, facility document record review, it was staff failed to maintain system for two of 41 manuals. The findings include: 1. The facility staff fair call bell was operation. Resident #8 was adm 8/13/20. Resident #8 were not limited to madiabetes and muscle annual minimum data assessment reference resident as being cog coded Resident #8 as assistance of two or resident of two or resident limited to madiabetes and muscle annual minimum data assessment reference resident as being cog coded Resident #8 as assistance of two or resident limited to madiabetes and muscle annual minimum data assessment reference resident as being cog coded Resident #8 as assistance of two or resident limited l | n, resident interview, staff ument review and clinical determined that the facility n an operational call bell residents in the survey 3 and #130. led to ensure Resident #8's nal since July 2021. nitted to the facility on l's diagnoses included but ajor depressive disorder, weakness. Resident #8's n set assessment with an le date of 8/2/21, coded the initively intact. Section G | | 1. Resident #8 and #130 call ringing bell in reach and oper Licensed Practical Nurse on 2. Quality review completed by Maintenance Director on 10/2 identify any other resident that been affected. 3. Staff re-education complete 11/18/2021 by DON/designed system and that call bells that operational is placed in the molog. 4. The Administrator is responsantaining compliance. The DON/designee will complete monitoring of call bells and/or in reach and operational, using round sheets and reviewing round sheets and reviewing round reported to the facilities reference. Quality Monitoring states. | ational by the 10/20/2021. by the 20/2021 to at could have ed on e on call bell tare not eaintenance ensible for e quality ringing bells and daily maintenance ere on findings monthly QAPI | | |
| | signal when the call be interview was conduction | pell was pressed. An sted with Resident #8 at this ted that he sometimes uses | | modified based on findings. 5. 12/01/2021 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---|-----|--|-------------------------------|----------------------------|
| | | 495315 | B. WING | | | | 26/ 2021 |
| NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | | 8 | STREET ADDRESS, CITY, STATE, ZIP CODE 103 SOUTH MAIN ST NOODSTOCK, VA 22664 | 10 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY) | | (X5) COMPLETION DATE |
| F 919 | conducted with OSM maintenance director #8's call bell has not 2021 but the resident bell. OSM #1 stated issues such as install cord but some issues fixed by an outside conducted had notified the outsing Resident #8's call between in the facility. On 10/20/21 at 5:12 pataff member) #1 (the ASM #2 (the director made aware of the all times, a system to is needed. The call be on a regularly scheduthe Call Bell System one hall, or the entire procedure must be for Procedure: -Maintenance, the Expirector of Clinical Seimmediately if any call inoperable. -Hand bells or tap typerach of any resident call bell. Residents all their usage. -The Director of Main Director will focus on | a.m., an interview was (other staff member) #1 (the). OSM #1 stated Resident been operational since July did have a hand held ring he can fix some call bell ling a new switch or new such as wiring have to be ompany. OSM #1 stated he de company regarding Ill but they had not recently o.m., ASM (administrative executive director) and of clinical services) were over concern. ed, "Call Bell System- nted, "Resident must have, at a notify staff when assistance ell system is to be inspected uled basis by Maintenance. If is inoperable, in one room, e unit, the following | F | 919 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495315 | B. WING _ | | | | C 26/2021 | |
| | NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK SUMMARY STATEMENT OF DEFICIENCIES | | | 80 | REET ADDRESS, CITY, STATE, ZIP CODE 3 SOUTH MAIN ST OODSTOCK, VA 22664 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 919 | Continued From page | : 184 | F S | 919 | | | | |
| | Note: The outside cor Resident #8's call bel | mpany came onsite to repair I during the survey. | | | | | | |
| | No further information | was presented prior to exit. | | | | | | |
| | · · | led to ensure Resident perational on 10/19/21. | | | | | | |
| | 10/14/21. Resident # but were not limited to diabetes and muscle admission minimum of | dmitted to the facility on 130's diagnoses included o chronic kidney disease, weakness. Resident #130's lata set assessment with an e date of 10/21/21, coded cognitively intact. | | | | | | |
| | resident's call bell wa | bserved in their room. The s tested and was not as no light or sound signal | | | | | | |
| | conducted with OSM maintenance director bells were checked by department during the Resident #130's call bell has to be pushed off or the bedroom call that stated this can especially be a stated this can especially be a support of the second of the bedroom switch is well on 10/19/21 at approximation. | e previous week and pell was functioning. OSM attached to the bathroom call all the way up when turned II bell will not signal. OSM pecially occur when the pern and loose. Eximately 3:00 p.m., the verified and Resident #130's | | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | IPLE CONSTRUCTION NG | COMPLETED | |
|--------------------------|--|---|---------------------|--|------------------------|----|
| | | 495315 | B. WING _ | | C 10/26/2021 | |
| | ROVIDER OR SUPPLIER | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE COMPLETION | NC |
| F 919 | replaced the call bell bathroom. On 10/10/21 at 12:3 conducted with Resishe uses the call be sure do." On 10/20/21 at 5:12 staff member) #1 (th ASM #2 (the director made aware of the ask was as a sure do." No further information Required In-Service CFR(s): 483.95(g)(1) §483.95(g) Required aides. In-service training mass systems with the service training mass systems and resident systems are sident systems and resident systems and resident systems are sident systems and resident systems are systems are systems are systems and systems are systems are systems are systems and systems are systems are systems are systems and systems are systems are systems and systems are systems. | p.m., OSM #1 stated he I switch in Resident #130's 2 p.m., an interview was ident #130. When asked if II, Resident #130 stated, "I p.m., ASM (administrative he executive director) and rof clinical services) were above concern. In was presented prior to exit. Training for Nurse Aides)-(4) Id in-service training for nurse hust- fficient to ensure the noce of nurse aides, but must hours per year. It dementia management to abuse prevention training. It is areas of weakness as aides' performance reviews | F 9 | 019 | 12/1/21 | |
| | address the special determined by the fa §483.95(g)(4) For not to individuals with co | neent at § 483.70(e) and may needs of residents as acility staff. urse aides providing services ognitive impairments, also the cognitively impaired. | | | | |
| | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | , , | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|---|-------------------------------|--|
| | | 495315 | B. WING _ | | | C 10/26/2021 | |
| NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | WOODSTOCK | | STREET ADDRESS, CITY, STATE, ZIP CODE 803 SOUTH MAIN ST WOODSTOCK, VA 22664 | | 10/20/2021 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 947 | by: Based on staff intereview, it was deteralled to ensure CN completed required two of three CNA re CNA #6). The facility staff fail completed annual a ensure CNA #6 con abuse training. The findings included to revice the conducted annual and record failed to revice the completed annual and training. CNA #6 was hirederecord failed to revice the completed annual and training. On 10/20/21 at 9:3 conducted with OS human resources call training are comprogram and the system thought abuse be done annually, each employee's tremployment on 5/3 stated she told employee's tremployment on their training. | erview and facility document rmined that the facility staff lAs (certified nursing aides) annual in-service trainings for ecord reviews, (CNA #5 and led to ensure CNA #5 abuse training and failed to enpleted annual dementia or let | F9 | 1. CNA #5 and CNA #6 cor abuse training on 11/20/202 completed annual dementia the policy on 11/20/2021. 2. Quality review of facility sthat annual abuse and dem completed per the policy. 3. Staff re-education on time of annual required in-service DON/designee. 4. The Administrator is resp maintaining compliance. Th DON/designee will complete monitoring monthly for 6 m compliance with staff require Follow-up based on findings to the monthly QAPI meetin monitoring schedule modified findings. 5. 12/01/2021 | 21. CNA #6 a training per staff to ensure entia training ely completion e by the consible for e quality onth to ensure ed in-services. s and reported ig. Quality | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|--|--------------------------------------|--|-------|----------------------------|
| | | 495315 | B. WING _ | | | 10/ | 26/2021 |
| NAME OF PROVIDER OR SUPPLIER CONSULATE HEALTH CARE OF WOODSTOCK | | | | STREET ADDRES 803 SOUTH MA WOODSTOCK | | 1 107 | 20/2021 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX | | PROVIDER'S PLAN OF CORRECTION ICH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 947 | abuse training for CN two days a month. On 10/20/21 at 5:12 p staff member) #1 (the ASM #2 (the director made aware of the above the facility policy title General" documented provided in-service train annual basis2. Fin-services may include requirements based of local regulations, and required in-service exception of the company o | for CNA #5 or dementia or A #6 who only works one or on ASM (administrative executive director) and of clinical services) were cove concern. d, "In-Service Training-d, "Employees will be aining on required topics on dequired education and de a combination of on Federal, State, and/or may include Company fucation topics. Each Care to ensure that required r Local regulations are | F | 47 | | | |
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