PRINTED: 04/21/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495389	B. WING		04	C 1/12/2023	
	ROVIDER OR SUPPLIER TER HEALTH & REHA	BILITATION		41212023			
(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 CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
E 000	An unannounced E survey was conduc 4/12/23/23. Correc compliance with 42 Requirement for Lo	tions are required for CFR Part 483.73, ng-Term Care Facilities. No dness complaints were	E 00	This Plan of Correction constitutes this facility's write allegation of compliance for deficiencies cited. This Plan Correction is submitted to no requirements established by state and federal law.	the of neet		
E 037 SS=D	EP Training Progra CFR(s): 483.73(d)( \$403.748(d)(1), \$4* \$441.184(d)(1), \$48 \$483.73(d)(1), \$48 \$485.68(d)(1), \$48 \$485.727(d)(1), \$48 \$485.727(d)(1).  *[For RNCHIs at \$4* Hospitals at \$482.1 at \$484.102, REHs under \$485.727, Ole RHC/FQHCs at \$48 (1) Training progra the following: (i) Initial training in policies and procedstaff, individuals pro arrangement, and v expected roles. (ii) Provide emerge least every 2 years (iii) Maintain docum preparedness traini (iv) Demonstrate st procedures. (v) If the emergence	m 1)  16.54(d)(1), §418.113(d)(1), 60.84(d)(1), §482.15(d)(1), 3.475(d)(1), §484.102(d)(1), 5.542(d)(1), §486.360(d)(1), 35.920(d)(1), §486.360(d)(1), 603.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" POs at §486.360, 31.12:] m. The [facility] must do all of emergency preparedness jures to all new and existing eviding services under volunteers, consistent with their ency preparedness training at entation of all emergency	E 03	1. CNA (Certified Nursing Assistant) #3 was provided training on the Emergency Preparedness Plan.  2. All residents of the facility can be affected by this deficient practice. The facility will complete an audit of all current staff to ensure all have had training on the EP Plan.  3. The facility staff will be provided with training on the Emergency Preparedness Plan.  4. The HR Coordinator will monitor education on the Emergency Plan upon hire and annually. The		05/26/23	

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.

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

Event ID: XQEH11

Facility ID: VA0123

If continuation sheet Page 1 of 130

NAME OF PROVIDER OR SUPPLIER  WINCHESTER HEALTH & REHABILITATION  (X4) 10 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  E 037  Continued From page 1 must conduct training on the updated policies and procedures.  "[For Hospices at §418.113(d):] (1) Training. The hospice employees, and individuals providing services under arrangement, consistent with their expected roles.  (ii) Demonstrate staff knowledge of emergency procedures.  (iii) Provide emergency preparedness training at least every 2 years.  (iv) Periodically review and rehearse its emergency preparedness placed on carrying out the procedures necessary to protect patients and procedures necessary to protect patients and the procedures necessary to protect patients.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
MINCHESTER HEALTH & REHABILITATION    SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)    E 037   Continued From page 1 must conduct training on the updated policies and procedures.    *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness staff), with special emphasis placed on carrying out the			495389	B. WING		_	
PRÉFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY   DATE      Continued From page 1   reviewed annually during   reviewed annually during   the facility assessment and   on an Ad hoc basis with   significant changes to the   facility.   facility.   facility.   facility   facility.   facility   facility.   facility   facilit			LITATION	110	0 LAUCK DR	( 04/1	2/2023
E 037 Continued From page 1 must conduct training on the updated policies and procedures.  *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL	OULO BE	COMPLETION
others.  (v) Maintain documentation of all emergency preparedness training.  (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.  *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:  (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.  (ii) After initial training, provide emergency preparedness training every 2 years.  (iii) Demonstrate staff knowledge of emergency procedures.	E 037	must conduct training procedures.  *(For Hospices at §4* hospice must do all of (i) Initial training in empolicies and procedure hospice employees, a services under arrange expected roles.  (ii) Demonstrate staff procedures.  (iii) Provide emergen least every 2 years.  (iv) Periodically revie emergency prepared employees (including special emphasis pla procedures necessar others.  (v) Maintain document preparedness training (vi) If the emergency procedures are significant must conduct training procedures.  *(For PRTFs at §441 program. The PRTF (i) Initial training in empolicies and procedus staff, individuals provarrangement, and vo expected roles.  (ii) After initial training preparedness training (iii) Demonstrate staff	is an the updated policies and is a 13(d):] (1) Training. The if the following: nergency preparedness res to all new and existing and Individuals providing gement, consistent with their knowledge of emergency cy preparedness training at w and rehearse its ness plan with hospice nonemployee staff), with ced on carrying out the ry to protect patients and intation of all emergency g. preparedness policies and ficantly updated, the hospice on the updated policies and all of the following: mergency preparedness res to all new and existing riding services under funteers, consistent with their g, provide emergency gevery 2 years.	E 037	the facility assessment and on an Ad hoc basis with significant changes to the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495389		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/12/2023		
	ROVIDER OR SUPPLIER TER HEALTH & REHA	BILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLÉTION		
E 037	preparedness train (v) if the emergency procedures are sign must conduct training procedures.  *[For PACE at §466 organization must (i) Initial training in policies and procedures, arrangement, contrivolunteers, consist (ii) Provide emerge least every 2 years (iii) Demonstrate sign procedures, including what to do, where case of an emerge (iv) Maintain document (v) If the emergency procedures are sign must conduct training procedures.  *[For LTC Facilities Program. The LTC following: (i) Initial training in policies and procedures staff, individuals prarrangement, and expected role. (ii) Provide emergered.	nentation of all emergency ing.  y preparedness policies and nificantly updated, the PRTF ng on the updated policies and  0.84(d):] (1) The PACE do all of the following: emergency preparedness dures to all new and existing oviding on-site services under factors, participants, and ent with their expected roles, ency preparedness training at the following at the following at the following participants of the go, and whom to contact in	E 037				
	least annually. (iii) Maintain docun preparedness train	nentation of all emergency ing.	_				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	COMP	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHA	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		324	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY 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	COMPLETION DATE	
*[For CORFs at §48 CORF must do all of (i) Provide initial trapreparedness policiand existing staff, in under arrangement with their expected (il) Provide emerge least every 2 years (iii) Maintain docum (iv) Demonstrate st procedures. All never and assigned speciathe CORF's emergentheir first workday, include instruction is alarm systems and equipment.  (v) If the emergent procedures are signing must conduct training procedures.  *[For CAHs at §485] The CAH must do and in the individuals providing and exting and where necessary personnel, and gue cooperation with fir authorities, to all ne individuals providing and existing and providing	aff knowledge of emergency 35.68(d):](1) Training. The of the following: Ining in emergency ies and procedures to all new individuals providing services , and volunteers, consistent roles. Incy preparedness training at inentation of the training. Inentation of the training. Inentation of the training at inentation of the training. Inentation of the training are personnel must be oriented iffic responsibilities regarding incy plan within 2 weeks of in the location and use of i	EO	37			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B. WING		04/12/2023		
	ROVIDER OR SUPPLIER	ABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COM	XS) PLETION IATE	
E 037	least every 2 year (iii) Maintain docur (iv) Demonstrate s procedures.  (v) If the emerge procedures are signast conduct train procedures.	ency preparedness training at s. mentation of the training. staff knowledge of emergency ncy preparedness policies and phificantly updated, the CAH ning on the updated policies and	E 037				
	CMHC must provipreparedness polipreparedness polipreparedness polipreparedness polipreparedness polipreparedness polipreparedness procedures. The emergency preparedness polipreparedness polipre	485.920(d):] (1) Training. The de initial training in emergency cies and procedures to all new individuals providing services at, and volunteers, consistent d roles, and maintain the training. The CMHC must knowledge of emergency eafter, the CMHC must provide redness training at least every 2 ENT is not met as evidenced terview and facility document staff failed to provide					
	CNA (certified nur The findings include		9				
		alled to evidence emergency ning was provided to CNA #3,	-			13	
	member) #4, the h stated she could r #3 was provided e	22 p.m., OSM (other staff numan resources manager, not provide evidence that CNA emergency preparedness stated the facility uses an					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C	
		495389	B. WING		04/12/2023	
	PROVIDER OR SUPPLIER STER HEALTH & REH	ABILITATION	STR 110 WIN			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
E 03	online training pro when the facility w OSM #4 stated sh then employees re certain trainings the On 4/12/23 at 1:39 staff member) #1, the director of nur- above concern.	gram and the program changed was sold in December 2022. The sets up the training program eceive automatic notifications of that are due.  9 p.m., ASM (administrative the administrator, and ASM #2, sing, were made aware of the	E 037			
	survey was condu Seven complaints survey (VA000556 deficiency; VA000 deficiency; VA000 deficiency; VA000 deficiency; VA000 deficiency). Corre compliance with 4 Term Care - Requ survey/report will	s 60 bed certified facility was 50 survey. The survey sample urrent resident reviews and 19		1. The physician/NP was	5/26/23	
F 58 SS≃	O Notify of Changes CFR(s): 483.10(g §483.10(g)(14) No (i) A facility must i consult with the re	(Injury/Decline/Room, etc.)	F 580	1. The physician/NP was notified of all dates that Lyrica was not available for administration and facility verified medication availability for residents #37, 14, 262.	3,20,23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495389	B. WING_		5 8	C 04/12/2023		
	ROVIDER OR SUPPLIER TER HEALTH & REHAB	ILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	WINCHESTER, VA 22603  PROVIDER'S PLAN OF CORF  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AI  DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 580	results in injury and in physician intervention (B) A significant charmental, or psychosory deterioration in health status in either life-the clinical complications (C) A need to alter the aneed to discontinue treatment due to advect commence a new for (D) A decision to transident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatics available and proving physician. (iii) The facility must resident and the resiwhen there is-(A) A change in room as specified in §483. (B) A change in resident and the resident and the resident and the resident and the resident that the address (phone number of the representative(s).  §483.10(g)(15) Admission to a computation of the representative(s).	en there isving the resident which has the potential for requiring on; age in the resident's physical, cial status (that is, a n, mental, or psychosocial reatening conditions or eatment significantly (that is, a an existing form of erse consequences, or to m of treatment); or eafer or discharge the elity as specified in ification under paragraph (g), the facility must ensure that ion specified in §483.15(c)(2) ided upon request to the elito promptly notify the dent representative, if any, an or roommate assignment 10(e)(6); or lent rights under Federal or ons as specified in paragraph is.  record and periodically mailing and email) and	F5	2. All residents of the facility can be affected by thi deficient practice. The facility will audit MARS for April, and the provider will be notified of an medications unavailable and corrections will be made as appropriate.  3. Licensed staff will be educated on the facility policy for medication availability an notification of missing medications.  4. The DON/Designee we audit 3 residents per week for 8 weeks for notification to physician. The results the weekly audits will reported monthly to the QAPI Committee x months. The facility QAPI Committee is responsible for the on-goi monitoring of Compliance.	see of III ye., ee oe oe of iIII ek on of be he 3 API ble ong			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495389	B. WING			=   0	C 4/12/2023	
NAME OF PR	OVIDER OR SUPPLIER		s	TREET ADDRESS, CIT	TY, STATE, ZIP CODE		11116	
WINCHES	TER HEALTH & REHABI	LITATION	95	10 LAUCK DR VINCHESTER, VA	22603			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	DER'S PLAN OF COP DRRECTIVE ACTION FERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 580	Continued From page	3 7 mg/m	F 580		8		三天	
	its physical configurationations that comprise part, and must specific room changes between	tion, including the various se the composite distinct y the policies that apply to en its different locations					·	
	by: Based on staff interv review, it was determ	is not met as evidenced iew, and clinical record ined the facility staff failed to				14		
	when medications we administration for three	party and/or the physician ere not available for see of 32 residents in the dents #37, #14 and #262.				t.	940	
	The findings include:						175,	
	to notify the physician	R37), the facility staff failed when medications when a, was not available for				Ve.		
) <	assessment, a quarte assessment reference resident scored a 12 interview for mental s	ADS (minimum data set) erly assessment, with an e date of 1/16/2023, the out of 15 on the BIMS (brief status) score, indicating the tely cognitively impaired for as.						
5-		mately 2:00 p.m. R37 stated f their Lyrica (used to treat		70			22	
65	The physician order of documented, "Lyrica mouth two times a da	75 mg; Give 1 capsule by			33		2 22	
	The February 2023 n	nedication administration					8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B. WING		C 04/12/2023		
	ROVIDER OR SUPPLIER	BILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
F 580	record (MAR) docum 2/12/2023 and 2/13/9:00 p.m. doses a "\$ 2/14/2023 for the 9:0 documented. A "9" is notes."  The nurse's notes for the "9" documented. A "9" is notes."  The nurse's notes for the "9" documented. An interview was copractical nurse) #2, When asked what the medication is not availed to be add. "The (name of pharmedications in the bhas many of the menarcotic, then you not available in the should the nurse docall the pharmacy to practitioner that it is Lyrica was not in the shown when the Lyr nurses documented stated she was not unavailability of the stated that sometimedications and even medications can take ASM (administrator, ASM and ASM #4, the restant of the state of	nented the above order. On (2023 for the 9:00 a.m. and 9" was documented. On 00 a.m. dose a "9" was ndicated, "Other/See nurse's or the dates and times with read, "On order."  Inducted with LPN (licensed on 4/11/2023 at 3:14 p.m. ne process is when a railable at the time it is ministered, LPN #2 stated, macy machine with building) is the best thing. It dications we need. If it's a eed two nurses to get it out of a asked if the medication is (name of machine), what the composition of	F 58				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A, BUILDING				COMP	(X3) DATE SURVEY COMPLETED C		
		495389	B. WING			_		12/2023	
	ROVIDER OR SUPPLIER	ILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603					04/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTED CROSS-REFEREI	PLAN OF CORRECTI CTIVE ACTION SHOUL NGED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 580	Continued From pag	e 9	F 5	80				28.	
	No further informatio	n was obtained prior to exit.							
2	following website:	was obtained from the ov/druginfo/meds/a605045.h		2				άŞ	
80		(R14), the facility staff failed n when medication, Lyrica, administration.							
	assessment, a quart assessment reference resident scored a 14 interview for mental	MDS (minimum data set) erly assessment, with an ce date of 12/28/2022, the out of 15 on the BIMS (brief status) score, indicating the initively impaired for making							
	The physician order documented, "Lyrica Give 1 capsule by meuropathic pain."	Capsule 25 mg (milligram);							
	record) documented "9" was documented	R (medication administration the above order for Lyrica. A for the 9:00 p.m. dose on 5/2023. A "9" indicated, notes."							
		r the above dates and 9:00 ation, read, "On order."							
	practical nurse) #2, 6 When asked what the medication is not av	ailable at the time it is ninistered, LPN #2 stated,							

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HAME OF C	ROVIDER OR SUPPLIER	495389	8. WING			1/12/2023	
	TER HEALTH & REH	ABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	has many of the marcotic, then you the machine." Who not available in the should the nurse of call the pharmacy practitioner that it by Lyrica was not in the shown when the Lanurses documented stated she was not unavailability of the ASM (administrative administrator, ASM and ASM #4, the made aware of the at 5:07 p.m.  No further informa 3. For Resident # failed to notify the administered as on R262 was admitted diagnoses that indicative the administered as on R262 was admitted diagnoses that indicative the administered as on R262 was admitted diagnoses that indicative the administered as on R262 was admitted diagnoses that indicative the machine that indicative the machine that indicative the same and the things of the	building) is the best thing. It redications we need. If it's a need two nurses to get it out of an asked if the medication is a (name of machine), what to to get it and notify the nurse is not here." LPN #2 stated the he machine. When LPN #2 was syrica was not given and the he it was on order, LPN #2 to made aware of the elyrica (for R14).  We staff member) #1, the M #2, the director of nursing, regional nurse consultant, were above concern on 4/11/2023  Ition was obtained prior to exit. 262 (R262), the facility staff physician of medications not redered on 12/28/2021.  In to the facility on with luded but were not limited to be pulmonary disease (1), congestive heart failure (2).  In the MCL (3) Solution 5mg/ml liter) Use 5mg intravenously for before meals. Start Date: 19:00 a.m.)." The eMAR in the administration area for	F 58				
	documented a *9"						

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(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 ( (EACH CORRECTIVE A  CROSS-REFERENCED T  DEFICIE	CTION SHOULD BE O THE APPROPRIAT	E	(X5) COMPLETION DATE
F 580	Other/See Nurse N - "Diltiazem HCL (4 mouth three times a Start Date: 12/28/20 documented a "9" in 12/28/2021 at 9:00	des documented in part, "9= otes" ) tablet 30mg Give 1 tablet by a day for high blood pressure. 021 0900." The eMAR n the administration area for a.m., 1:00 p.m. and 5:00 p.m.	F 58	30			# # # # # # # # # # # # # # # # # # #
	Solution 2.5 mcg/ac orally in the morning 12/28/2021 0600 (6 documented a "9" in 12/28/2021 at 6:00 - "Symbicort (6) aer (Budesonide-Formationally two times a d 12/28/2021 0900." in the administrational.m. - "acetazolamide (7 by mouth one time	rosol 160-4.5 mcg/act oterol Fumarate) 2 puff inhale ay for COPD. Start Date: The eMAR documented a "9" in area for 12/28/2021 at 9:00  The tablet 125mg Give 1 tablet a day for fluid retention. Start					S S
% ⊕	a "9" in the adminis 9:00 a.m. - "Lexapro (8) 10mg 1 tablet by mouth ir Start Date: 12/28/2	900." The eMAR documented tration area for 12/28/2021 at g (Escitalopram Oxalate) Give the afternoon for depression. 1300 (1:00 p.m.)." The a "9" in the administration at 1:00 p.m.					860 3 11 36
	- "12/28/2021 05:49 waiting on meds fro - "12/28/2021 15:32 (available)- waiting (pharmacy)." - "12/28/2021 18:38 Should be coming	2 (3:32 p.m.) med not avail for delivery from pharm  3 (6:38 p.m.) med not here yet.	ŏ			0 #E	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B. WING		1	C /12/2023	
	ROVIDER OR SUPPLIER	ABILITATION	110 L	ET ADDRESS, CITY, STATE, ZIP CODE AUCK DR CHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULO BE	(X6) COMPLETION DATE	
F 580	is not here and cladone." The nurses notes the physician for the administered as of a.m., 9:00 a.m., 1 documented above. The physician orders for the medion 12/27/2021.  The discharge surful 12/27/2021.  The discharge surful 12/27/2021 from [in part, "Severe in the setting of chave scheduled a inhaler), prn (as not (nebulizers), Spiringly SymbicortDischedist: Start taking theacetazolamide as: Diamox, Take mouth daily. Startul 2021tiotropium Commonly known puffs into the lungon: December 28, these medications 160-4.5 mcg/act in Symbicort Dose: 25 into the lungs 2 (the lungs 2 (the lungs 2) (the lungs 3) (three) times daily con 4/11/2023 at a con 4/11/2023 at a con 4/11/2023 at a constructions: Take 3.	failed to evidence notification of the medications not ordered on 12/28/2021 at 6:00 at 200 p.m. or 5:00 p.m. as the common of the medications not ordered on 12/28/2021 at 6:00 at 200 p.m. or 5:00 p.m. as the common of the medications of the medication p.m. or 5:00 p.m. as the common of the medications of the common of the	F 580				
		aff member) #1, the ed that there were no nurses					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETED C
		495389	B. WING		04/12/2023
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING					
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE COMPLETION
F 580	Continued From page	ge 13	F 58	30	
W	conducted with LPN LPN #2 stated that r documented as give eMAR. LPN #2 stat	(licensed practical nurse) #2. nedications were n by signing them off on the ed that any refusals or any			
	was notified and it w				
	conducted with ASM #3 stated that they e getting their medica after admission to they would expect a as blood pressure in started by the next e stated that they would inform them of a research with the stated that they would be stated that they would b	1 #3, nurse practitioner. ASM expected for a resident to start tions as soon as possible are facility. ASM #3 stated that my pertinent medications such nedications and inhalers to be day after admission. ASM #3 ald expect the nursing staff to slident not receiving their			
	pharmacy and at tin alternate from the s On 4/12/2023 at 1:2 administrator, ASM	nes they were able to use an tock medications.  9 p.m., ASM #1, the #2, the director of nursing and al nurse consultant were			
	Reference: (1) chronic obstruct (COPD) Disease that makes	ve pulmonary disease it difficult to breathe that can breath. This information was rebsite:			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495389	A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 04/12/2023
150	ROVIDER OR SUPPLIER	ILITATION	1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIEMENCY)	ULD BE COMPLETION
F 580	(2) congestive heart A condition in which blood to meet the bodoes not mean that about to stop workin not able to pump bloaffect one or both signiformation was obtainformation was obtainformation was obtaintps://medlineplus.cg (3) Metoclopramide symptoms caused be people who have distinctude nausea, vor appetite, and feeling after meals. Metoclopramide injet to empty the intestin procedures. Metoclopramide injet to empty the intestin procedures in the stomach and into obtained from the whites://medlineplus.cgml  (4) Diltiazem is used and to control angina class of medication blockers. It works by so the heart does not also increases the stomach. This infor website:	gov/medlineplus/copd.html.  failure the heart can't pump enough dy's needs. Heart failure your heart has stopped or is g. It means that your heart is od the way it should. It can des of the heart. This ained from the website: yov/heartfailure.html  injection is used to relieve y slow stomach emptying in abetes. These symptoms aiting, heartburn, loss of of fullness that lasts long pramide injection is also sea and vomiting caused by at may occur after surgery. ction is also sometimes used es during certain medical epramide Injection is in a called prokinetic agents. It the movement of food through estines. This information was	F 580		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B. WING		04/12	2/2023	
	ROVIDER OR SUPPLIER	DER OR SUPPLIER HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
F 580	Continued From pa	ge 15	F 58			- 1.	
	shortness of breath tightness in patient pulmonary disease that affect the lungs bronchitis (swelling to the lungs) and eleases in the lungs), medications called relaxing and opening lungs to make breatwas obtained from	ed to prevent wheezing, , coughing, and chest s with chronic obstructive (COPD, a group of diseases and alrways) such as chronic of the air passages that lead mphysema (damage to air Tiotropium is in a class of bronchodilators. It works by ng the air passages to the thing easier. This information the website: .gov/druginfo/meds/a604018.h					
	wheezing, shortness tightness caused be pulmonary diseased diseases that include emphysema). Form medications called (LABAs). It works to passages in the lurbreathe. This inforwebsite:	inhalation is used to control as of breath, and chest y chronic obstructive (COPD; a group of lung des chronic bronchitis and noterol is in a class of long-acting beta agonists by relaxing and opening air ags, making it easier to mation was obtained from the agov/druginfo/meds/a602023.h					
	condition in which can lead to gradua decreases the pres Acetazolamide is a and duration of syr headache, shortne	is used to treat glaucoma, a ncreased pressure in the eye I loss of vision. Acetazolamide sure in the eye. Iso used to reduce the severity nptoms (upset stomach, ss of breath, dizziness, tigue) of altitude (mountain)	7-2 th				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C
		495389	B. WING_		04/12/2023
	ROVIDER OR SUPPLIER TER HEALTH & REHA	BILITATION		STREET ADDRESS, CITY, STATE, ZIP COD 110 LAUCK DR WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 580	medicines to reduce retention) and to he types of epilepsy. T from the website:	ge 16 mide is used with other eledema (excess fluid p control seizures in certain his information was obtained gov/druginfo/meds/a682756.h	F 50	80	
F 607 SS=E	adults and children ago or older. Escita generalized anxiety worry and tension t for 6 months or long in a class of antide serotonin reuptake increasing the amo substance in the br balance. This infort website: https://medlineplus.tml  Develop/Implement CFR(s): 483.12(b)( §483.12(b) The fact implement written present written present and exploit misappropriation of §483.12(b)(2) Estato investigate any serior and exploit investigate and e	lity must develop and colicies and procedures that:  bit and prevent abuse, ation of residents and resident property,  blish policies and procedures uch allegations, and	F	1. The facility did an audiall current employee ensure they have a curciminal backgrocheck. The facility does have access to employee files employees terminarior to 12/1/22 cannot make change the personnel files.  2. All residents of the facility does have access to employee files employees terminarior to 12/1/22 cannot make change the personnel files.	s to rrent ound s not the for ated and s to

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G		LETED
		495389	B. WING_			C 12/2023
	ROVIDER OR SUPPLIER  TER HEALTH & REHAE  SUMMARY S	SILITATION  TATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603  PROVIDER'S PLAN OF COR		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	1	SHOULD BE	COMPLETION DATE
F 607	QAPI program requisions occurring in federally facilities in accordant Act. The policies are but are not limited to \$483.12(b)(5)(ii) Polymer Programs (3) of the Act.  \$483.12(b)(5)(iii) Polymer Programs (2) of the Act.  This REQUIREMENT by:  Based on staff internance and employee record refundation and employee record refundations included For the following employee record refundations in the following employee refunda	lish coordination with the red under §483.75.  The reporting of crimes by-funded long-term care ace with section 1150B of the ad procedures must include to the following elements.  In the following elements action 1150B(d)  The reporting and preventing and at section 1150B(d)(1) and at sect	F 6	deficient practice. The facility will complete criminal background check within 30 days of hire. The facility will complete as audit on current employed files to ensure they have current criminal background check.  3. Facility leadership and H will receive education of facility policy and procedure for obtaining criminal background checks.  4. The administrator/designee will audit up to 3 new himpersonnel files weekly X weeks to ensure compliance with the new hime check list. Results the weekly audits will be reported monthly to the facility QAPI Committee 3 months. The QAI Committee is responsible for the on-goin monitoring of compliance	R n d g d d e e w of e e x PI e e g g	
	12/1/2022, criminal 9/26/2022. 3. LPN #7 hired on evidence of a crimir was no employee re	background check was dated 2/14/2022. There was no all background check. There			_	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495389		PLE CONSTRUCTION  G	cc	TE SURVEY MPLETED  C 04/12/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		141 1212023
WINCHES	TER HEALTH & REHA	BILITATION		110 LAUCK DR WINCHESTER, VA 22603		» III
(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 (EACH CORRECTIVE ACC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 607	check. There was n 5. CNA (certified nu 7/1/2022. The crimin dated 3/15/2023. 6. LPN #8, hired 7/1 evidence of a crimin was no employee re 7. LPN #9, hired 2/1 evidence of a crimin was no employee re 8. CNA (certified nu 3/11/2022. There w background check. record. 9. RN #5, hired 5/10 evidence of a crimin was no employee re 10. OSM #12, Hum hired 8/2/2021. The criminal background employee record.	nce of a criminal background of employee record. It is in a sasistant) #7, hired and background check was a sale background check. There is in a sasistant i	F 6			
	evidence of a crimir was no employee rd 12. OSM #14, activity 8/2/2021. There was background check. 13. OSM #15, socia 7/7/2022. Criminal id 3/20/2023.  An interview was considered business office/hummember, on 4/12/20 asked the process for OSM #4 stated the and select potential	nal background check. There				

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG	(X3) DATE S	.ETEO
		495389	B. WING _		1	12/2023
	ROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	recruitment site, do the complete the rest of the	on if not already done on the ne reference checks, they he package, which includes	Fe	507		
* &	the employee, then the offenders registry, Offenders registry, Offenders registry, Offenders all done, there for orientation. When records are retained, know that answer, buyears. When asked whost completed crimin #4 stated that she justin addition to her bus further stated she did months ago and ran She stated the other	reackground check from statement. If accepting freey pull the license, sex G (office of the inspector criminal background check. by bring the staff member in asked how long employee OSM #4 state she did not to thinks it might be seven by there are missing and/or al background checks, OSM st took on this position as HR liness office duties. OSM #4 I complete an audit a few some of the ones missing. records were not available by the pullding.				
	"The organization will for a history of abuse residents."  ASM (administrative	buse" documented in part, I screen potential employees , neglect or mistreating staff member) #1, the				
	and ASM #4, the reg	2, the director of nursing, ional nurse consultant, were bove on 4/12/2023 at 1:31				
F 622 SS=D	Transfer and Dischar CFR(s): 483.15(c)(1)	(i)(i)(2)(i)-(iii)	F	1. Resident #23. #25 are discharged from the facility and the facility is		05/26/23
	§483.15(c) Transfer §483.15(c)(1) Facility			unable to make any corrective actions to the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	495389	B. WING		C 04/12/2023	
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHAB	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	1 04122023	
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)	ULD BE COMPLETION	
remain in the facility, discharge the reside (A) The transfer or d resident's welfare and cannot be met in the (B) The transfer or d because the resident sufficiently so the resident sufficiently so the resident services provided by (C) The safety of indicating end due to the status of the resident (D) The health of indicating of the resident has appropriate notice, the under Medicare or Monpayment applies submit the necessare payment or after the Medicare or Medicair esident refuses to payment or after the Medicare or Medicair esident who become admission to a facility resident only allowal or (F) The facility may resident while the aps 431.230 of this charge notice from 431.220(a)(3) of this discharge or transferor safety of the resident safety. The facility residentity. The facility residentity.	permit each resident to and not transfer or not from the facility unless-ischarge is necessary for the ad the resident's needs a facility; ischarge is appropriate t's health has improved sident no longer needs the at the facility; lividuals in the facility is the clinical or behavioral t; lividuals in the facility would gered; a failed, after reasonable and to pay for (or to have paid fedicaid) a stay at the facility. If the resident does not by paperwork for third party third party, including the doing the claim and the gray for his or her stay. For a less eligible for Medicaid after ty, the facility may charge a ble charges under Medicaid;	F 622	record. #44 went to the hospital and returned and facility is unable to make corrective action for the previous stay.  2. All residents could be affected by the alleged deficient practice. The facility will audit the last 30 days of discharges to validate what was sent with the resident when they discharged from the facility. Corrective action will be performed as appropriate.  3. Licensed nursing staff of the facility will be provided with education on the facility policy for what to send with the patient when discharged to the hospital and where to document what was sent.  4. The DON (Director of Nursing) or designee will perform an audit of up to three discharges each week for 8 weeks for		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE : COMPL	
	21	495389	B. WING _		04/1	; 12/2023
	COVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	9.	MI = 3
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 622	resident under any in paragraphs (c)(1 section, the facility or discharge is door medical record and communicated to the institution or provide (i) Documentation must include:  (A) The basis for the (i) of this section.  (B) In the case of pasection, the specific be met, facility atterneds, and the serfacility to meet the (ii) The documentate (2)(i) of this section (A) The resident's discharge is necess (A) or (B) of this section (B) A physician who necessary under pathis section.  (iii) Information promust include a min (A) Contact information processible for the (B) Resident representact information (C) Advance Direct (D) All special instrongoing care, as a (E) Comprehensive	umentation. ansfers or discharges a of the circumstances specified 1)(i)(A) through (F) of this must ensure that the transfer cumented in the resident's d appropriate information is the receiving health care ler. in the resident's medical record the transfer per paragraph (c)(1) caragraph (c)(1)(i)(A) of this ic resident need(s) that cannot empts to meet the resident vice available at the receiving need(s). Intion required by paragraph (c) in must be made by- physician when transfer or issary under paragraph (c) (1) action; and ten transfer or discharge is tearagraph (c)(1)(i)(C) or (D) of the vided to the receiving provider nimum of the following: ation of the practitioner the care of the resident. Issentative information including including or the propriate.	F	compliance for sending documentation and documenting what was sent upon resident transfer to the hospital. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495389	B. WING		04	C 1/12/2023	
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP C 110 LAUCK DR WINCHESTER, VA 22603		77 1272020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	consistent with §48 any other documer a safe and effective. This REQUIREME by: Based on staff into and facility docume failed to evidence sent to the receiving discharge for three sample, Residents.  The findings included the findings included to evidence required resident's clinical solist and care plan of when the resident on 2/25/23.  A review of R23's of resident was disched the review of the reveal evidence the receiving hospital to plan goals at the times resident's E-Interative that the receiver plan goals were care plan goals were resident was disched the receiving hospital to plan goals at the times resident's E-Interative plan goals were care plan goals were resident was disched the resident of the receiving hospital to plan goals were resident that the receiving hospital solutions are plan goals were considered that the receiving hospital solutions are plan goals were care plan goals were resident to the receiving hospital solutions are plan goals were considered that the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals were considered to the receiving hospital solutions are plan goals	at's discharge summary, 33.21(c)(2) as applicable, and atation, as applicable, to ensure a transition of care.  NT is not met as evidenced  erview, clinical record review, ant review, the facility staff clinical documentation was ag facility at the time of resident at 632 residents in the survey #23, #25, and #44.  de:  3 (R23), the facility staff failed and information regarding the status, including a medication goals, to the receiving facility was discharged to the hospital clinical record revealed the arged to the hospital on at the facility provided the with a medication list or care me of the discharge. The cut form dated 2/25/23 did not resident's medication list and are sent to the hospital.	F 62		(2Y)		
	nurse) #2, the unit She stated when a hospital, a docume form) which includ	p.m., LPN (licensed practical manager, was interviewed. resident is discharged to the ent is generated (an E-Interact es a place to check off which rse is sending to the hospital					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495389	B. WING			12/2023	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-47	122020	
WINCHES	TER HEALTH & REHAB	ILITATION		110 LAUCK DR WINCHESTER, VA 22603		43	
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 622	Continued From page	e 23	F 62	22			
	medication list and coreviewing R23's E-In LPN #2 stated she di	teract form dated 2/25/23, d not understand why the checked off as sent to the				9 30 4/2	
	staff member) #1, the	m., ASM (administrative a administrator, ASM #2, the nd ASM #4, the regional re informed of these					
<b>188</b>	Transfers," revealed recordWill clearly in for transfer or discha provided to the recei	y policy, "Facility Initiated in part: "The medical dentify the basis or reason rgeIdentify Information ving provider which at a				77	
	precautions for ongo which must include, limited to treatments implants, IVs, tubes/ comprehensive care	:Special instructions and/or ing care, as appropriate, if applicable, but are not and devices (oxygen, catheters)The resident's plan goals; cluding when last received)."					
	No further informatio	n was provided prior to exit.				20	
반	to evidence required resident's clinical sta list and care plan go	(R25), the facility staff failed information regarding the tus, including a medication als, was sent to the receiving dent was discharged to the					
	resident was dischar	nical record revealed the ged to the hospital on ted to the facility on 1/31/23.				548	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495389	B. WING		04/12/2023	
	ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TON SHOULD BE COMPLETION DATE	
F 622	Further review of the reveal evidence that receiving hospital wiplan goals at the time resident's E-Interact evidence that the recare plan goals were on 4/11/23 at 3:55 goals at 3:55 goals at 3:55 goals were on 4/11/23 at 3:55 goals were on the stated when a reposition of the nurse with the resident. Some dication list and comments were not to spital with the resident of the comments were not hospital with the resident of the comm	e clinical record failed to the facility provided the fith a medication list or care the of the discharge. The form dated 1/26/23 did not sident's medication list and the sent to the hospital.  The facility provided the form dated 1/26/23 did not sident's medication list and the sent to the hospital.  The facility provided the hospital form dated to the facility and the sending to the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand why the to the control of the hospital form dated 1/26/23, did not understand dated 1/26/23, did not understand dated 1/26/23, d	F 62	22		
	3. For Resident #44 to evidence which d	on was provided prior to exit.  (R44), the facility staff failed ocuments were sent to the a transfer to the hospital on				
	a.m. documented in (emergency departr treat (treatment) after	orm, dated 1/8/2023 at 7:39 part, "FallSend to ED nent) for eval (evaluation) and er being found on the floor bar, unwitnessed. Resident	1			

	AD DI AN OF CORRECTION IN INCIDENTIAL INCI		(X2) MULTIPLE COI	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495389	B. WING		C 04/12/2023	
	ROVIDER OR SUPPLIER	ABILITATION	110 L	ET ADDRESS, CITY, STATE, ZIP CODE AUCK DR CHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR 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	on Eliquis (used to forming) (1) 5 mg  An interview was practical nurse) #2 When asked what resident when the emergency room, E-INTERACT transcritate) form, orders, vital signs notice. When asked sent with the resident with the reside. E-INTERACT form E-INTERACT form LPN #2 stated, "Toot the transfer for documentation of	prevent blood clots from	F 622			
F 623 SS=D	the regional nurse of the above cond No further information following website: https://medlineplutml. Notice Requireme CFR(s): 483.15(c) (3) Not Before a facility tresident, the facility in Notify the resident.	s.gov/druginfo/meds/a613032.h ents Before Transfer/Discharge )(3)-(6)(8) lice before transfer. ansfers or discharges a	F 623	I. Resident #23. #25 are discharged from the facility and the facility is unable to make any corrective actions to the record. #44 was sent to hospital and returned and facility is unable to correct	05/26/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495389		A. BUILDING  B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
NAME OF B	OVIDED OD BUIDDI IED	495569			04/12/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR	
WINCHES	TER HEALTH & REHA	BILITATION			
				WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 623			F 623	record from previous admission.	
	the reasons for the	move in writing and in a		2. All residents of the facility	
	, , , , , , , , , , , , , , , , , , ,	ner they understand. The		can be affected by the	· ·
		copy of the notice to a		alleged deficient practice.	
	· · · · · · · · · · · · · · · · · · ·	e Office of the State		An audit will be performed	
	Long-Term Care O				200
		ons for the transfer or sident's medical record in		for the last 30-day	
		aragraph (c)(2) of this section;		discharges to validate that	
	and			the resident, emergency	
	(iii) include in the n	otice the items described in		contact and Ombudsman	
	paragraph (c)(5) of	this section.		were notified of the	
				discharges. Corrections	
	§483.15(c)(4) Timir			will be made as	
		fied in paragraphs (c)(4)(ii) and		appropriate.	
		n, the notice of transfer or			
		under this section must be at least 30 days before the			
	resident is transfer			3. Social Service staff of the	
		made as soon as practicable		facility and IDT team	
	before transfer or d			members will be educated	
	(A) The safety of in	dividuals in the facility would	a la	on the company policy and	
	-	der paragraph (c)(1)(i)(C) of		guidance for notification	
	this section;			of Residen	
		ndividuals in the facility would		Representative, resident	
	this section;	der paragraph (c)(1)(i)(D) of		and Ombudsman in	
		health improves sufficiently to		writing of facility-initiated	
		ediate transfer or discharge,			
		c)(1)(i)(B) of this section;		discharges.	
		ransfer or discharge is			
		ident's urgent medical needs,		8	
		c)(1)(i)(A) of this section; or		4. The Administrator o	
	1 ' '	not resided in the facility for 30		designee will audit up to	3
	days.			residents weekly X 8 week	S
	8483 15(a)(E) Can	tente of the notice. The written		who have discharged from	n
		tents of the notice. The written paragraph (c)(3) of this section		the facility for complianc	e
	must include the fo			for notification. Results of	of
				the weekly audits will b	е

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	COMPLETED COMPLETED
		495389	B. WING		C 04/12/2023
	ROVIDER OR SUPPLIER	BILITATION	11	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAUCK DR INCHESTER, VA 22603	
(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 623	(ii) The reason for (iii) The effective da (iii) The location to transferred or disch (iv) A statement of including the name and telephone num receives such requite to obtain an appea completing the form hearing request; (v) The name, additelephone number Long-Term Care O (vi) For nursing fact and developmental disabilities, the matelephone number the protection a	transfer or discharge; the of transfer or discharge; which the resident is harged; the resident's appeal rights, discharges (mailing and email), her of the entity which hests; and information on how form and assistance in hand submitting the appeal hress (mailing and email) and of the Office of the State hudsman; hillity residents with intellectual hild disabilities or related hilling and email address and hof the agency responsible for hadvocacy of individuals with habilities established under Part hental Disabilities Assistance hot of 2000 (Pub. L. 106-402, hot of the mailing and hot telephone number of the her for the protection and hot duals with a mental disorder hot protection and Advocacy hot viduals Act. hot of the notice of the facility hot protection of the notice as soon her or discharge, the facility hot protection of the notice as soon her the updated information	F 623	reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
N		495389	8. WING _		0	C 4/12/2023	
NAME OF PR	ROVIDER OR SUPPLIER			STREET AODRESS, CITY, STATE, ZIP CO			
MINCHES	TER HEALTH & REHAB	HITATION		110 LAUCK DR			
WINCHES	IER HEALIN & KENAD	ELIXION		WINCHESTER, VA 22603			
(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 ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 623	Continued From page	e 28	F6	23			
	§483.15(c)(8) Notice	in advance of facility closure					
		closure, the individual who is				X	
	•	he facility must provide		NV		a	
		ior to the impending closure				2 0	
		gency, the Office of the	1	The second secon			
		re Ombudsman, residents of			134		
		esident representatives, as				5340	
	well as the plan for th	ne transfer and adequate					
	relocation of the resid	dents, as required at §	1				
	483.70(I).		1				
	This REQUIREMEN	T is not met as evidenced					
	by:						
	Based on staff interv	view, clinical record review,					
		t review, the facility staff				E4	
		itten notification to the				75 L	
		ve (RR), the resident and/or		DH AND			
	the Office of the Stat						
	Ombudsman of a res	sident's discharge for three of				F 68	
	32 residents in the se	urvey sample, Residents	5			1	
W	#23, #25, and #44.		1	OHILL VILLE		80.1	
	The findings include:					· ·	
		(R23), the facility staff failed				IE .	
		otification to the RR, resident		- X			
	and ombudsman wh			a were a measurement in			
	discharged to the ho	spital on 2/25/23.					
	4				78		
		nical record revealed the				F 22	
		ged to the hospital on					
		ted to the facility on 2/28/23.					
	1	clinical record failed to					
		the facility notified the RR,				100	
	discharge.	sman in writing of the	70				
					8		
		.m., LPN (licensed practical			*5		
		nanager, was interviewed.					
	She stated when a re	esident is discharged to the				Į	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495389	B, WING			C /12/2023	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603				
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR 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	hospital, the nursinotifying the omb providing written on 4/11/23 at 4:2 member) #1, the interviewed. She the hospital, she RR. She stated si quarterly of facility stated she could notifications were On 4/11/23 at 5:0 staff member) #1 director of nursing	es are not responsible for udsman in writing or for notification to the resident or RR.  9 p.m., OSM (other staff social services director, was stated if a resident is admitted to types a letter to be sent to the he notifies the ombudsman y discharges to the hospital. She not provide evidence these	F 62	3			
9	Transfers," reveal transfers or dischance in notify the resident representative(s) the reasons for the language and manust be made as transfer or dischaurgent medical recopy of the notice of the State Long OmbudsmanContransfers will be smay be sent whe residents on a medical residents on a medical recognitionContransfers will be smay be sent whe residents on a medical recognitionContransfers will be smay be sent whe residents on a medical recognition.	opies of notices for emergency sent to the ombudsman, but they n practicable, such as in a list of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
		495389	B. WING		04	/12/2023	
	ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 110 LAUCK DR WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD SE IE APPROPRIATE	(X5) COMPLETION DATE	
F 623		5 (R25), the facility staff failed	F 62	23		9	
	resident and ombu discharged to the h	W				8	
	resident was disch 1/26/23 and readm Further review of the reveal evidence the	clinical record revealed the arged to the hospital on litted to the facility on 1/31/23. The clinical record failed to at the facility notified the RR, dsman in writing of the					
	nurse) #2, the unit She stated when a hospital, the nurse notifying the ombu	p.m., LPN (licensed practical manager, was interviewed. resident is discharged to the s are not responsible for dsman in writing or for otification to the resident or RR.					
	member) #1, the s interviewed. She s the hospital, she ty RR. She stated sh quarterly of facility	p.m., OSM (other staff ocial services director, was tated if a resident is admitted to rpes a letter to be sent to the e notifies the ombudsman discharges to the hospital. She ot provide evidence these made for R25.					
	staff member) #1, director of nursing.	p.m., ASM (administrative the administrator, ASM #2, the and ASM #4, the regional were informed of these					
	1	tion was provided prior to exit. 4 (R44), the facility staff failed				8	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	Œ	495389	B. WING _		0.4/	12/2023	
	NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, 110 LAUCK DR WINCHESTER, VA 22603		- 14	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 623	written notice of w transferred to the l to notify the ombu	age 31 dent and/or responsible party, a hy the resident was being nospital on 1/8/2023, and failed dsman of the transfer of	F€	523		# OF THE STREET	
	a.m. documented (emergency departreat (treatment) a	form, dated 1/8/2023 at 7:39 in part, "FallSend to ED tment) for eval (evaluation) and fter being found on the floor it bar, unwitnessed."				* 1	
	practical nurse) #2 When asked if she family anything in being transferred she has called the given them anythi transfer. When as	conducted with LPN (licensed 2, on 4/11/2023 at 3:14 p.m. 2 gives the resident and/or writing as to why the resident is to the hospital, LPN #2 stated 2 emergency room but has not no in writing regarding the ked if she notifies the #2 stated she did not.					
	member) #1, the s 4/11/2023 at 4:34 the notices of resi hospital to the om send them if they don't send them if asked if she sent	conducted with OSM (other staff social services director, on p.m. When asked if she send dents being transferred to the budsman, OSM #1 stated, "I go over night or are admitted. I they go and come back." When one for R44, OSM #1 stated no, get admitted and was not out at					
	the regional nurse	nistrator, ASM #2, and ASM #4, consultant, were made aware ern on 4/11/2023 at 5:07 p.m.					
	No further informa	ition was provided prior to exit.				W 181	

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	495389	B. WING	8. WING		
ROVIDER OR SUPPLIER	BILITATION	1	10 LAUCK DR	04/12/2023	
(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
Notice of Bed Hold	Policy Before/Upon Trnsfr	F 625 F 625		5/26/23	
§483.15(d) Notice of \$483.15(d)(1) Notice of the resident goes of nursing facility must the resident or return and resume facility; (ii) The reserve become and the resume facility; (iii) The reserve become and resume facility; (iii) The nursing facility the nursing facility and periods, we say that the resume facility the reserve become and the resume facility; (iii) The nursing facility that the reserve become and the resume facility that the reserve become and the resume facility that the resident facility that	of bed-hold policy and return- te before transfer. Before a sfers a resident to a hospital or in therapeutic leave, the t provide written information to dent representative that the state bed-hold policy, if the resident is permitted to residence in the nursing d payment policy in the state so of this chapter, if any; illity's policies regarding which must be consistent with		ere discharged from the facility and changes cannot be made to the resident record.  2. All residents of the facility can be affected by this deficient practice. Facility will conduct an audit on the last 30 days of discharges and validate bed hold policy was given and documented. Corrections will be made as appropriate.		
resident to return; a (iv) The information of this section.  §483.15(d)(2) Bedthe time of transfer hospitalization or the facility must provide resident represental specifies the duration described in paragrams. This REQUIREMENT by:  Based on staff internal facility docume failed to evidence the provided to the resident representative at the control of the resident representative at the	hold notice upon transfer. At of a resident for herapeutic leave, a nursing a to the resident and the ative written notice which on of the bed-hold policy raph (d)(1) of this section.  NT is not met as evidenced herview, clinical record review, ent review, the facility staff that a bed hold notice was ident and/or resident the time of transfer to the		3. Licensed nurses, Social Services and Admissions staff will be provided education on the facility policy for providing bed hold notice and documentation of providing bed hold notice to resident and resident representative upon resident discharge from the facility.		
	CORRECTION  ROVIDER OR SUPPLIER  TER HEALTH & REHA  SUMMARY (EACH DEFICIER REGULATORY OF  Continued From particles of Bed Hold CFR(s): 483.15(d)(1)  §483.15(d) Notice of Season in the resident goes of the facility must the resident or return and resume facility;  (ii) The nursing facility must provide to return; and continued facility or resident to return; and continued facility must provide the time of transfer hospitalization or the facility must provide the specifies the duration of this section.  §483.15(d)(2) Bedthe time of transfer hospitalization or the facility must provide the specifies the duration of the section o	ROVIDER OR SUPPLIER TER HEALTH & REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 32  Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)  §483.15(d) Notice of bed-hold policy and return-  §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-  (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;  (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;  (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.  §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.  This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER TER HEALTH & REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST SE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 32  Notice of Bed Hold Policy Before/Upon Trnsfr  CFR(s): 483.15(d)(1)(2)  \$483.15(d) (1) Notice of bed-hold policy and return- \$483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-  (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;  (ii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and  (iv) The information specified in paragraph (e)(1) of this section.  \$483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident and the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.  This REQUIREMENT is not met as evidenced by:  Based on staff interview, clinical record review, and facility document review, the facility staff failed to evidence that a bed hold notice was provided to the resident and/or resident representative at the time of transfer to the	ROVIDER OR SUPPLIER  TER HEALTH & REHABILITATION    CACH DEFICIENCY MUST BE PRECEDED BY FULL   REGULATORY OR LSC (DENTRYING INFORMATION)	

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED C	
		495389	B. WING		04/	12/2023
	ROVIDER OR SUPPLIER TER HEALTH & REHAB	ILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	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 .	(X5) COMPLETION DATE
F 625	to evidence bed hold the resident when the hospital on 2/25/24. A review of R23's cli resident was dischared 2/25/23 and readmit Further review of the reveal evidence that required bed hold not the time of discharge form dated 2/25/23 and hold notification was On 4/11/23 at 3:55 pnurse) #2, the unit in She stated when a rehospital, a document form) which includes information the nurs with the resident. She hold notification. After dated 2/25/23, understand why the checked off as having On 4/11/23 at 5:07 pstaff member) #1, the director of nursing, anurse consultant, we	23 and #25.  (R23), the facility staff failed in notification was provided to e resident was discharged to	F 625	designee will audit up to 3 residents weekly x 8 weeks who have discharged from the facility for compliance for notification. Results of the weekly audits will be reported monthly to the facility QAPI Committee x 3 months. The QAPI Committee is responsible for the on-going monitoring of compliance.		
32		ity policy, "Facility Initiated reveal information related to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	457.1	PIPLE CONSTRUCTION	СОМРІ	(X3) DATE SURVEY COMPLETED	
		495389	B. WING_		04/12/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		12/2023	
WINCHES	TER HEALTH & REHAB	ILITATION		110 LAUCK DR WINCHESTER, VA 22603		MILITANE	
(X4) IĐ 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)	SHOULD BE	(X5) COMPLETION DATE	
F 625	Continued From pag	e 34	F	525		2:	
		at the time of discharge.				9.	
	No further informatio	n was provided prior to exit.					
£	to evidence bed hold	(R25), the facility staff failed notification was provided to e resident was discharged to 23.					
- 10 6	resident was dischar 1/26/23 and readmitt Further review of the reveal evidence that required bed hold not the time of discharge form dated 1/26/23 of	nical record revealed the ged to the hospital on led to the facility on 1/31/23. In clinical record failed to the facility provided the stification to the resident at some the resident's E-Interact lid not evidence that the bed issued to the resident.				* ¥	
	nurse) #2, the unit meshe stated when a meshe hospital, a document form) which includes information the nurse with the resident. She hold notification. After form dated 1/26/23, understand why the checked off as having On 4/11/23 at 5:07 per staff member) #1, the director of nursing, a nurse consultant, we concerns.						
	No further information	n was provided prior to exit.		8,0		F 10 10	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING		C 04/12/2023
WINCHES	ROVIDER OR SUPPLIER TER HEALTH & REHA	BILITATION	S 11		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 640 SS=B	CFR(s): 483.20(f)(1) §483.20(f) Automat requirement- §483.20(f)(1) Encode a facility completes facility must encode each resident in the (i) Admission assess (ii) Annual assessmition (iv) Quarterly review (v) A subset of item reentry, discharge, (vi) Background (fairs no admission asses §483.20(f)(2) Transafter a facility compa facility must be cac CMS System information contained in the ME standard record lay and that passes state CMS and the State §483.20(f)(3) Transafter a facility and that passes state (ii) Annual assessment, a facility encoded, accurate, the CMS System, in (i) Admission assessment (iii) Significant corrections (iii) Significant corrections assessment.	ding data. Within 7 days after a resident's assessment, a the following information for facility: sment. Itent updates. Ige in status assessments. Is upon a resident's transfer, and death. Itensessment. Inditing data. Within 7 days eletes a resident's assessment, apable of transmitting to the mation for each resident DS in a format that conforms to outs and data dictionaries, andardized edits defined by inditing the following: It must electronically transmit and complete MDS data to including the following: It is ment. It is the following: It is the	F 640	reach out to Consulate Leadership to request they complete and transmit the discharge MDS' on residents #17, 16,48,47,6,49, and 46. The facility staff do not have access to complete and transmit.  2. All residents who discharge from the facility can be affected by this deficient practice. An audit will be conducted by the MDS coordinator to ensure all discharged residents discharged in the past 30 days have a discharge MDS completed and transmitted.  3. The facility MDS Coordinator will be educated on the RAI manual for completing and transmitting discharge MDS.	5/26/23
	(vi) Quarterly review (vii) A subset of iter	w. ns upon a resident's transfer,		4. The MDS coordinator will audit up to 3 discharged	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	PINSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING		C 04/12/2023	
	ROVIDER OR SUPPLIER	ABILITATION	110	EET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR ICHESTER, VA 22603	1 04/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 640	initial transmission does not have an \$483.20(f)(4) Data transmit data in the for a State which by CMS, in the for approved by CMS This REQUIREMED by:  Based on staff in review, the facility transmit MDS (mill to the CMS (Cent Services) system	, and death. (face-sheet) information, for an of MDS data on resident that admission assessment.  a format. The facility must e format specified by CMS or, mas an alternate RAI approved mat specified by the State and	F 640	residents weekly x 8 weeks to ensure the discharge MDS has been completed and transmitted. Results of the weekly audits will be submitted to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.		
	to encode and tra assessment after home on 11/30/22 R17 discharged to of the resident's of discharge MDS at transmitted. On 4/11/23 at 2:3 conducted with Lifthe MDS coordinal employment at the the facility was be LPN #1 stated she	17 (R17), the facility staff falled nsmit a discharge MDS the resident was discharged				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		SURVEY LETED	
		495389	B. WING			12/2023	
	ROVIDER OR SUPPLIER TER HEALTH & REHAB	ILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		TTIMEVEU	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE	
F 640	Continued From pag	e 37	F 64	30		4	
10	was sold in Decembe not pull over once the	er 2022 and the record did a facility was sold.			8 30	i i	
3-	staff member) #1, the	.m., ASM (administrative e administrator, and ASM #2, g, were made aware of the					
3	Submission Timefrar facility will conduct a	rdance with current federal					
	to encode and transi	(R16), the facility staff failed mit a discharge MDS resident was discharged			E 19		
	of the resident's clini	ome on 11/25/22. A review cal record failed to reveal a essment was encoded and					
20	conducted with LPN the MDS coordinator employment at the father facility was behind LPN #1 stated she discharge MDS assess was sold in December not pull over once the						
	staff member) #1, th	.m., ASM (administrative e administrator, and ASM #2, g, were made aware of the					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/21/2023 **FORM APPROVED** 

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	COMPLETED
		495389	B. WING		C 04/12/2023
	ROVIDER OR SUPPLIER	ABILITATION	12	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 640	to encode and trar assessment after thome on 11/22/22 R48 discharged to of the resident's clidischarge MDS as transmitted. On 4/11/23 at 2:38 conducted with LP the MDS coordina employment at the facility was believed the facility was believed and transmitted on 4/11/23 at 5:18 staff member) #1, the director of nursabove concern.  4. For Resident #4 to encode and transassesment after another facility on R47 discharged to review of the residencoded and transfer encoded encode	8 (R48), the facility staff failed ismit a discharge MDS he resident was discharged home on 11/22/22. A review inical record failed to reveal a sessment was encoded and p.m., an interview was N (licensed practical nurse) #1, tor. LPN #1 stated she began a facility in September 2022 and hind on MDS assessments. In did not get to complete R48's assessment before the company on the record did the facility was sold.  It p.m., ASM (administrative the administrator, and ASM #2, sing, were made aware of the large MDS the resident was discharged to 11/21/22. A dent's clinical record failed to MDS assessment was	F 64		
	the MDS coordina	PN (licensed practical nurse) #1, tor. LPN #1 stated she began a facility in September 2022 and			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B. WING		C 04/12/202	,
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP C 110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCE	ION SHOULD BE COMPL THE APPROPRIATE DA	LETION
F 640	LPN #1 stated sh discharge MDS a was sold in Dece	page 39 whind on MDS assessments. e did not get to complete R47's essessment before the company mber 2022 and the record did e the facility was sold.	F 64	0		
	staff member) #1	8 p.m., ASM (administrative the administrator, and ASM #2, sing, were made aware of the				ia Kil A
	encode and trans	6 (R6), the facility staff failed to mit a discharge MDS the resident was discharged 2.				
	the resident's clin	home on 11/23/22. A review of ical record failed to reveal a ssessment was encoded and			19	3
	conducted with L the MDS coording employment at the the facility was be LPN #1 stated she discharge MDS a was sold in Dece	8 p.m., an interview was PN (licensed practical nurse) #1, ator. LPN #1 stated she began e facility in September 2022 and whind on MDS assessments. e did not get to complete R6's ssessment before the company mber 2022 and the record did a the facility was sold.				
	staff member) #1	8 p.m., ASM (administrative , the administrator, and ASM #2, rsing, were made aware of the				
	to encode and tra	49 (R49), the facility staff failed ansmit a discharge MDS the resident was discharged				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495389	B. WING		C 04/12/2023
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CO 110 LAUCK DR WINCHESTER, VA 22603		
(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 ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE COMPLETION DATE
F 640	of the resident's clin discharge MDS assistransmitted.  On 4/11/23 at 2:38 pconducted with LPN the MDS coordinate employment at the fithe facility was behindled by the facility was behin	come on 11/25/22. A review ical record failed to reveal a ressment was encoded and on.m., an interview was (licensed practical nurse) #1, r. LPN #1 stated she began acility in September 2022 and and on MDS assessments. It did not get to complete R49's ressment before the company per 2022 and the record did	F 64		
	conducted with LPN the MDS coordinate employment at the f the facility was behi LPN #1 stated she of	o.m., an interview was (licensed practical nurse) #1, r. LPN #1 stated she began acility in September 2022 and nd on MDS assessments. did not get to complete R46's essment before the company			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING		C 04/12/2023	
	ROVIDER OR SUPPLIER	ABILITATION	11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR /INCHESTER, VA 22603	1 04722023	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 640	was sold in Decen not pull over once	page 41 mber 2022 and the record did the facility was sold.  B p.m., ASM (administrative	F 640			
	staff member) #1,	the administrator, and ASM #2, sing, were made aware of the	F 655	Resident #210 was     provided with a copy of	5/26/23	
	Planning §483.21(a) Baseli §483.21(a)(1) The implement a base that includes the i effective and pers that meet professi The baseline care (i) Be developed admission. (ii) Include the min necessary to prop including, but not (A) Initial goals ba (B) Physician order (C) Dietary orders (D) Therapy servi (E) Social service (F) PASARR reco §483.21(a)(2) The comprehensive ca care plan if the co (i) Is developed v admission. (ii) Meets the requ	e facility must develop and eline care plan for each resident instructions needed to provide con-centered care of the resident ional standards of quality care. It is plan must-within 48 hours of a resident's enimum healthcare information perly care for a resident limited to-ased on admission orders.		her base line care plan as well as her comprehensive care plan.  2. All new admissions have the potential to be affected by the alleged deficient practice. An audit will be done for the past 30 days to ensure residents are given a copy of their care plan. The base line care plan will be completed within 48 hours and given to the resident by the IDT team at their discharge planning meeting, held within 72 hours of admission.  3. Licensed nursing staff and Social Service staff of the facility will be provided education on the facility		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495389	B. WING		04/12/2023
	ROVIDER OR SUPPLIER TER HEALTH & REHAI	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	0412/2020
(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 APPROPROFICIENCY)	BE COMPLETION
F 655	this section).  §483.21(a)(3) The resident and their reof the baseline care limited to: (i) The initial goals (ii) A summary of the dietary instructions. (iii) Any services are administered by the on behalf of the facility Any updated infof the comprehensist This REQUIREMENTH by:  Based on staff intereview, the facility sor the resident represented the survey sample,  The findings included For Resident #210 to provide the resides summary of the baseline care planted for the provided the resides summary of the baseline care planted for April 2023 staff provided R210 representative, a suplanted.  On 4/11/23 at 4:28	facility must provide the expresentative with a summary plan that includes but is not of the resident. The resident's medications and and treatments to be a facility and personnel acting illity. Formation based on the details we care plan, as necessary. Now it is not met as evidenced review and clinical record staff failed to provide a resident essentative with a summary of lan for one of 32 residents in Resident #210.  EXECUTE:  (R210), the facility staff failed ent or the representative a seline care plan.  In to the facility on 4/1/23. A inicial record, including the dated 4/1/23 and progress b, failed to reveal the facility	F 65	policy on completing the base line care plan and documenting that the resident has received a copy of the base line care plan.  4. The DON or designee will audit 3 residents weekly x 8 weeks to ensure that the residents have base-line care plan is completed within 48 hours and documented as given to the resident at the discharge planning meeting held within 72 hours of admission. The results of the weekly audits will be submitted to the QAPI Committee monthly x 3. The QAPI Committee is responsible for the on-going monitoring for compliance.	
	1	ctor. OSM #1 stated a care			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIP	PLE CONSTRUCTION  3		(X3) DATE SURVEY COMPLETED	
		495389	8. WING		l l	12/2023	
	ROVIDER OR SUPPLIER	ILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			2 1.3	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 655	representatives within OSM #1 stated at the residents and their fat baseline care plant doesn't specifically doesn	ith residents and/or their n 72 hours of admission. e care conference, she offers amilies a summary of the OSM #1 stated that she ocument that she offered a eline care plan, but she mation was given or	F 65	55	(12)		
F 656 SS=E	CFR(s): 483.21(b)(1 §483.21(b) Compreh §483.21(b) Compreh §483.21(b)(1) The faimplement a comprecare plan for each resident rights set for §483.10(c)(3), that in objectives and timefinedical, nursing, an needs that are identificated assessment. The condescribe the following (i) The services that or maintain the reside physical, mental, an required under §483 (ii) Any services that under §483.24, §483 provided due to the under §483.10, inclustreatment under §483.	nensive Care Plans cicility must develop and hensive person-centered resident, consistent with the rith at §483.10(c)(2) and neludes measurable rames to meet a resident's d mental and psychosocial fied in the comprehensive mprehensive care plan must g are to be furnished to attain lent's highest practicable d psychosocial well-being as .24, §483.25 or §483.40; and would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights liding the right to refuse	F 65	1. Residents #110 and #6 are discharged from the facility and no changes cate to the comprehensive care plant. The care plans for #1. #37, and #3 were reviewed and updated to reflect the resident's current plant.  2. All residents of the facility can be affected by the deficient practice. Facility will conduct an audit residents Care Plan where Ostomies, Pressu Ulcers, O2 Therapy and Midodrine. The care play will be updated appropriate.	ie n ie n 4, ed ne of ity nis ity of no ore	5/26/23	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
495389 B. WING		B. WING		C 04/12/2023	
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILIT	ATION	1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTION OF	BE COMPLETION	
by the facility, as outline care plan, must- (iii) Be culturally-compet This REQUIREMENT is by: Based on observation, record review, it was de failed to implement the of for five of 32 residents in Residents # 110, #14, # The findings include:  1. For Resident #110 (R to implement the care p On the most recent MD assessment, an admiss	e nursing facility will ASARR acility disagrees with the it must indicate its is medical record. The resident and the de(s)- for admission and Tence and potential for the smust document the ed and any referrals to find/or other appropriate the comprehensive care the accordance with the the paragraph (c) of this the paragraph (c) of this the smooth of the smooth of the smooth of the facility staff the comprehensive care plan the survey sample, the	F 656	<ul> <li>3. Licensed nursing staff of the facility will be given education on the care plan's implementation. And the IDT will be provided education of the facility policy and procedure on following/implementing the resident's care plan.</li> <li>4. The DON or designee will conduct an audit of up to 3 resident care plans per week x 8 weeks for residents who have Ostomies, pressure ulcers, O2 therapy and/or Midodrine. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.</li> </ul>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	8. WING _		C 04/12/2023
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	
MINICHES	TER HEALTH & REL	A BU ITATION		110 LAUCK DR	
WINCHES	TER HEALTH & REH	ABILITATION		WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION APPROPRIATE DATE
F 656	Continued From p	page 45	F6	556	- 1
₹.	resident was mod daily decisions. In the resident was The comprehensi documented in pa colostomy." The "Administer care				
	documented, "Os shift and as need The TAR (treatme June 2022 docum 48 opportunities ( care, 11 were bla	der dated, 6/3/2022, tomy: Colostomy Care every ed, every 12 hours for Ostomy."  ent administration record) for mented the above order. Of the for completing the colostomy nk. The TAR for July and August order for colostomy care.			
	documented in the noted." There was through August of colostomy.  An interview was practical nurse) # When asked the #2 stated it is so resident's care, the further stated the and you have to each resident. Sido them. When a followed, LPN #2	· ·			
	ASM #1, the adm	ninistrator, ASM #2, and ASM #4,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495389  NAME OF PROVIDER OR SUPPLIER  WINCHESTER HEALTH & REHABILITATION			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389 B. WING			C 04/12/2023
		BILITATION		ODE	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO TO DEFICIENCE	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 656	the regional nurse c	ge 46 onsultant, were made aware ns on 4/12/2023 at 1:31 p.m.	F6	556	
	No further information	on was provided prior to exit.  (R14), the facility staff failed re plan for administering			
	The comprehensive documented in part, pressure injury to sa pressure injury developressure area to say documented in part, ordered and monitor has a wound vac. Carea M-W-F and as	care plan dated, 2/23/2022, "Focus: The resident has acral area or potential for elopment. Resident has a cral area." The "Interventions" "Administer treatments as r for effectiveness. Resident Change dressing to pressure necessary. Wound vac has ttings. Check for functioning			
	sponge to be chang	nd Vac (vacuum) with black ed M-W-F (Monday - v) every day shift every Mond,			
N	record) documented following dates the value documented as being staff would initial the performed were black 5/16/2022, 5/18/2025/25/2022, 5/27/202	nk: 5/11/2022, 5/13/2022, 22, 5/20/2022, 5/23/2022,			
83		lanks (unsigned areas) on the			15

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

i i i		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		LETED	
		495389	B. WING		•	12/2023	
	ROVIDER OR SUPPLIER	BILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			04/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES ICY 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 656	Continued From pa	ge 47	F 65	66			
8.		documented the above order. on the TAR for 7/1/2022, 2022.					
	with normal saline, wound, place Aqua silicone super abso daily and PRN (as	r dated, 8/19/2022, nd Care: Sacrum - Cleanse pat dry, apply skin prep to peri Cel AG on wound, secure with rbent sacral dressing once needed) when soiled or tht shift for wound care."	***		2 2		
	The September TA order. On the follow not documented as	R documented the above ving dates the treatment was being done, the boxes were 3/2022, 9/9/2022, 9/16/2022,					
	with normal saline, wound, place collar with foam dressing	r dated, 9/23/2022, nd Care: Sacrum - Cleanse pat dry, apply skin prep to peri gen particles on wound, secure once daily and PRN when , every night shift for wound					
	order. On the follow not documented as	R documented the above ving dates the treatment was being done, the boxes were 1/24/2022, 9/25/2022, 0/2022.				7 I	
	practical nurse) #2 When asked the pu #2 stated it is so ev residents) and see	onducted with LPN (licensed on 4/11/2023 at 3:14 p.m. Irpose of the care plan, LPN Veryone can see them (the what is going on with the ir refusals, behaviors. LPN #2				R	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTIO		(X3) DATE SURVEY COMPLETED C		
		495389	B. WING			04/12/2023		
	ROVIDER OR SUPPLIER	ILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				04/12/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EAC	ROVIDER'S PLAN OF CORR CH CORRECTIVE ACTION SI S-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 656	and you have to go each resident. Som do them. When aske followed, LPN #2 state ASM #1, the administ the regional nurse cof the above concernormal formation of the above conc	re plans come up generic in and personalize them to enurses don't know how to ed if the care plan should be ated yes.  strator, ASM #2, and ASM #4, consultant, were made aware ins on 4/12/2023 at 1:31 p.m.  on was provided prior to exit.  In the facility staff failed to plan for hypotension (low care plan dated 9/8/2022, "Focus: The resident has interventions" documented, the fluid intake and a healthy ident to get up slowly, sit on tanding. Give medications as side effects and tor/document/report PRN (as igns and symptoms) of ess, fainting, syncope, blurred entration, nausea, fatigue, cold dated, 10/7/2022, drine 10 mg (milligrams)(used ypotension. Midodrine works ssels to tighten, which essure) (1); 1 tablet by mouth potension. Hold if above SBP	F 68	56				
		AR (medication administration the above order. The MAR					9	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495389	B. WING	<del></del>		12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COU 110 LAUCK DR WINCHESTER, VA 22603	DE		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE	
F 656	following days and pressure greater 3/1/2023 at 6:00 3/1/2023 at 10:00 3/2/2023 at 10:00 3/4/2023 at 10:00 3/4/2023 at 10:00 3/10/2023 at 2:00 3/15/2023 at 2:00 3/15/2023 at 2:00 3/15/2023 at 2:00 3/15/2023 at 2:00 3/20/2023 at 2:00 3/25/2023 at 2:00 3/25/2023 at 2:00 3/25/2023 at 0:00 3/25/2023 at 2:00 3/25/2023 at 2:00 3/25/2023 at 6:00 The April 2023 Morder. The MAR administered on a systolic blood p 4/4/2023 at 2:00	lication was administered on the d times with a systolic blood or above 120: a.m 134/76 ) p.m 130/76 a.m 122/63 ) p.m 122/60 ) p.m 131/71 ) p.m 134/62 ) a.m 124/76 ) a.m 124/76 ) a.m 122/60 ) p.m 161/69 ) a.m 128/70 ) p.m 124/68 00 p.m 124/68 00 p.m 145/83 0 p.m 145/83 0 p.m 130/72  IAR documented the above revealed the medication was the following days and times with pressure greater or above 120: p.m. there was documented a	F 656				
3	should have bee was documented 4/5/2023 at 10:00 4/7/2023 at 6:00 4/8/2023 at 6:00 4/11/2023 at 6:00 An interview was practical nurse) of When asked the #2 stated it is so	a.m 128/70 a.m 158/78					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT (DENTIFICATION NUMBER: A. BUILDIE		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495389 B. WING		H 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	o.	C 04/12/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
WINCHES	TER HEALTH & REHAB	ILITATION		110 LAUCK DR WINCHESTER, VA 22603				
(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 CO	N SHOULD BE E APPROPRIATE	(X\$) COMPLETION DATE		
F 656	further stated the car and you have to go it each resident. Some do them. When aske followed, LPN #2 state ASM (administrative administrator, ASM # and ASM #4, the reg made aware of the a at 5:07 p.m.  No further information of following website: https://medlineplus.gtml.  4. For Resident #3 (I implement the care padministration.  The comprehensive documented in part, oxygen therapy r/t (rillness." The "Interve" OXYGEN SETTING prongs @ (at) 2L (litte (oxygen saturation) is humidified."  On 4/11/2023 at 9:14 bed with oxygen on oxygen concentrator per minute). A seco	refusals, behaviors. LPN #2 e plans come up generic n and personalize them to e nurses don't know how to d if the care plan should be ted yes.  staff member) #1, the #2, the director of nursing, ional nurse consultant, were bove concern on 4/11/2023  In was obtained prior to exit.  was obtained from the lov/druginfo/meds/a616030.h  R3), the facility staff failed to plan for oxygen  care plan dated, 8/14/2022, "Focus: The resident has elated to) Respiratory entions" documented in part, iS: O2 (oxygen) via nasal ers) PRN to maintain SPO2	F	356				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		495389	B. WING		04/1	2/2023
	ROVIDER OR SUPPLIER		110	EET ADDRESS, CITY, STATE. ZIP CO LAUCK DR ICHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 656	observe what rate stated, it was son When asked if sh supposed to be o LPM. LPN #2 adj The physician ord documented, "Ox needed) via nasa	page 51 annula. LPN #2 was asked to the oxygen was set to. LPN #2 newhere around 1.5 (LPM). the knew what rate R3 was in, LPN #2 stated, it should be 2 usted the rate to 2 LPM. The der dated, 1/16/2023 tygen as needed PRN (as it cannula at 2 L.PRN to maintain aturation) if <(less than) 90%,	F 656			
	An interview was practical nurse) # When asked the #2 stated it is so residents) and se resident's care, the further stated the and you have to each resident. S	conducted with LPN (licensed 2 on 4/11/2023 at 3:14 p.m. purpose of the care plan, LPN everyone can see them (the se what is going on with the neir refusals, behaviors. LPN #2 care plans come up generic go in and personalize them to ome nurses don't know how to sked if the care plan should be stated yes.				
	administrator, AS and ASM #4, the made aware of that 1:31 p.m.  No further inform  5. For Resident implement the coadminister oxyge					
		linical record revealed a dated 2/23/22 oxygen at 3 liters,				88

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING		04/12/2023	
	ROVIDER OR SUPPLIER	ABILITATION	1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603		
(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 OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CO	(X5) DMPLETION DATE
F 656	dated 2/28/22 for emphysema/COP pulmonary disease intervention dated nasal prongs at 31 humidified."  A review of the Me Administration Re and March 2022 fithe oxygen being  A review of the number of the oxygen was defined and march 2022 fithe oxygen was defined and march 2022 fithe oxygen was defined and march 2022 fithe oxygen was defined and march 2022/1/2/3/14/22 and 3/17/2 as being administrational of the order of 2/26/22, 2/27/3/11/22, 3/13/22, 3/22/22, and 3/22 that the oxygen was defined at the oxyg	sident's care plan revealed one the resident has D (chronic obstructive e)." This care plan included the 2/28/22 for "O2 (oxygen) via L (liters per minute) continuous edication / Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.  Treatment cords (MAR / TAR) for February ailed to reveal any evidence of administered as not being used.	F 656			
X	On 4/12/23 at 11:	16 AM, an interview was	2:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495369	B. WING		04/12/2023	
	ROVIDER OR SUPPLIER	ABILITATION	_	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL)		HOULD BE COMPLETION	
F 656	Member) the Dire if staff are docume oxygen is not in u documented why was not in use an refused, then it is ordered.	page 53 SM #2 (Administrative Staff ctor of Nursing. She stated that enting that physician ordered se, then it should also be She stated that if it just says it d does not say the resident not being administered as	F 65	56		
	conducted with LI Nurse). When as the care plan, she how to care for th followed. When a documented to ac and the oxygen w	PN #3 (Licensed Practical ked what was the purpose of a stated that it was a guide on a resident and that it should be asked if the care plan a state of the care plan as not being administered as care plan being followed, she				
	On 4/12/23 at ap end-of-day meetid Member) the Adm	proximately 1:30 PM at the ng, ASM #1 (Administrative Staff ninistrator, and ASM #2 were				
F 657 SS≑D	information was particle.  Care Plan Timing CFR(s): 483.21(b)  §483.21(b) Comp §483.21(b)(2) A complete in the comprehension of the survey of the comprehension of the survey of the comprehension of the survey of the comprehension of the comprehension of the survey of	)(2)(i)-(iii) rehensive Care Plans comprehensive care plan must nin 7 days after completion of	F 6	57 1. The care plans for residents #34 and #4 were reviewed are updated to reflect the resident's current plan care.	nd ne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		7.0	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	495389	B. WING		1.1	
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHAB	ILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	04/12/2023	
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	ULD BE COMPLETION	
resident.  (C) A nurse aide with resident.  (D) A member of food (E) To the extent praithe resident and the An explanation must medical record if the and their resident report practicable for the resident's care plan.  (F) Other appropriate disciplines as determor as requested by the (iii)Reviewed and revite am after each assessments.  This REQUIREMENT by:  Based on observation record review, the farevise the compreheresidents in the survey and #44.  The findings include:  1. For Resident #34 to review and revise comprehensive care  A review of R34's clintal (bed rail) evaluated documented bilatera	nited to ysician.  e with responsibility for the  responsibility for the  d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined e development of the e staff or professionals in nined by the resident's needs he resident. vised by the interdisciplinary essment, including both the quarterly review  T is not met as evidenced  on, staff interview and clinical cility staff failed to review and nsive care plan for two of 32 ey sample, Residents #34	F 657	2. All residents of the facility can be affected by this deficient practice. Facility will conduct an audit of residents Care Plan who have had falls or have bed ralls. The care plan will be updated as appropriate.  3. Administrative nurses and the IDT will be provided education of updating care plan to reflect current clinical condition of the residents and with any change of status per facility policy and procedure for care planning.  4. The DON or designee will conduct an audit of up to 3 resident care plans per week x 8 weeks for residents who have had falls or have bed rails. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495389	B. WING					C 12/2023	
	ROVIDER OR SUPPLIER	LITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				04/12/2023		
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F 657		e 55 prehensive care plan dated al documentation regarding	F	657	for the monitoring compliance.	on-going for		2	
8		m., R34 was observed lying uarter bed rails in the upright							
	LPN #2 stated the pu "Where everybody ca what's going on with residents' care plans	(licensed practical nurse) #2. Irpose of the care plan is, an see them and go off with the resident." LPN #2 stated should be reviewed and d rails, "So everybody can							
=	staff member) #1, the	.m., ASM (administrative e administrator, and ASM #2, g, were made aware of the							
	to review and/or revis					3			
	assessment, a quart assessment reference resident scored a five interview for mental s	MDS (minimum data set) erly assessment, with an ee date of 1/18/2023, the e out of 15 on the BIMS (brief status) score, indicating the cognitively impaired for hs.							
231	documented in part, (emergency departm treat (treatment) afte	ed 1/8/2023 at 7:39 a.m. "FallSend to ED ent) for eval (evaluation) and r being found on the floor ear, unwitnessed. Resident						74 # II	

AND PLAN OF CORRECTION IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING		04/12/2023
	NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION		1 Y		
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F 657	on Eliquis (used to forming) (1) 5 mg  The comprehension documented in particle for falls r/t (regait/balance prob	o prevent blood clots from (milligrams)."  ve care plan dated 9/6/2022  art, "Focus: The resident is at lated to) deconditioning, lems, unaware of safety needs."	F 657		
	On 4/11/2023 at 2 conducted with A member) #2, the stated she could form (fall investig She stated that we stated the risk madocumented the care plan if new input into place. The with ASM #2, ASI revising of the cathat sent the residuely.	2:43 p.m., an interview was SM (administrative staff director of nursing. ASM #2 not find the risk management ation) for the fall of 1/8/2023. has before her time. She further anagement form would have reviewing and revising of the interventions would have been e above care plan was reviewed M #2 stated she did not see any re plan after the fall on 1/8/2023 dent to the hospital.			
F 658 SS≃E	the regional nurs of the above condition of t	us.gov/druginfo/meds/a613032.h	F 658	1. Resident #310 has been discharged and no changes can be made. NP reviewed the order and parameter for the medications on	5/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		
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F 658	as outlined by the omust- (i) Meet professions. This REQUIREMEI by: Based on staff intereview, it was deterailed to follow proffor medication and four of 32 residents. Residents #310, #3 The findings includ. 1. The facility staff regarding the frequent changes for Reside colostomy bag was and 3/5/22, for a professions.	comprehensive care plan, al standards of quality. NT is not met as evidenced erview and clinical record rmined that the facility staff ressional standards of nursing treatment administration for in the survey sample; 37, #14 and #34. e: failed to obtain an order rency of colostomy bag ent #310. Resident #310's in not changed between 2/25/22 eriod of 9 days.	F 658	residents #37 and #14. Resident #14 wound has healed so no changes can be made. Resident #34 is getting her medications as ordered.  2. All residents of the facility can be affected by this deficient practice. The facility will conduct an audit of residents Care Plan who have blood pressure parameters and ostomies. The care plan will be updated as appropriate. All residents with ostomies will have an appropriate order in place.	
	A review of the clin were no orders on ostomy bag until 3/2 "change colostomy included a "start data A review of the Tre (TAR) revealed the The next schedule review of the nurse documented, "Reshad [their] shower bag/appliance. Wi	s admitted to the facility on a new colostomy resident.  ical record revealed that there frequency to change the (4/22. This order documented, overy 3 days." This order ate" of 3/5/22.  atment Administration Record bag was changed on 3/5/22.  d change was for 3/8/22. A c's notes dated 3/8/22 that ident wanted to wait till [they] to change (their] colostomy II pass on to the next shift to "There was no evidence it		3. Licensed nursing staff of the facility will be provided education on following physicians orders with special focus on orders with parameters.  4. The DON or designee will audit 3 residents per week x 8 weeks to ensure physician orders are being followed. The audits will be reviewed for trends and	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495389		(X2) MULTIPLE (	(X3) DATE SURVEY COMPLETED			
		495389	B. WING		04/12/2023	
	NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	D BE COMPLETION	
	Area is red, irritated, S/S (signs/symptoms resident has required past few days from prand reminders given  A nurse's note dated "resident has required the past few days from Education and reminders."  On 4/12/23 at 1:00 P conducted with ASM Member) the Nurse F Every 3 days is not bag changes. Every When asked about a colostomy bag, she sfacility there should but the frequency is and patient. If they have days. As long as the breakdown. I say that last that long. The set it makes it 3 to 4 day order) for 3 days become become and patient of the max time would there is not an order the frequency, should	wing shift.  3/6/22 documented, flained of) pain to stoma site. with slight inflammation. No ) of infection noted but several bag changes in the ficking at wafer. Education to not pick at the wafer"  3/7/22 documented, red several bag changes in m picking at wafer. ders given to not pick at the	F 658	issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.		
	to clarify an order for	frequency, she stated that rses to clarify at the time of				

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F 658	conducted with Lf Nurse). When as often to change a there should be a a new admission should the reside more before an or She stated that a admission. When colostomy bag be not sure, hence the change it.  There was no evit the above order a admission on 2/2 3/5/22 was a peribag change. This practitioner's state at least every 7 depends of the provided.  On 4/12/23 at append-of-day meetimed aware of the made aware of the should be a solution of the should be a solution as the same and services was provided.	1 PM an interview was PN #3 (Licensed Practical ked how a nurse know how colostomy bag, she stated n order. When asked if there is resident with a colostomy, nt be in the facility for a week or reder is obtained, she stated no. n order should be obtained on a asked how often should a changed, she stated she was ne need for an order for when to dence of bag changes before and nurse's notes. From 5/22 to the first bag change on od of 9 days without an ostomy is exceeds the nurse ement that it should be changed	F 658		
			<u> </u>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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ROVIDER OR SUPPLIER	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603		
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2. For Resident #37	7, the facility staff failed to	F 65	8		
of Midodrine (used hypotension. Midod	to treat orthostatic frine works by causing blood				
On the most recent	MDS (minimum data set)				
assessment, a qua assessment referer resident scored a 1 interview for menta resident was mode	rterly assessment, with an nee date of 1/16/2023, the 2 out of 15 on the BIMS (brief il status) score, indicating the rately cognitively impaired for	7			
documented, "Midd tablet by mouth ever Hold if above SBP  The March 2023 M record) documented documented the method following days apressure greater or 3/1/2023 at 6:00 a. 3/1/2023 at 10:00 p. 3/2/2023 at 10:00 p. 3/10/2023 at 2:00 p. 3/14/2022 at 6:00 a. 3/15/2023 at 2:00 p. 3/15/2023 at 2:00 p. 3/16/2023 at 2:00 p. 3/16/2023 at 2:00 p. 3/18/2023 at 6:00 a. 3/18/	odrine 10 mg (milligrams); 1 ery 8 hours for hypotension. (systolic blood pressure) 120."  AR (medication administration of the above order. The MAR edication was administered on and times with a systolic blood or above 120: m 134/76 o.m 130/76 m 122/63 o.m 122/60 o.m 134/62 a.m 134/76 a.m 130/74 o.m 122/60 o.m 128/70				
	CORRECTION  ROVIDER OR SUPPLIER  SUMMARY (EACH DEFICIE REGULATORY OF  Continued From particles of Midodrine (used hypotension. Midodine (used hypotension.)  On the most recent assessment reference interview for mental resident was mode making daily decision. The physician order documented, "Midodine (used hypotension) daily decision. The physician order documented the midodine hypotension of the midodine hypotension order documented the midodine hypotension (used hypotension) daily 2023 at 6:00 a 3/1/2023 at 6:00 a 3/1/2023 at 10:00 a 3/1/2023 at 2:00 a 3/	ROVIDER OR SUPPLIER  STER HEALTH & REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 60  2. For Resident #37, the facility staff failed to follow the physician orders for the administration of Midodrine (used to treat orthostatic hypotension. Midodrine works by causing blood vessels to tighten, which increases blood	ROVIDER OR SUPPLIER  TER HEALTH & REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 60  2. For Resident #37, the facility staff failed to follow the physician orders for the administration of Midodrine (used to treat orthostatic hypotension. Midodrine works by causing blood vessels to tighten, which increases blood pressure) (1).  On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/16/2023, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired for making daily decisions.  The physician order dated, 10/7/2022, documented, "Midodrine 10 mg (milligrams); 1 tablet by mouth every 8 hours for hypotension. Hold if above SBP (systolic blood pressure) 120."  The March 2023 MAR (medication administration record) documented the above order. The MAR documented the medication was administered on the following days and times with a systolic blood pressure greater or above 120: 3/1/2023 at 6:00 a.m 134/76 3/1/2023 at 10:00 p.m 130/76 3/2/2023 at 6:00 a.m 122/60 3/4/2023 at 2:00 p.m 122/60 3/16/2023 at 2:00 p.m 128/70 3/16/2023 at 2:00 p.m 128/70 3/16/2023 at 2:00 p.m 128/70 3/16/2023 at 2:00 p.m 122/68	ROVIDER OR SUPPLIER  TER HEALTH & REHABILITATION  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC (IBENTIFY'NS INFORMATION)  Continued From page 60  2. For Resident #37, the facility staff failed to follow the physician orders for the administration of Midodrine (used to treat orthostatic hypotension. Midodrine works by causing blood vessels to tighten, which increases blood pressure) (1).  On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/61/2023, the resident was moderately cognitively impaired for making daily decisions.  The physician order dated, 10/7/2022, documented, "Midodrine to D mg (milligrams); 1 tablet by mouth every 8 hours for hypotension. Hold if above SBP (systolic blood pressure) 120."  The March 2023 MAR (medication administration record) documented the above order. The MAR documented the medication was administered on the following days and times with a systolic blood pressure greater or above 120: 3/1/2023 at 6:00 a.m 124/76 3/1/2023 at 10:00 p.m 134/76 3/1/2023 at 6:00 a.m 122/80 3/16/2023 at 2:00 p.m 134/76 3/1/2023 at 6:00 a.m 122/80 3/16/2023 at 2:00 p.m 134/76 3/1/2023 at 6:00 a.m 122/80 3/16/2023 at 2:00 p.m 134/76 3/1/2023 at 6:00 a.m 122/80 3/16/2023 at 2:00 p.m 184/76 3/16/2023 at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495389	B. WING	-78 <sub>W</sub>	0.4	C J/12/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		1212023	
WINCHES	TER HEALTH & REHAB	ILITATION		WINCHESTER, VA 22603			
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 658	Continued From pag 3/25/2023 at 2:00 p.r 3/25/2023 at 10:00 p 3/26/2023 at 2:00 p.r	m 124/68 .m 145/83	F 65	58			
	3/29/2023 at 6:00 a.r The April 2023 MAR order. The MAR dock administered on the a systolic blood pres 4/4/2023 at 2:00 p.m "NA" (not applicable) should have been downed was documented as 4/5/2023 at 10:00 p.t 4/7/2023 at 6:00 a.m 4/8/2023 at 6:00 a.m	documented the above umented the medication was following days and times with sure greater or above 120:  there was documented a where the blood pressure ocumented. The medication being administered.  m 124/76  n 128/70  n 158/78  m 132/78					
	documented in part, hypotension." The "li "Encourage adequat diet. Encourage resi side of bed before st ordered. Monitor for effectiveness. Monit needed) any s/sx (si hypotension, dizzine	or/document/report PRN (as gns and symptoms) of ss, fainting, syncope, blurred					
	An interview was con p.m. with LPN (licent of the nurses that ad when the blood prestabove order for Midd were reviewed with 1 for when she gave the series of the series	nducted on 4/11/2023 at 2:26 sed practical nurse) #2, one lministered the Midodrine sure was above 120. The odrine and the March MAR LPN #2. The blood pressures ne Midodrine were reviewed.					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		495389	B. WING			C 04/12/2023	
	PROVIDER OR SUPPLIER	BILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			04/12/2023	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 658	given, LPN #2 state following the physic A request was made Medication Administrative administrator, ASM and ASM #4, the remade aware of the at 5:07 p.m.  No further information following website: https://medlineplus.tml  3. For Resident #14 follow the physician of Midodrine.  On the most recent assessment, a quarassessment, a quarassessment references identification.  On the most recent assessment references as a 1 interview for mental resident was not condaily decisions.  The physician order documented, "Midomouth two times a condition of March 2023 Mar	d, no. When asked if that is lan order, LPN #2 stated, no.  e for the facility policy on tration on 4/12/2023. No  e staff member) #1, the #2, the director of nursing, gional nurse consultant, were above concern on 4/11/2023  on was obtained prior to exit.  was obtained from the gov/druginfo/meds/a616030.h  If, the facility staff failed to corders for the administration  MDS (minimum data set) treity assessment, with an ince date of 12/28/2022, the 4 out of 15 on the BIMS (brief I status) score, indicating the gnitively impaired for making  or dated, 1/6/2023, drine 5 mg; Give 5 mg by day for hypotension. Hold for	F 65				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		405200	B. WING		h	С	
	lijk.	495389			04/	12/2023	
NAME OF PI	ROVIDER OR SUPPLIER		- 1	TREET ADDRESS, CITY, STATE, ZIP CODE			
WINCHES	TER HEALTH & REHAB	BILITATION	l l	10 LAUCK DR			
***************************************			w	/INCHESTER, VA 22603		- 64	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 658	Continued From pag	ge 63	F 658				
	administered on the	following days and times with					
		ssure greater or above 100:		- 31			
	3/1/2023 at 5:00 p.m					12	
	3/2/2023 at 9:00 a.m				3		
	3/3/2023 at 9:00 a.m			and the second second		12 1	
	3/3/2023 at 5:00 p.m						
	3/4/2023 at 9:00 a.m			E			
	3/4/2023 at 5:00 p.m					1	
	3/5/2023 at 9:00 a.m			7			
	3/5/2023 at 5:00 p.m	n 118/68					
	3/13/2023 at 9:00 a.						
	3/14/2023 at 5:00 p.	m 118/68				.34	
	3/17/2023 at 9:00 a.						
	3/17/2023 at 5:00 p.	.m 116/60					
	3/22/2023 at 9:00 a.	m 117/60					
	3/22/2023 at 5:00 p.	.m 132/76			4.5	8 8	
	3/23/2023 at 9:00 a.	.m 116/79					
	3/23/2023 at 5:00 p.	.m 124/76				22	
	3/27/2023 at 9:00 a.	m 124/76					
	3/27/2023 at 5:00 p.	.m 107/69		!			
	=======================================		>311				
	The April 2023 MAR	documented the above order					
	for Midodrine. The N	MAR documented the				13	
	medication was adm	ninistered on the following				370	
		a systolic blood pressure					
	greater or above 10	0:	100	- 1112			
	4/1/2023 at 9:00 a.n	n 119/60				107	
	4/1/2023 at 5:00 p.n	n 105/65					
	4/2/2023 at 9:00 a.n			200			
	4/2/2023 at 5:00 p.n			-0.0000000			
	4/5/2023 at 9:00 a.n					87	
	4/5/2023 at 5:00 p.n						
	4/6/2023 at 9:00 a.n					126	
	4/6/2023 at 5:00 p.n			10 00		0)32	
	4/10/2023 at 9:00 a.			649H=W1VII			
	4/10/2023 at 5:00 p.						
	4/11/2023 at 9:00 a.					ļ	
	4/11/2023 at 5:00 p.	.m 136/72		=11.82		5,00	
ł				THE PERSON NAMED IN		22.4.7	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	COM	(X3) DATE SURVEY COMPLETED	
		495389	B. WING			C /12/2023
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			1
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES SENCY MUST BE PRECEDED BY FULL OR 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 658	documented in party hypertension r/t (I Resident has orth "Interventions" do anti-hypertensive Monitor for side e effects of medical (medical doctor/n).  An interview was p.m. with LPN (lic of the nurses that when the blood p above order for the were reviewed with given, LPN #2 strollowing the phy ASM (administrator, AS and ASM #4, the made aware of the at 5:07 p.m.  No further inform 4. For Resident # to administer the the physician's order physician's order physician's order	page 64  Ive care plan dated, 11/9/2022, art, "Focus: The resident has related to) Heart Failure.  Inostatic hypotension." The recumented in part, "Give medications as ordered.  Iffects. Monitor/record use/side tion. Report tyo MD/NP urse practitioner) as necessary."  Iconducted on 4/11/2023 at 2:26 rensed practical nurse) #2, one administered the Midodrine ressure was above 120. The Midodrine and the March MAR ith LPN #2. The blood pressures the Midodrine were reviewed. The medication should have been ated, no. When asked if that is sician order, LPN #2 stated, no.  Itive staff member) #1, the im #2, the director of nursing, regional nurse consultant, were ne above concern on 4/11/2023 ation was obtained prior to exit. If 34 (R34), the facility staff failed medication gabapentin (1) per order on 3/28/23 and 3/29/23.  Is clinical record revealed a dated 3/2/23 for gabapentin in the capsules every eight	F 658			
l-x*F*	2023 MAR (medifailed to reveal e	athy. A review of R34's March cation administration record) vidence that R34 was papentin on 3/28/23 at 10:00 p.m.				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED C	
		495389	B, WING	B. WING 04/			
	ROVIDER OR SUPPLIER		110	EET ADDRESS, CITY, STATE, ZIP COO LAUCK DR ICHESTER, VA 22603	DE		
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR 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 658	3/28/23 and 3/29/ delivery from pha A review of the fa medications that a case a specific m is not available) re capsules were av	00 a.m. Nurses' notes dated 23 documented, "Awaiting	F 658				
	conducted with A member) #2, the nurse who docum notes). ASM #2 nurses ran out of practitioner sent a pharmacy and the medication would ASM #2 stated sh from the Omnicel morning of 3/29/2 and she was the stated two nurses	4 p.m., an interview was SM (administrative staff director of nursing (and the nented the above progress stated that on 3/28/23, the R34's gabapentin so the nurse a new prescription to the e pharmacy staff stated the I be delivered on the next run. The could not obtain gabapentin II during the night of 3/28/23 or 23 because two nurses called in only nurse working. ASM #2 is are required to pull gabapentin II because it is a controlled					
F 677	administrator, and the above concert Reference: (1) Gabapentin is information was continuous. (1) https://medlinepletml.	8 p.m., ASM #1, the d ASM #2 were made aware of rn. s used to relieve pain. This obtained from the website: us.gov/druginfo/meds/a694007.h	F 677	1. Resident Identifier #	2262	5/26/23	
	CFR(s): 483.24(a		F 6//	and #263 have both b		3/20/23	

PRINTED: 04/21/2023 FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING		C 04/12/2023	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, , , , , , , , , , , , , , , , , , , ,	
1111101150	TPD 11541 511 6 5511451	U ITATION	1	110 LAUCK DR	The second second	
WINCHES	TER HEALTH & REHABI	ILITATION		WINCHESTER, VA 22603		
(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)	GE COMPLETION	
				discharged from the		
F 677	Continued From page	e 66	F 677	facility and no corrections		
				can be made.		
	§483.24(a)(2) A resid	lent who is unable to carry			ive :	
		living receives the necessary			8 8	
		good nutrition, grooming, and				
	personal and oral hyg			2. All dependent residents of		
	•	is not met as evidenced		the facility can be affected		
	by:			by this deficient practice.		
		riew, facility document review		The facility will audit the		
	and clinical record re	view, the facility staff failed		last 14 days of Point of		
		ities of daily living) care for	1	Care (ADL documentation)		
	two of 32 residents in					
	Residents #263 and	#262.		for compliance and		
				address any findings with		
	The findings include:			corrective action as	10 P	
				appropriate.		
		63 (R263), the facility staff				
		sident with bathing/showers				
	on multiple dates Ma	y 2022 through July 2022.		3. Nursing staff will be		
	D262's somershorsi	up care plan detect 10/29/21				
		ve care plan dated 10/28/21 ) has an ADL self-care		educated in the following		
	performance deficit r			areas, aiding residents,		
	I *	Impaired balance, Limited		and documenting ADLs for		
		letal impairment and Chronic		dependent residents.		
		res extensive to total care of	Ì	EVER BELLEVILLE BUILDING BUILD	ring S	
		pletion of ADL care"		4. DON or designee will		
				audit nurse aid	13	
	R263's quarterly MD	S (minimum data set)		documentation of ADL's		
		ARD (assessment reference			27	
	date) of 5/30/22, cod	ed the resident as being		weekly X 8 weeks. The		
	totally dependent on	one staff with bathing.	1	audits will be reviewed for		
				trends and issues. Results	6	
	A review of R263's a	ctivities of daily living records		of the weekly audits will be		
		h July 2022 revealed a		reported to the QAPI	81	
	section for staff to do			Committee monthly x 3		
		view of R263's clinical		months. The QAPI	1.0	
		L records and nurses' notes		Committee is responsible		
		h July 2022, failed to reveal		for the on-going	.03	
	documentation that t	he resident was assisted with		Int the on-Bourg		

T' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		495389	B. WING			C 04/12/2023	
	ROVIDER OR SUPPLIER	BILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		VE ACTION SHOULD BE ED TO THE APPROPRIATE	(X5) COMPLETION DATE	
			=	monitoring	for		
F 677	_	wers from 5/18/22 until 5/24/22 until 6/7/22 (six days) and	F 677	compliance.		5.	
	conducted with LPN LPN #2 stated resid two days each wee #2 stated showers documentation in the	p.m., an interview was N (licensed practical nurse) #2. dents are provided showers k and when requested. LPN are evidenced by ne computer (ADL records) on shower sheets, but the e just implemented a month					
	conducted with CN #1. CNA #1 stated showers or a comp preference, twice a	p.m., an interview was A (certified nursing assistant) residents are provided lete bed bath, per their week. CNA #1 stated that on residents are provided partial					
	bed baths. CNA#1	I stated that CNAs should that any type of bathing is					
	staff member) #1, t	p.m., ASM (administrative he administrator, and ASM #2, ing, were made aware of the					
F21	(ADLs)" documente "4. Appropriate car for residents who a independently, with	tled, "Activities of Daily Living ed, e and services will be provided are unable to carry out ADLs the consent of the resident with the plan of care, including					
24 N	appropriate suppor a. Hygiene (bathing care);	t and assistance with: g, dressing, grooming, and oral				Ξ	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495389	B. WING		0.	C 4/12/2023	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		411212023	
WINCHES	TER HEALTH & REHAE	BILITATION		I10 LAUCK DR WINCHESTER, VA 22603			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE	
F 677	weekly or as require preference and/or we prohibit tub or show both daily.  ii. Residents will be grooming as approping as approping the respected.  iii. Residents shall be needed.  b. Mobility (transfer walking); i. Residents will be a mobility as ordered and/or as instructed c. Elimination (toilet i. Residents shall be needed.  ii. Residents who are bowel, will be proving the resident's cand.  1.b. For Resident #3 failed to assist the rebed on multiple date 2022.  R263's comprehensed documented, "(R26) performance deficit intolerance, Fatigue Mobility, Musculosk pain. Resident requirements and requirements and requirements.	but not less than twice d by state law. Residents hose medical conditions er baths shall have a sponge assisted with dressing and riate and resident choice will e assisted with oral care as and ambulation, including assisted with transfer and by the physician/practitioner in the resident's care plan. ing); assisted with toileting as e incontinent of bladder or led care in a timely manner. d snacks); and quire assistance with eating or ided assistance as instructed	F 677				
	R263's quarterly MI	OS (minimum data set)			1 11		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	, ,	SURVEY PLETED	
		495389	B. WING		0.4	C /12/2023
	ROVIDER OR SUPPLIER	ABILITATION	11	TREET ADORESS, CITY, STATE, ZIP COD 10 LAUCK DR HNCHESTER, VA 22603		71212425
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 677	date) of 5/30/22, of extensive assistant transfers.	an ARD (assessment reference coded the resident as requiring noce of two or more staff with	F 677			24 24 00
	for May 2022 thro section for staff to review of R263's of records and nurse July 2022) failed to resident was assist 5/4/22, 5/5/22, 5/1	s activities of daily living records ugh July 2022 revealed a document transfers. Further clinical record (including ADL es' notes for May 2022 through to reveal documentation that the sted with transfers on 5/1/22, 17/22, 6/13/22, 6/24/22, 6/28/22, 1/2/22, 7/3/22, 7/4/22, 7/8/22, 2.				
	conducted with LF LPN #2 stated sta	2 p.m., an interview was PN (licensed practical nurse) #2. off should offer residents etting out of bed every day.				
	conducted with C #1. CNA #1 state throughout the da	4 p.m., an interview was NA (certified nursing assistant) ed, "I offer multiple (transfers) ey, every day, to prevent bed f we transfer at all, it should be	**			
W	staff member) #1	8 p.m., ASM (administrative , the administrator, and ASM #2, rsing, were made aware of the				8
	failed to provide 6	#263 (R263), the facility staff eating assistance on multiple through July 2022.				
		ensive care plan dated 10/28/21 262) has an ADL self-care	8			‡   

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		SURVEY PLETED	
		495389	B. WING		C 04/43/2022		
	ROVIDER OR SUPPLIER	ABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE	
F 677	performance defici Intolerance, Fatigu Mobility, Musculos pain. Resident red 1-2 staff for the collection of the collection of the collection of 5/30/22, collection of 5/30/22, collection of 5/30/22, collection of 5/30/22, collection of the colle	t r/t (related to) Activity e, Impaired balance, Limited keletal impairment and Chronic quires extensive to total care of impletion of ADL care"  IDS (minimum data set) in ARD (assessment reference oded the resident as requiring ice of one staff with eating.  activities of daily living records igh July 2022 revealed a document eating assistance. R263's clinical record (including inurses' notes for May 2022 if alled to reveal documentation is assisted with eating on 3/22, 5/14/22, 5/17/22, 5/19/22, 5/29/22, 5/30/22, 6/10/22, 6/12/22, 5/29/22, 6/8/22, 6/10/22, 6/12/22, 5/30/22, 7/1/22, 7/2/22, 7/3/22, 7/22, 7/8/22, 7/9/22, 7/10/22, 22.  It p.m., an interview was in (licensed practical nurse) #2. It most of the time, nurses resident needs to be fed and ritified nursing assistants) to LPN #2 stated feeding the documented in the ADL	F 677				
	conducted with CN	NA #1. CNA #1 stated that ch therapist or a report from the	31				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 7	LE CONSTRUCTION	СОМР	(X3) DATE SURVEY COMPLETED C	
		495389	B. WING		04/12/2023		
	ROVIDER OR SUPPLIER	LITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603		E  6E	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 677	need assistance with she makes the nurse if she sees that they	aware of residents who eating. CNA #1 stated that aware and assists residents are having an issue with	F 67	77		100 E	
	_	ed she at least sits with ises them to see if they and she documents the			<u>4</u> , e:		
	staff member) #1, the the director of nursin- above concern.	m., ASM (administrative administrator, and ASM #2, g, were made aware of the 2 (R262), the facility staff ntinence care.			8	7	
		MDS (minimum data set) ted for R262 due to the short in the facility.					
	dated 12/27/2021 do being alert and orien time. The assessme being moderately sho continuous oxygen, of bowel and frequently	ng assessment for R262 cumented the resident as ted to person, place and nt further documented R262 ort of breath, requiring occasionally incontinent of incontinent of urine. The nted R262 using pads and/or				64	
	(bowel and bladder) documentation dated R262 documented in 12/28/2021 on the 7 requiring extensive a member. The ADL Tailed to evidence incompared to the result of the re	f daily living) Toilet use, B&B Bowel and B&B Bladder I 12/1/2021-12/31/2021 for continence care provided on 00 a.m. to 3:00 p.m. shift ssistance of one staff oilet use documentation continence care provided on (3:00 p.m. to 11:00 p.m.) shift			B)		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495389	(X2) MULTIP! A. BUILDING B. WING	LE CONSTRUCTION	COM	E SURVEY PLETED
NAME OF B	ROVIDER OR SUPPLIER	433363	B. WING			1/12/2023
	TER HEALTH & REHAL	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 110 LAUCK DR WINCHESTER, VA 22603	00E	15.6
(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 (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 677	and night (11:00 p.m failed to evidence in on 12/28/2021 on the The documentation 12/28/2021 evening observed to be bland On 4/11/2023 at 3:2 conducted with LPN LPN #2 stated that // computer. LPN #2 stated that // computer. LPN #2 stated that // conducted with CNA#1. CNA#1 stated provided every two incontinence care we computer in the ADI it was completed.  On 4/12/2023 at 10: conducted with CNA#1 was completed.  On 4/12/2023 at 10: conducted with CNA#1 incontinence care we CNA #2 stated that incontinence care in under the ADL-Toile areas. CNA #2 stated incontinence care er CNA #2 reviewed the elimination summan 12/1/2021-12/31/20 not document that a #2 stated that there	n. to 7:00 a.m.) shift. It further continence care was provided e evening and night shift. areas for 12/27/2021 and and night shifts were k.  5 p.m., an interview was (licensed practical nurse) #2. ADL's were documented in the stated that blanks meant that hing. LPN #2 stated that they anything was done.  4 p.m., an interview was a (certified nursing assistant) that incontinence care was hours. CNA #1 stated that as documented on the assistant of the electronic medical record to the electro	F 67	7		
		ne day shift.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	8. WING		C 04/12/2023
	ROVIDER OR SUPPLIER TER HEALTH & REHAE	BILITATION	-	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 686 SS=E	2017 documented in 's comprehensive a are Incontinent will rand services"  On 4/12/2023 at apple (administrative staff administrator, ASM ASM #4, the regions made aware of the Company	part, "Based on the resident ssessment, all residents that eccive appropriate treatment proximately 1:29 p.m., ASM member) #1, the #2, the director of nursing and all nurse consultant were concern.  In was provided prior to exit. Prevent/Heal Pressure Ulcer ()(i)(ii)  Pegrity sure ulcers. rehensive assessment of a must ensure that-	F 68	1. Resident Identifier #14's wound was healed effective 10/6/2022.	5/26/23
	professional standa pressure ulcers and ulcers unless the in- demonstrates that it (ii) A resident with p necessary treatmen with professional standard promote healing, pr new ulcers from de This REQUIREMEN by: Based on staff intereview, it was deter administer treatmen	IT is not met as evidenced rview and clinical record mined the facility staff failed to a pressure injury for one survey sample, Resident		wounds can be affected by this alleged deficient practice. An audit of all residents with wounds will be completed by the DON or designee to ensure treatments are in place and being done.  3. An in-service on wound care treatments and documentation will be provided to licensed nurses.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
300 110		495389	B, WING		04/12/2023
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	04/12/2023
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 686	to evidence the act vacuum for a sacra vacuum for relative or pressure in contolerance of soft timay also be affect perfusion, co-mortissue. (1)  On the most recei assessment, a quassessment refer the resident score (brief interview for the resident was making daily decimalized for the MDS, closinjury, with an AR in Section M - Ski four pressure injum Full-thickness skir skin and tissue lopalpable fascia, macartilage or bone eschar may be visundermining and/varies by anatom	14 (R14), the facility staff failed diministration of a wound ral pressure injury.  It is localized damage to the skin fit tissue usually over a bony ated to a medical or other can present as intact skin or an any be painful. The injury occurs has and/or prolonged pressure inbination with shear. The issue for pressure and shear ited by microclimate, nutrition, bidities and condition of the soft arterly assessment, with an ence date (ARD) of 12/28/2022, and a 14 out of 15 on the BIMS is mental status) score, indicating not cognitively impaired for sions.  The status is the pressure injury:  The and tissue loss Full-thickness is swith exposed or directly intact, tendon, ligament, in the ulcer. Slough and/or sible. Epibole (rolled edges), or tunneling often occur. Depthical location. If slough or escharant of tissue loss this is an	F 68	4. The DON/Designee will monitor current residents with wounds weekly for compliance with physicians' treatment orders. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the ongoing monitoring for compliance.	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING				MPLETED
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	ROVIDER OR SUPPLIER	BILITATION	1	110 LAU	ADDRESS, CITY, STATE, ZIP CODE ICK DR IESTER, VA 22603	T-1	-:
(X4) ID PREFIX TAG	(EACH DEFICIER	STATEMENT OF DEFICIENCIES ICY 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 686	Continued From pa	ge 75	F 68	6			
	sponge to be chang	nd Vac (vacuum) with black ged M-W-F (Monday - y) every day shift every Mond,					
	record) documente following dates the documented as bei blank: 5/11/2022, 5	t (treatment administration d the above order. On the wound vac dressing was not ng done, the boxes were /13/2022, 5/16/2022, 22, 5/23/2022, 5/25/2022, 0/2022.					
		R documented the above blanks on the TAR for		125,		3	57 ml
		documented the above order. on the TAR for 7/1/2022, /2022.					
	documented in par pressure injury to so pressure injury developressure area to so documented in par ordered and monitor has a wound vac. area M-W-F and as	e care plan dated, 2/23/2022, t, "Focus: The resident has eacral area or potential for relopment. Resident has a ecral area." The "Interventions" t, "Administer treatments as or for effectiveness. Resident Change dressing to pressure is necessary. Wound vac has ettings. Check for functioning					
	practical nurse) #2 When asked what LPN #2 stated, "It	onducted with LPN (licensed on 4/11/2023 at 3:14 p.m. blanks on the TAR indicated, means they didn't do it. You I it. The nurse might have					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		/12/2023
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL RR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	Continued From pa	age 76	F6	586		
	forgotten to sign it that it was done."	off but you can't really prove	2			
	administrator, ASM and ASM #4, the re	re staff member) #1, the I #2, the director of nursing, egional nurse consultant, were above concern on 4/11/2023				a ]
	No further informati	ion was obtained prior to exit.				
	following website: https://cdn.ymaws.	n was obtained from the com/npuap.site-ym.com/resour pressure_injury_stages.pdf				
		4, the facility staff failed to cian ordered treatment to a ury.				
	documented, "Wou with normal saline wound, place Aqua silicone super abso daily and PRN (as	er dated, 8/19/2022, und Care: Sacrum - Cleanse pat dry, apply skin prep to peri aCel AG on wound, secure with orbent sacral dressing once needed) when soiled or ght shift for wound care."				
	order. On the followed not documented as	R documented the above wing dates the treatment was being done, the boxes were 8/2022, 9/9/2022, 9/16/2022,			φ261	
	documented, "Work with normal saline wound, place colla	er dated, 9/23/2022, und Care: Sacrum - Cleanse pat dry, apply skin prep to peri gen particles on wound, secure ponce daily and PRN when				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING		C 04/12/2023
	OVIDER OR SUPPLIER	ABILITATION	11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 686	care."	d, every night shift for wound	F 686		
	order. On the follo	AR documented the above wing dates the treatment was s being done, the boxes were 9/24/2022, 9/25/2022, 30/2022.	20.		
	practical nurse) #: When asked what LPN #2 stated, "It can't prove you di	conducted with LPN (licensed 2 on 4/11/2023 at 3:14 p.m. blanks on the TAR indicated, means they didn't do it. You d it. The nurse might have off, but you can't really prove	0.0		
	administrator, AS and ASM #4, the	ve staff member) #1, the M #2, the director of nursing, regional nurse consultant, were e above concern on 4/11/2023			
		ation was obtained prior to exit. Hazards/Supervision/Devices )(1)(2)	F 689	Education was provided to the family member on the smoking policy.	5/26/23
	as free of accider §483.25(d)(2)Ead supervision and a accidents. This REQUIREM by:			2. Residents of the facility who have been assessed as being unsafe smokers have the potential to be affected by this deficient practice. Facility staff will be educated on the	

495389	B. WING		C 04/12/2023
TION	1	10 LAUCK DR	04/12/2023
ST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
de smoking supervision the survey sample,  on 4/10/23, the facility noking apron per the ssessment.  facility with diagnoses case (1).  and 3:53 p.m., R33 was side on the smoking cigarette in hand. R33 ag apron at either that was supervised per moking assessment in part: "1. Is the resident to smoke with an dated 4/8/23 ident is going to smoke e smoking apron."  LPN (licensed practical ger, was interviewed.	F 689	smoking policy. The facility	
	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  Inical record review, the de smoking supervision the survey sample,  on 4/10/23, the facility moking apron per the assessment.  facility with diagnoses ease (1).  and 3:53 p.m., R33 was tside on the smoking cigarette in hand. R33 ang apron at either t was supervised per  moking assessment n part: "1. Is the resident to smoke with  an dated 4/8/23 sident is going to smoke the smoking apron."  LPN (licensed practical ager, was interviewed. ent had not smoked to 10/23. She stated on	ENTON  ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)  F 689  Inical record review, the de smoking supervision the survey sample,  on 4/10/23, the facility moking apron per the assessment.  facility with diagnoses ease (1).  and 3:53 p.m., R33 was tside on the smoking cigarette in hand. R33 ing apron at either t was supervised per  moking assessment in part: "1. Is the resident to smoke with  an dated 4/8/23 sident is going to smoke the smoking apron."  LPN (licensed practical ger, was interviewed. ent had not smoked to	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603  ID PROVIDER'S PLAN OF CORRECTION  STIBLE PRECEDED BY PULL DENTIFYING INFORMATION)  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX TAG  PREFIX (CACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)  Smoking policy. The facility will educate residents and families of smokers by providing them with the smoking apron per the assessment.  facility with diagnoses asses (1).  and 3:53 p.m., R33 was taide on the smoking cigarette in hand. R33 ng apron at either t was supervised per  moking assessment n part: "1. Is the resident to smoke with  an dated 4/8/23 sident is going to smoke  the smoking apron."  STREET ADDRESS, CITY, STATE, ZIP CODE WINCHESTER, VA 22603  PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR (CECH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR (CECH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR CEACHOORY WILL deducate residents and families of smokers by providing them with the smoking policy.  The facility will educate residents and families of smokers by providing them with the smoking policy.  The facility will educate residents and families of smokers by providing them with the smoking policy.  The facility will educate residents and families of smokers by providing them with the smoking policy.  The facility will educate residents and families of smokers by providing them with the smoking policy.  The facility will educate residents and families of smokers by provided with an education on the facility will educate residents and families of smokers by providing them with the smoking policy.  The facility will educate residents and families of smokers by providing them with the smoking policy.  The facility will educate residents and families of smokers by providing them education on the facility will educate residents and families of smokers by providing them educate residents and families of smokers by provided with an education on the families o

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING		04/12/2023
	ROVIDER OR SUPPLIER	ABILITATION	11	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAUCK DR IINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 689	staff member) #1, director of nursing nurse consultant, concerns.  A review of the fa	7 p.m., ASM (administrative the administrator, ASM #2, the g, and ASM #4, the regional were informed of these cility policy, "Smoking	F 689		
	equipment to product offered as appropriate assessment, and and assisted as indevices."  No further information of the county of	led, in part: "Protective mote safe smoking will be briate based on resident the resident will be encouraged eccessary in using the protective ation was provided prior to exit.  Isease is a progressive brain ses uncontrolled movements, ms, and loss of thinking ability information is taken from the			
F 691 SS=E	S483.25(f) Colosicare. The facility must require colostomy services, receive professional standomprehensive puthe resident's god	tomy, or Ileostomy Care  tomy, urostomy,, or ileostomy ensure that residents who y, urostomy, or ileostomy such care consistent with dards of practice, the terson-centered care plan, and als and preferences. ENT is not met as evidenced	F 691	1. Resident #110 and #310 have been discharged from the facility and staff can make no changes at this time.  2. All residents with a colostomy can be affected by the alleged deficient practice. An audit of all inhouse residents with	

MANE OF PROVIDER OR SUPPLIER  WINCHESTER HEALTH & REHABILITATION  WINCHESTER, VA 22603  FREED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES ACCOMPANY OF LISC IDENTIFYING INFORMATION)  FREED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST ARE PRECEDED BY FULL REQULATORY OR LISC IDENTIFYING INFORMATION)  FREED COntinued From page 80  Based on staff interview and clinical record review, it was determined the facility staff failed to provide colostomy care for two of 32 residents in the survey sample, Residents #110 and #310.  The findings include:  Colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the skin of the abdomen. (1)  1. For Resident #110, the facility staff failed to evidence that colostomy care was completed.  On the most recent MDS (minimum dala set) assessment, an admission assessment, the resident was coded as having an ostomy.  The physician order dated, 6/2/2022, documented, "Ostomy." Colostomy Care every shift and as needed, every 12 hours for Ostomy."  The TAR (treatment administration record) for June 2022 documented the above order. Of the 48 opportunities for completing the colostomy care, 11 were blank. A blank on the TAR indicates the treatment was documented as performed. The TAR for July and August did not have the order for colostomy care.		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
MAKE OF PROVIDER OR SUPPLIER  WINCHESTER HEALTH & REHABILITATION  ### WINCHESTER, VA. 22603  ### PROVIDERS PLAN OF CORECTION OF THE PROVIDERS PLAN OF COMMENT OF THE PROVIDERS PLAN O	0.045		495389	B. WING		
WINCHESTER HEALTH & REHABILITATION    VA) ID   REPERK   TAG	NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS CITY STATE 710 CODE	04/12/2023
Description						
Color   Colo	WINCHES	TER HEALTH & REHA	BILITATION			
FREETIX TAG  REQULATORY OR LSC IDENTIFYING INFORMATION)  F 691  Continued From page 80  Based on staff interview and clinical record review, It was determined the facility staff failed to provide colostomy care for two of 32 residents in the survey sample, Residents #110 and #310.  The findings include:  Colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the skin of the abdomen. (1)  1. For Resident #110, the facility staff failed to evidence that colostomy care was completed.  On the most recent MDS (minimum data set) assessment, an admission assessment, the resident was moderately impaired for making daily decisions. In Section H - Bladder and Bowel, the resident was noderately impaired for making daily decisions. In Section H - Bladder and Bowel, the resident was coded as having an ostomy.  The physician order dated, 6/3/2022, documented, 75ctomy: Colostomy Care every shift and as needed, every 12 hours for Ostomy."  The TAR (treatment administration record) for June 2022 documented the above order. Of the 48 opportunities for completing the colostomy care, 11 were blank. A blank on the TAR indicates the treatment was documented apperformed.  The TAR for July and August did not have the				V	VINCHESTER, VA 22603	
Continued From page 80 Based on staff interview and clinical record review, it was determined the facility staff failed to provide colostomy care for two of 32 residents in the survey sample, Residents #110 and #310.  The findings include:  Colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the stoma into a bag attached to the skin of the abdomen. (1)  1. For Resident #110, the facility staff failed to evidence that colostomy care was completed.  On the most recent MDS (minimum data set) assessment, an admission assessment, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) sore, indicating the resident was moderately impaired for making daily decisions. In Section H - Bladder and Bowel, the resident was coded as having an ostomy.  The physician order dated, 6/3/2022, documented, "Ostomy: Colostomy Care every shift and as needed, every 12 hours for Ostomy."  The TAR (treatment administration record) for June 2022 documented the above order. Of the 48 opportunities for completing the colostomy care, 11 were blank. A blank on the TAR indicates the treatment was documented as performed.  The TAR for July and August did not have the	PREFIX	(EACH DEFICIEI	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	D BE COMPLETION
Based on staff interview and clinical record review, it was determined the facility staff failed to provide colostomy care for two of 32 residents in the survey sample, Residents #110 and #310.  The findings include:  Colostomy is a surgical procedure that brings one end of the large intestine out through an opening (stoma) made in the abdominal wall. Stools moving through the intestine drain through the storma into a bag attached to the skin of the abdomen. (1)  1. For Resident #110, the facility staff failed to evidence that colostomy care was completed.  On the most recent MDS (minimum data set) assessment, an admission assessment, the resident scored a 12 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired for making daily decisions. In Section H - Bladder and Bowel, the resident was coded as having an ostomy.  The physician order dated, 6/3/2022, documented, "Ostomy: Colostomy Care every shift and as needed, every 12 hours for Ostomy."  The TAR (treatment administration record) for June 2022 documented the above order. Of the 48 opportunities for completing the colostomy care, 11 were blank. A blank on the TAR indicates the treatment was documented as performed. The TAR for July and August did not have the	F 691	Continued From pa	ige 80	F 691		- 1
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The TAR for July and August did not have the						
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		- Stadi for Coloa(Off)	, 00.0.	ł		
The nurse's notes were reviewed. The nurses		The nurse's notes	were reviewed. The purses			*
documented in their notes, "Bowel has ostomy		The second secon				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE COMP	SURVEY
		495389	B. WING			C 12/2023
127	ROVIDER OR SUPPLIER	ABILITATION	110 L	EET ADDRESS, CITY, STATE, ZIP CO LAUCK DR CHESTER, VA 22603		12
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C {EAGH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DÂTE
F 691	through August of colostomy.  The comprehensi documented in pa	s no documentation from June fany care provided for the ve care plan dated, 6/16/2022, art, "Focus: Resident has a "Interventions" documented,	F 691			2 2
	practical nurse) # When asked wha LPN #2 stated, "I can't prove you d	conducted with LPN (licensed 2 on 4/11/2023 at 3:14 p.m. t blanks on the TAR indicated, t means they didn't do it. You id it. The nurse might have t off but you can't really prove				
	(administrative st nursing, on 4/12/2 what colostomy of the wafer has to with soap and wafor breakdown ar thoroughly, apply apply the wafer a seal. When asker ASM #2 stated the	conducted with ASM aff member) #2, the director of 2023 at 11:09 a.m. When asked are consists of, ASM #2 stated, be removed, the area cleaned ater, the skin should be inspected at redness, then dry the area a ostomy paste to make a seal, and make sure you have a good d how often this is to be done, be ostomy should be checked When asked where it is M #2 stated on the TAR.				
	ASM #1, the adm the regional nurs of the above con	tomy care was requested, as provided.  ninistrator, ASM #2, and ASM #4, e consultant, were made aware cerns on 4/12/2023 at 1:31 p.m.  ation was provided prior to exit.				#1 #1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING		04/12/2023	
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP O 110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE COMPLET THE APPROPRIATE DATE	TION
F 691	Continued From p	V 801	F 69	1		35
		's colostomy bag was not 2/25/22 and 3/5/22, for a		Part 1		
	were no orders or ostomy bag until	nical record revealed that there in frequency to change the 3/4/22. The order documented, by every 3 days" and included a				
	A review of the Tr	eatment Administration Record se bag was changed on 3/5/22.				
	was not done. A revealed one date "Resident wanted shower to change bag/appliance. V	ed change was for 3/8/22. This review of the nurse's notes ed 3/8/22 that documented, I to wait till [they] had [their] e [their] colostomy vill pass on to the next shift to y." There was no evidence it				
==,,	"Resident C/O (co Area is red, irritat S/S (signs/sympt resident has requ past few days fro	ted 3/6/22 documented, complained of) pain to stoma site. ed, with slight inflammation. No coms) of infection noted but lired several bag changes in the m picking at wafer. Education wen to not pick at the wafer"				
120	"resident has re the past few days Education and re wafer."	ated 3/7/22 documented, equired several bag changes in a from picking at wafer.  minders given to not pick at the				
		00 PM, an interview was SM #3 (Administrative Staff				1.7

+	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CO	DNSTRUCTION	(X3) DAT	E SURVEY
		495389	B. WING			C 1/12/2023
	ROVIDER OR SUPPLIER	ILITATION	110	EET ADDRESS, CITY, STATE, LAUCK DR ICHESTER, VA 22603		11212323
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 691	"Every 3 days is not bag changes. Every When asked about a colostomy bag, she facility there should but the frequency is and patient. If they days. As long as the breakdown. I say the last that long. The sit makes it 3 to 4 day order) for 3 days be Depends on the resi The max time would there is not an order the frequency, should clarify an order for	Practitioner. She stated that, the protocol for colostomy 7 days or when it leaks." In order for when to change a stated, "To be clear for the be an order on the frequency variable depending on doctor have a good seal, every 7 be and a good seal, every 7 be and a good seal and no at but a lot of times it doesn't leal breaks, etc., It is good if a good if	F 691			
<b>L</b> =	the above order and admission on 2/25/2 3/5/22 was a period bag change. This e practitioner's statem at least every 7 days	ent that it should be changed s. stomy care and services was				
es:	end-of-day meeting Member) the Admin made aware of the t	eximately 1:30 PM at the ASM #1 (Administrative Staff istrator, and ASM #2 were indings. No further vided by the end of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495389		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
NAME OF P	ROVIDER OR SUPPLIER	10000		TREET ADDRESS OFF STATE TO SODE	04/12/2023
WINCHESTER HEALTH & REHABILITATION		ABILITATION	11	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR /INCHESTER, VA 22603	and agreement.
(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 OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE COMPLETION
F 691	Continued From p	age 84	F 691		100
F 695 SS=E	Respiratory/Trache CFR(s): 483.25(i)  § 483.25(i) Respiratory care and tracheal care, consistent was practice, the compoure plan, the resident 483.65 of this This REQUIREME by:  Based on observation interview, clinical indocument review, facility staff failed in services per plan in manner for four of sample; Residents The findings included.  1. For Resident # ensure that oxyge on multiple dates in the services in the services in the findings included.	ation, resident interview, staff record review and facility it was determined that the to provide respiratory care and of care and/or in a sanitary 32 residents in the survey \$6461, #14, #3, and #7.  de:  61, the facility staff failed to in was administered as ordered in February and March 2022.	F 695	1. Resident #1 has been discharged from the facility and no intervention can be provided by facility staff. Resident #14 and resident #3 O2 setting was corrected on the spot during the survey. Resident #14 and #7 O2 tubing was bagged and labeled per policy.  2. All residents that use O2 can be affected by the alleged deficient practice. A facility wide O2 audit will be made for residents utilizing O2. Audit will focus on the setting is correct according to physician order and that O2 tubing is stored in a sanitary manner when not in use.	5/26/23
		nical record revealed a sted 2/23/22 for oxygen at 3 continuous.			Salima and Salima

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING		C 04/12/2023
	ROVIDER OR SUPPLIER TER HEALTH & REHAB	BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	
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F 695	A review of the Media Administration Reco and March 2022 failed documentation of the A review of the nurse following:  On 3/1/22, 3/8/22, 3 the oxygen was documented of the ordered oxygen was administered instead of the ordered oxygen was administered of the ordered oxygen was administered of the oxygen was administered of the oxygen was administered oxygen, it should be TAR and that if a resistant oxygen, it should be TAR and that if a resistant oxygen, it should be TAR and that if a resistant oxygen, it should be documented with ASM Member) the Directed that if staff are documented oxygen is not be documented why not in use and does	ication / Treatment rds (MAR / TAR) for February ed to reveal any e oxygen being administered. e's notes revealed the //14/22, 3/18/22, and 3/21/22 umented as not being used. 3/6/22, 3/7/22, 3/12/22, the oxygen was documented ed at 2 liters per minute ed 3 liters per minute.  , 2/28/22, 3/9/22, 3/10/22, 15/22, 3/16/22, 3/19/22, and o documentation at all that ninistered as ordered.  AM an interview was #5 (Licensed Practical ed that when a resident is on a documented on the MAR or sident has oxygen on, it	F 695	to nursing staff following physicians' orders for therapy and a facilipolicy for storing tubing in a sanital manner when not in unby the resident.  4. DON or designee waudit 3 residents with weekly X 8 weeks following physicians ordered and the sanitary storage of O2 tubing when not use by the resident. The audits will be reviewed trends and issues. Resure of the weekly audits with the providence of the committee monthly a months. The Quality committee is responsible for the committee for the committee is responsible for the committee in the committee is responsible for the committee is	ng D2 ity D2 iry ise  vill D2 for der e in The for ilts will API 3 API
	A review of the resid	dent's care plan revealed one			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COI	NSTRUCTION		E SURVEY APLETED C
		495389	B. WING			4/12/2023
	ROVIDER OR SUPPLIER	BILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR			4/12/2023
			WING	CHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	Continued From pa		F 695			
	pulmonary disease intervention dated	The resident has (chronic obstructive )." This care plan included the 2/28/22 for "O2 (oxygen) via (liters per minute) continuous				
	reviewed. This pol "Preparation: 1. physician's order for physician's orders administrationDo and time that the p The name and title performed the proof flow, route, and rat duration of the trea obtained before, di procedure8. If the	Verify that there is a per this procedure. Review the cor facility protocol for oxygen cumentation1. The date rocedure was performed. 2. of the individual who sedure. 3. The rate of oxygen ionale. 4. The frequency and attent6. All evaluation data				
	end-of-day meeting Member) the Admi made aware of the information was prosurvey.  2. For Resident #1 to store oxygen tub.  On the most recent assessment, a qual assessment referencesident scored a finterview for mental.	oximately 1:30 PM at the g, ASM #1 (Administrative Staff nistrator, and ASM #2 were findings. No further ovided by the end of the 4 (R14), the facility staff failed bing in a sanitary manner.  It MDS (minimum data set) arterly assessment, with an ince date of 12/28/2022, the last out of 15 on the BIMS (brief all status) score, indicating the organitively impaired for making				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		495389	B. WING			12/2023
	NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP O 110 LAUCK DR WINCHESTER, VA 22603		
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F 695	Continued From p	age 87	F 695			
	sitting in their whe concentrator behi cannula was drap the nose prongs v tubing was dated	2:25 p.m. R14 was observed selchair with an oxygen and the resident. The nasal ed over the concentrator and overe touching the floor. The 4/9/2023. A second observation p.m. The oxygen tubing was				
	still draped over the prongs were touck stated they only understood occasionally during episode." Observations of the property	ne concentrator and the nasal hing the floor. The resident se the oxygen at night and g the day if they have an ration on 4/11/2023 at 8:30 a.m. en tubing was draped over the				8 2 1
	documented in paraltered respiratory (related to) pneum (chronic obstructions Respiratory Failure "Interventions" do SETTING: O2 via	ve care plan dated, 6/10/2022, int, "Focus: The resident has y status/difficulty breathing r/t monia, Exacerbation COPD ve pulmonary disease), Chronic re with hypoxia." The cumented in part, "OXYGEN nasal prongs @ (at) 2 LPM PRN (as needed)."				
	practical nurse) # When asked how when not in use, to be a bag with t attached to the or	conducted with LPN (licensed 2, on 4/12/2023 at 8:11 a.m. oxygen tubing is to be stored LPN #2 stated there is supposed he resident's name on it tygen concentrator.				
	to evidence docu	, "Oxygen Administration" failed mentation related to storing the it when not in use."				
24		ive staff member) #1, the M #2, the director of nursing,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		495389	B. WING _			C 04/12/2023
	ROVIDER OR SUPPLIER	BILITATION	n = =	STREET ADDRESS, CITY, STATE, ZIP COD 110 LAUCK DR WINCHESTER, VA 22603	E	04/12/2023
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F 695	made aware of the at 1:31 p.m.  No further informat	age 88 agional nurse consultant, were above findings on 4/12/2023 ion was provided prior to exit.  (R3), the facility staff failed to	F 6	595		
	administer oxygen rate.  On 4/11/2023 at 9: bed with oxygen or oxygen concentrate per minute). A sec 4/12/2023 at 8:19 at (licensed practical use via a nasal car observe what rate stated, it was some When asked if she supposed to be on	at the physician prescribed  14 a.m. R3 was observed in a via a nasal cannula. The per was set at 1.5 LPM (liters and observation was made on a.m., accompanied by LPN anurse) #2. The oxygen was in anula. LPN #2 was asked to the oxygen was set to. LPN #2 awhere around 1.5 (LPM). knew what rate R3 was LPN #2 stated, it should be 2 sted the rate to 2 LPM.				
5	needed) via nasal SPO2 (oxygen sate humidified."  The comprehensiv documented in par	gen as needed PRN (as cannula at 2 L.PRN to maintain uration) if <(less than) 90%, e care plan dated, 8/14/2022, t, "Focus: The resident has				
	illness." The "Inter "OXYGEN SETTIN prongs @ (at) 2L (i (oxygen saturation humidified."	(related to) Respiratory ventions" documented in part, IGS: O2 (oxygen) via nasal iters) PRN to maintain SPO2 ) if <(less than) 90%, "Oxygen Administration"				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			110 LA	T ADDRESS, CITY, STATE, ZI AUCK DR HESTER, VA 22603	P CODE		
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F 695	physician's order f physician's orders administrationTu	rt, "Verify that there is a or this procedure. Review the or facility protocol for oxygen irn on the oxygen at the inute as ordered by the	F	695				
	administrator, ASM and ASM #4, the r	ve staff member) #1, the M #2, the director of nursing, egional nurse consultant, were a above findings on 4/12/2023						2.5
	No further informa	tion was provided prior to exit.						184
	4. For Resident #7 oxygen tubing in a	7 (R7), the facility failed to store a sanitary manner.	111					
	oxygen tubing was handlebars of the had an oxygen tar	pproximately 12:45 p.m. the sobserved wrapped around the resident's rollator (walker), and hk attached to it. The oxygen he tubing was dated 4/9/2023.			20			
		er dated, 11/11/2022, (liters) oxygen as needed,						
	documented in pa oxygen therapy r/ "Interventions" do	ve care plan dated, 10/28/2022, rt, "Focus: The resident has t respiratory illness." The cumented in part, "OXYGEN a nasal prongs @ 2L dified."						
	practical nurse) #: When asked how	conducted with LPN (licensed 2, on 4/12/2023 at 8:11 a.m. oxygen tubing is to be stored LPN #2 stated there is supposed						er m

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	TER HEALTH & REH	ABILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	
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F 695	Continued From p	age 90	F 695		
	attached to the ox asked if it was acc	ne resident's name on it ygen concentrator. When eptable to have the tubing ne resident's rollator, LPN #2			
	administrator, ASI and ASM #4, the r	ve staff member) #1, the M #2, the director of nursing, regional nurse consultant, were above findings on 4/12/2023			
		ition was provided prior to exit.			
F 697 SS≃D	§483.25(k) Pain Market for facility must be provided to reside consistent with prothe comprehensive and the residents' This REQUIREMED by:	lanagement. Insure that pain management is nts who require such services, ofessional standards of practice, e person-centered care plan, goals and preferences.  ENT is not met as evidenced	F 697	resident's pain. She was medicated with relief. The nurses were educated on the process to ensure patient care continuity while one is on break/lunch.	5/26/23
	interview, clinical document review, facility staff failed pain management 32 residents in the The findings included address the reside 4/10/23 at 4:10 Pl	the facility staff failed to ent's complaint of pain on M.		2. All residents who experience pain can be affected by the alleged deficient practice. The facility will complete a pain assessment on every resident and provide intervention as appropriate.	
	On the most recei	nt MDS (Minimum Data Set), an		3. All licensed nurses will be	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NOD PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE (	(X3) DATE SURVEY COMPLETED		
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F 697	Admission / 5-Day N 3/15/23, Resident #1 cognitively intact in a decisions.  On 4/10/23 at 4:10 F observed and the refor pain from this surexpression reflected that time, RN #1 (Reformed that time, LPN (Licensed that the pain, the resident statement of the pain, the resident statement that she just returned that she just returned written note on her companied that she just returned written note on her companied that she just returned written note on her companied that she just returned written note on her companied that she just returned written note on her companied that she just returned that she in the stated with LPN notified RN #1 that she in the stated RN #1 that she	In In It is a seed of the seed	F 697	educated on the timely intervention for pain management.  4. DON/Designee will conduct random audits of 3 residents per week for 8 weeks by asking residents if their pain is addressed timely and corrective action made, as necessary. The audits will be reviewed for trends and issues. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	
	When asked about a treatment and/or me when she is on brea nurse cannot give m	another nurse providing care, adications to her residents ik, she stated that "The other neds to my patients, that are noty one that can is the DON	I x		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			
		495389	B. WING		04/12/2023	
NAME OF PROVIDER OR SUPPLIER  WINCHESTER HEALTH & REHABILITATION		110	REET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR NCHESTER, VA 22603	04/12/2023		
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F 697	On 4/11/23 at app (Administrative St Nursing, was asked provide medication when a nurse is of nurses have acced medication record absolutely can ast and check for app medications, if app nurse would have other nurse's medications of the record in the rec	proximately 7:45 AM, ASM #2 aff Member) the Director of ad about nurses being able to ns to another nurse's residents in break. She stated that the ss to all of the residents and that another nurse sess another nurse's resident propriate orders and administer propriate. She stated that the to just get the keys for the dication cart from the other (the DON) who has a set of medication carts. ASM #2 was N #1's failure to address the int of pain while LPN #4 was on	F 697			
F 698 SS=E	reviewed. This programization will eprovided to reside consistent with programmer plan, and the preferences"  On 4/11/23 at the ASM #1 (the Administration was paurey.  Dialysis	Pain Management, was olicy documented, "The ensure that pain management is ents who require such services, ofessional standards of prehensive person-centered e residents' goals and end-of-day meeting at 5:00 PM, sinistrator) and ASM #2, were e findings. No further provided by the end of the	F 698	Facility currently gettin dialysis communication for the second sec		
	§483.25(I) Dialysi	s.	74	resident #32.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 698	require dialysis rec	age 93 asure that residents who eive such services, consistent tandards of practice, the	F 69	by the alleged deficient practice. The facility will	
	comprehensive per the residents' goals This REQUIREME by:	rson-centered care plan, and	=	audit residents with dialysis to ensure the communication book is being used.	
	and clinical record to provide complet	review, the facility staff failed e dialysis care and services for s in the survey sample,		All licensed nurses will be educated on completion and monitoring of the preand post dialysis	
XI	For Resident #32 ( ensure adequate o	R32), the facility staff failed to ommunication and are with the resident's		communication forms.  4. DON or designee will audit	
ts Ilm	physician's order d every Monday, We comprehensive ca failed to document	clinical record revealed a ated 2/15/22 for hemodialysis idnesday and Friday. R32's re plan revised on 2/26/22 information regarding h the dialysis center.		three charts of residents on dialysis every week for 8 weeks. The audits will be reviewed for trends and issues. Results of the weekly audits will be	
	book that containe completed by facili to dialysis, and retrommunication fro reveal any docume following dialysis described.	dialysis communication book (a d communication forms to be ty staff, sent with the resident urned with documented of the dialysis center) failed to ented communication for the lays: 3/10/23, 3/13/23, 3/17/23, 3/29/23, 3/31/23 and 4/5/23.		reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance	
	conducted with LP	p.m., an interview was N (licensed practical nurse) #2. re should be a communication			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 698	dialysis. LPN #2 sidialysis communicathere is stuff missir On 4/11/23 at 5:18 staff member) #1, the director of nursiabove concern. The facility policy to	each day R32 goes to lated she reviewed R32's lation book and, "It looks like lag."  p.m., ASM (administrative lag. administrator, and ASM #2, lang, were made aware of the lated, "End Stage Renal	F 698		
	Agreements betwee contracted ESRD (facility will include a resident's care will limited to:  a. the developmen integrated care plate b. the communications facility and	Resident" documented, "3. en this facility and the end stage renal disease) all aspects of how the be managed including but not t of a comprehensive and notion process between the the dialysis center that will nmunication, coordination, and			
F 700 SS=D	S483.25(n) Bed Ra The facility must at alternatives prior to a bed or side rail is correct installation, rails, including but elements. \$483.25(n)(1) Asse entrapment from b		F 700	1. Residents #29 and #34 had consents signed on 4-10-23 and resident #29 had a bedrail assessment completed on 4-10-23.  2. All residents could be affected by the alleged deficient practice. A facility wide bed rail audit will be conducted, and corrective actions taken as appropriate.	5/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	ABILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	1 04/12/2023
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F 700	to installation. §483.25(n)(3) Ensi	-	F 700	3. All licensed nurses will be educated on the facility policy and procedure for utilizing bed rails on a resident.	
	§483.25(n)(4) Folial recommendations and maintaining be This REQUIREME by: Based on observation document review, facility staff failed in requirements for two sample, Residents.  The findings included to review with the interpresentative to the obtain consent for, On the most recent quarterly assessman reference date) of requiring the extern mobility and transformall three observationalls were up.	ow the manufacturers' and specifications for installing ad rails.  NT is not met as evidenced ation, staff interview, facility and clinical record review, the implement bed rail avo of 32 residents in the survey #29 and #34.  The:  19 (R29), the facility staff failed resident (and/or resident's arisks and benefits of, and the use of bed rails.  11 MDS (minimum data set), a rent with an ARD (assessment 2/13/23, R29 was coded as a sive assistance of staff for bed ers.  12 p.m. and 3:11 p.m., and on m., R29 was sitting up in bed. At ons, bilateral bed rails (quarter		4. DON/Designee will monitor bed rail assessments completed on 3 residents per week for 8 weeks. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	
	following: "2/24/21	physician orders revealed the Patient is required (sic) alls to assist with repositioning."	<b>a</b> f⁵		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED				
		495389	B. WING		04/12/2023		
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				
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F 700	Continued From p	page 96	F 700				
	reveal an assessi education regardi	R29's clinical record failed to ment for the use of bed rails, ing the risks and benefits of raconsent for the use of bed					
	nurse) #2, the uni She stated the nu completes an eva She stated, "We h	5 p.m., LPN (licensed practical it manager, was interviewed. ursing staff and therapy staff situation for the use of bed rails. have to get the consent. We gnosis why they need a bed					
	staff member) #1, director of nursing	7 p.m., ASM (administrative , the administrator, ASM #2, the g, and ASM #4, the regional were informed of these					
	the facility staff pr education and co document contair facility's procedur	request for the bed rail policy, rovided a copy of a blank nsent for side rails. The ned no information related to the e for assessing for, education ag consent for the use of side t.					
	2. For Resident # to review the risk: the resident (and	and failed to obtain informed					
	A review of R34's	clinical record revealed a side					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER TER HEALTH & REHAB	ILITATION	11	TREET ADDRESS, CITY, STATE, ZIP CODE IO LAUCK DR /INCHESTER, VA 22603		
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F 700	documented bilateral recommended to ass review of R34's clinic documentation that trisks and benefits of the resident's represent.  On 4/10/23 at 4:43 prin bed with bilateral or position.  On 4/11/23 at 3:12 proconducted with LPN in regard to residents stated, "We are suppressed in the suppressed in	ion dated 11/17/22 that I quarter side rails was sist with bed mobility. Further cal record failed to reveal the facility staff reviewed the bed rails with R34 (and/or entative) and obtain informed .m., R34 was observed lying quarter bed rails in the upright .m., an interview was (licensed practical nurse) #2 so use of bed rails. LPN #2 posed to have an eval rapy. We do an assessment, the consent and find a they need the bed rails."	F 700			
F 725 SS=D	staff member) #1, the the director of nursing above concern. Sufficient Nursing St CFR(s): 483.35(a)(1 §483.35(a) Sufficient The facility must have the appropriate comprovide nursing and resident safety and a practicable physical, well-being of each resident assessment and considering the	t Staff.  re sufficient nursing staff with petencies and skills sets to related services to assure attain or maintain the highest mental, and psychosocial esident, as determined by its and individual plans of care	F 725	1. Resident #34 received her medication as ordered the following morning with no adverse effects.  2. All residents can be affected by the alleged deficient practice.		5/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		7112
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 725	at §483.70(e).  §483.35(a)(1) The by sufficient numb types of personnel nursing care to all resident care plans (i) Except when we this section, licens (ii) Other nursing plimited to nurse aid §483.35(a)(2) Except paragraph (e) of the designate a licens nurse on each tou This REQUIREME by:  Based on staff intended and clinical record to provide sufficient residents in the sufficient resident #34 administer the method physician's order of the rewas only one nurses were requifications that a case a specific method is not available).  A review of R34's physician's order of the sufficient residents in the sufficien	facility assessment required  facility must provide services ers of each of the following on a 24-hour basis to provide residents in accordance with s: aived under paragraph (e) of sed nurses; and personnel, including but not des.  ept when waived under nis section, the facility must ed nurse to serve as a charge of duty. ENT is not met as evidenced erview, facility document review review, the facility staff failed at staffing for one of 32 urvey sample, Resident #34.	F 7:	to come in when nect to access the Or (Medication disposation) for commedications.  4. DON or Designee with schedules and sheets to ensure ad	nurse essary mnicel! eensing trolled  fill audit staffing equate address and the emental weekly orted to nmittee hs. The e is he on-	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED	
						С	
		495389	B. WING		04	/12/2023	
NAME OF PROVIDER OR SUPPLIER  WINCHESTER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			7771212020	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETION DATE	
F 725		athy. A review of R34's March	F 725	=155		7:	
42	failed to reveal ev administered gab and 3/29/23 at 6:	cation administration record) ridence that R34 was apentin on 3/28/23 at 10:00 p.m. 00 a.m. Nurses' notes dated /23 documented, "Awaiting rmacy."					
		cility Omnicell list revealed g capsules were available in the					
	conducted with A member) #2, the nurse who docum notes). ASM #2 nurses ran out of practitioner sent pharmacy and the medication would ASM #2 stated si from the Omnicel	4 p.m., an interview was SM (administrative staff director of nursing (and the nented the above progress stated that on 3/28/23, the R34's gabapentin so the nurse a new prescription to the e pharmacy staff stated the I be delivered on the next run. he could not obtain gabapentin II during the night of 3/28/23 or					
	morning of 3/29/2 and she was the stated two nurses from the Omnice substance. A revnight of 3/28/23 is revealed two nurse in On 4/11/23 at 4:4 conducted with C	23 because two nurses called in only nurse working. ASM #2 is are required to pull gabapentin ill because it is a controlled view of the staffing sheet for the into the morning of 3/29/23 is called in and ASM #2 was the building.  43 p.m., an interview was DSM (other staff member) #2, the	-				
	work 12-hour shi nurses for each s couple of nurses	neduler. OSM #2 stated nurses fts and she schedules two shift. OSM #2 stated there are a who are willing to pick up extra ses call in, and ASM #2 and the				2 6	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495389	B. WING		C 04/12/2023	
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION		BILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 725	unit manager will w nurse able to work. also contracts with On 4/11/23 at 5:18	ork the floor if there is no other OSM #2 stated the facility agency staff.  p.m., ASM #1, the ASM #2 were made aware of	F 72			
F 727 SS≃E	Reference: (1) Gabapentin is used information was observed interest in the second in the second interest in the second interest in the se	sed to relieve pain. This tained from the website: .gov/druginfo/meds/a694007.h /k, Full Time DON 1)-(3)	F 72	7 1. The facility is unable to make corrections to past noncompliance.	5/26/23	
	paragraph (e) or (f) must use the service least 8 consecutives \$483.35(b)(2) Exceparagraph (e) or (f) must designate a redirector of nursing \$483.35(b)(3) The as a charge nurse average daily occurnis REQUIREME by:  Based on staff intereview, the facility is the service of the	of this section, the facility ces of a registered nurse for at a hours a day, 7 days a week.  The twhen waived under of this section, the facility egistered nurse to serve as the on a full time basis.  Idirector of nursing may serve only when the facility has an pancy of 60 or fewer residents.  Now is not met as evidenced erview and facility document staff failed to provide RN coverage on three of 30 days		2. All residents could be affected by the alleged deficient practice.  3. The staffing coordinator will schedule the facilities two staff RNs (Registered Nurse) on opposite rotations to cover 7 days per week. Administrative RN will fill in as needed. Staffing coordinator will be inserviced on the regulation for 7 day a week RN coverage for 8 hour per day. The staffing coordinator will notify the	e e k s	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILDING _		c	
		495389	B. WING		04/12/2023	
	ROVIDER OR SUPPLIER		11	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAUCK DR INCHESTER, VA 22603		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	1D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 727	Continued From p	page 101	F 727	administration if RN coverage is inadequate.		
	there was no RN 4/9/23.  On 4/11/23 at 4:1 conducted with A member) #2, the stated the facility of RN coverage e 365 days a year. one other RN best another RN.  On 4/11/23 at 5:1 administrator, and the above concert.	titled, "Department Duty Hours -		4. DON or Designee will audit schedules and staffing sheets weekly to ensure adequate RN coverage. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.		
F 755	nurse hours will b day; 7 days a we	" documented, "7. Registered be eight consecutive hours per ek." Procedures/Pharmacist/Records	F 755	1. Resident #262 has	5/26/23	
SS=E	S483.45 (all S483.45 (all S483.45 Pharmac The facility must drugs and biologithem under an as \$483.70 (g). The personnel to administry but only a licensed nurse.  \$483.45 (a) Procepharmaceutical sthat assure the all S483.45 (a)	a)(b)(1)-(3)  cy Services provide routine and emergency icals to its residents, or obtain greement described in facility may permit unlicensed ninister drugs if State law under the general supervision of		discharged from the facility and no corrective action can be taken by the facility. Carts were checked to ensure resident #14 and #37 had all ordered medications available.  2. All residents could be affected by the alleged deficient practice. All medication carts will be audited to ensure current		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495389 B. WING			04/12/2023	
	ROVIDER OR SUPPLIER	ABILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR WINCHESTER, VA 22603	04/12/2009
(X4) ID PREFIX TAG	(EACH DEFICI	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 755	§483.45(b) Service must employ or of pharmacist whospanial whospan	et the needs of each resident.  e Consultation. The facility oftain the services of a licensed  vides consultation on all vision of pharmacy services in  ablishes a system of records of sition of all controlled drugs in enable an accurate  ermines that drug records are in account of all controlled drugs periodically reconciled.  ENT is not met as evidenced  at interview, staff interview, iew, and facility document ermined that the facility staff fat medications were available for three of 32 residents in the esidents #262, #14, and #37.  de: facility staff failed to ensure available for administration on  ed to the facility with diagnoses were not limited to chronic mary disease (1), hypertension	F 755	residents have all medications as ordered.  3. Licensed nurses will be educated on the facility Policy and Procedure for ordering and refilling medications promptly.  4. DON/Designee will audit medication availability on 3 residents per week for 8 weeks. Results of the weekly audits will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495389	B. WING		0.4	C 1/12/2023
NAME OF PROVIDER OR SUPPLIER			= =	STREET ADDRESS, CITY, STATE, ZIP CODE		7 TATALOE
WINCHESTER HEALTH & REHABILITATION			ac l	110 LAUCK DR WINCHESTER, VA 22603		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF COI	RRECTION	(XS)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION
F 755	Continued From page	e 103	F 75	35		
i	record) for R262 date documented in part,	ed 12/1/2021-12/31/2021				
200	- "Metoclopramide H	_	18			1
		er) Use 5mg intravenously				
	•	before meals. Start Date:				
3		00 a.m.)." The eMAR		2		• 1
		the administration area for				
		.m., 1:00 p.m. and 5:00 p.m. les documented in part, "9=		441		Ĩ
	Other/See Nurse No		(1)	4		85
	i i	let 30mg Give 1 tablet by	- 422			
		day for high blood pressure.				
		21 0900." The eMAR				
		the administration area for				. [
	12/28/2021 at 9:00 a	i.m., 1:00 p.m. and 5:00 p.m.				
	- "Tiotropium Bromid	e Monohydrate Aerosol		221		
		(micrograms) 2 puff inhale				4 9
		for COPD. Start Date:				
	i .	00 a.m.). The eMAR				
2.		the administration area for				
	12/28/2021 at 6:00 a					N 20 1
	- "Symbleort aerosol	terol Fumarate) 2 puff inhale				
- 2	1 '	y for COPD. Start Date:				
		The eMAR documented a "9"	1			8a 1
	1	area for 12/28/2021 at 9:00	Ì			
	a.m.					
	- "acetazolamide tab	let 125mg Give 1 tablet by				
	mouth one time a da	y for fluid retention. Start	•			12
	Date: 12/28/2021 09	00." The eMAR documented				
ļ		ration area for 12/28/2021 at				
	9:00 a.m.					\$55 m
		citalopram Oxalate) Give 1				U E:
	,	e afternoon for depression.				
		21 1300 (1:00 p.m.)." The a "9" in the administration				
	area for 12/28/2021			W = 1		
	The nurses notes for	r R262 documented in part,			0.	
	<del>`                                      </del>					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495389	B. WING		04/12/2023	
	ROVIDER OR SUPPLIER	BILITATION	STRE 110 L WINC	04/15/2020		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 755	waiting on meds free "12/28/2021 15:3" (available)- waiting (pharmacy)."  - "12/28/2021 18:3" Should be coming - "12/28/2021 18:3" is not here and claddone."  The physician order orders for the medion 12/27/2021 and 12/28/2021.  The discharge sum 12/27/2021 from [Nin part, "Severe (in the setting of chinave scheduled all inhaler), prin (as ne (nebullzers), Spiriv SymbicortDischalist: Start taking theacetazolamide 1: as: Diamox, Take mouth daily. Start 2021tiotropium 2 Commonly known puffs into the lungs on: December 28, these medications: 160-4.5 mcg/act in Symbicort Dose: 2 into the lungs 2 (twablet Commonly known)	9 (5:49 a.m.) new resident om pharmacy." 2 (3:32 p.m.) med not avail for delivery from pharm 8 (6:38 p.m.) med not here yet. in very shortly." 7 (6:38 p.m.) not given as med diffication of order needs to be see for R262 documented deations listed above entered scheduled to start on a scheduled	F 755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	8. WING		C 04/12/2023
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			110 L	ET ADDRESS, CITY, STATE, ZIP CODE AUCK DR CHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 755	Continued From pa	age 105	F 755	2	
ii.	(administrative sta administrator state who worked at the were currently emp	oproximately 5:00 p.m., ASM  If member) #1, the  Id that there were no nurses  If acility in December 2021 that  ployed at the facility, and the  and for R262 no longer worked			
	conducted with LP LPN #2 stated that admitted to the fact summary from the to the resident arrivadmissions coording prior to the resident had everything in and they reviewed the physician or not resident arriving a computer for the particular with social therapy to prepare the resident may reansport arrived with discharge sum the after visit summedischarge medications for sent new orders to that prior to Januar pharmacy which resident morning. The medications were	0:08 a.m., an interview was to (licensed practical nurse) #2. It when a new resident was stillity they received the after visit admissions coordinator prior ving. LPN #2 stated that the nator worked with the hospital at arriving to ensure that they place to care for the resident if the discharge medications with the discharge medications with the entered the orders into the charmacy. LPN #2 stated that meeting" prior to the resident if services, admissions and is the room with any equipment need. LPN #2 stated that when with the resident they provided many which was compared to many for any changes to the tions. They notified the expractitioner of any changes in om the discharge summary and of the pharmacy. LPN #2 stated any of 2023 they used another equired the medications to be 00 p.m. to get the medications LPN #2 stated that when the entered after 4:00 p.m. they until the following day at			

		IDENTIFICATION NUMBER:  A. BUILDII		PLE CONSTRUCTION  G	(X3) DATE SI COMPLE	
		495389	95389 B. WING		04/1:	2/2023
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CO 110 LAUCK DR WINCHESTER, VA 22603		
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 755	midnight. LPN #2 that were needed the pharmacy and pharmacy in about that the former phase facility but it mostly to use, and that the getting inhalers to have to get them shave the hospital sidischarge.  On 4/12/2023 at 11 conducted with AS #3 stated that they getting their medicafter admission to they would expect as blood pressure started by the next stated that they we inform them of a remedications due to pharmacy and at the alternate from the On 4/12/2023 at a request was made medications availatin the facility in De at approximately 1 they were unable that were available 2021 from the form.  The facility policy,	stated that any medications urgently were called as "stat" to they were delivered by a local four hours. LPN #2 stated armacy kept a "stat box" at the contained antibiotics for them a former pharmacy was slow the facility and they would often ent from the local pharmacy or end them with the resident at 2:44 p.m., an interview was M #3, nurse practitioner. ASM expected for a resident to start ations as soon as possible the facility. ASM #3 stated that any pertinent medications such medications and inhalers to be a day after admission. ASM #3 suld expect the nursing staff to esident not receiving their of it not arriving from the imes they were able to use an stock medications.  ASM #1 for a listing of the able to staff in the stat box kept cember of 2021. On 4/12/2023 100 p.m., ASM #1 stated that to get the list of medications as in the stat box in December of	F 7			
= 1	biologicals that are	ed in part, IT. Drugs and e required to be refilled will be e issuing pharmacy in a timely			( <sub>4</sub> )	2.  V

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495389	8. WING		04/12/2023	
NAME OF P	ROVIDER OR SUPPLIER	5	-	STREET ADDRESS, CITY, STATE, ZIP CO		
MUNICUES	TED LICAL THE OCCU	A SH ITATION	1	110 LAUCK DR	40	
WINCHES	TER HEALTH & REHA	ABILITATION	İ	WINCHESTER, VA 22603		
(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 OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLÉTION DATE	
F 755	Continued From page	age 107	F 75	55		
		e last dosage being			· ·	
	•	sure that refills are readily				
	available"	isolo that folias are readily				
	The facility policy.	"General Guidelines for				
		stration" revised 8/2020				
		rt, "The facility has sufficient				
	,	ition distribution system to				
	b contract of the contract of	histration of medication without				
		ruptionsIf a dose of regularly				
		tion is withheld, refused, not				
	available, or given	at a time other than the		98		
	scheduled time (e.	g., the resident is not in the			- 2	
		led time or a starter dose of an			IIIVA A	
	antibiotic is neede	d), the space provided on the				
	front of the MAR for	or that dosage administration is		100		
0	initialed and circle	d. An explanatory note is				
	entered on the rev	verse side of the record. If 3	Ĭ			
	consecutive doses	s, or in accordance with facility				
	policy, of a vital m	edication are withheld, refused,	1			
	or not available, th	ne physician is notified. Nursing			t (i	
		tification and physician	·	100		
		ectronic MAR system is used,				
		es required for resident				
		tification of medications due at				
	,	d documentation of				
34		fusal, holding of doses, and			39	
		s such as vital signs and lab			44.1	
		ped in the system's user			N 5	
	manual"					
	0- 440,0000	200				
		:29 p.m., ASM #1, the				
		M #2, the director of nursing and				
	made aware of the	onal nurse consultant were e findings.				
	No further informa	ation was obtained prior to exit.			-=	
	Reference:					

		IDENTIFICATION NUMBER: A. BUIL		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED C
		495389	B. WING		04/12/2023
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 755	Continued From pa	age 108	F 7	55	
	(COPD) Disease that make lead to shortness obtained from the				
	(2) congestive hea A condition in which blood to meet the does not mean the about to stop work not able to pump to affect one or both information was of https://medlineplus/2. For Resident #1	rt failure th the heart can't pump enough body's needs. Heart failure at your heart has stopped or is ing. It means that your heart is slood the way it should. It can sides of the heart. This btained from the website: s.gov/heartfailure.html 4 (R14), the facility staff failed inister Lyrica, per the physician			
	assessment, a qua assessment refere resident scored a interview for ment resident was not of daily decisions.  The physician ordadocumented, "Lyri neuropathic pain)	at MDS (minimum data set) arterly assessment, with an ence date of 12/28/2022, the 14 out of 15 on the BIMS (brief al status) score, indicating the ognitively impaired for making  er dated, 1/6/2023, ca Capsule (used to treat (1) 25 mg (milligram); Give 1 at bedtime for neuropathic			
	record) document	MAR (medication administration ed the above order for Lyrica. A ed for the 9:00 p.m. dose on 3/15/2023. A "9" indicated, s notes."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495389	B. WING _		04/12/2023
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 755	Continued From p	age 109	F 7	55	
	p.m. dose adminis order."	for the above dates and 9:00 stration, documented, "On			ê
		me of drug dispensing machine) ducted however, the Lyrica was in the machine.			
98	practical nurse) #3	conducted with LPN (licensed 2, on 4/11/2023 at 3:14 p.m. the process was when a			367
	scheduled to be a (name of pharma the building) is the medications we n	available at the time it is dministered, LPN #2 stated the cy machine with medications in a best thing. It has many of the eed. If it's a narcotic, then you o get it out of the machine.			
	the (name of mac do, LPN #2 stated to get it and notify not here. When a LPN #2 stated, no	e medication is not available in hine), what should the nurse to if you have to call the pharmacy the nurse practitioner that it is sked if Lyrica is in the machine, if it is not. LPN #2 was shown			22
	dates and the nur #2 stated she was unavailability of th that sometimes it medications and	was not given on the above ses documented, on order. LPN is not made aware of the se Lyrica for R14. LPN #2 stated takes two days to get even the stat (right away) ake up to 24 hours to get.			
	A policy on Medic	ation Administration and allability was requested. No			
	administrator, AS	ive staff member) #1, the M #2, the director of nursing, regional nurse consultant, were	004		

	CORRECTION	DENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	C (X3) DATE SURVEY
		495389	B. WING		04/12/2023
	ROVIDER OR SUPPLIER TER HEALTH & REHA	BILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	SHOULD BE COMPLETION
F 755	made aware of the at 5:07 p.m.	age 110 above concern on 4/11/2023 ion was obtained prior to exit.	F 755		
	following website:	was obtained from the .gov/druginfo/meds/a605045.h			
		7 (R37), the facility staff failed nister Lyrica, per the physician			
	assessment, a qua assessment refere resident scored a interview for menta	t MDS (minimum data set) interly assessment, with an ince date of 1/16/2023, the I2 out of 15 on the BIMS (brief al status) score, indicating the prately cognitively impaired for ions.			
	4/10/2023 at appro	conducted with R37 on eximately 2:00 p.m. R37 stated t of their Lyrica at times.			
	documented, "Lyric	er dated, 2/10/2023, ca 75 mg; Give 1 capsule by day for neuropathy."			
	order. On 2/12/202 a.m. and 9:00 p.m On 2/14/2023 for t	3 MAR documented the above 23 and 2/13/2023 for the 9:00 doses a "9" was documented. the 9:00 a.m. dose a "9" was indicates, "Other/See nurse's			
		for the dates and times with d, documented "On order."			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		495389	B, WING _	Ä	04/	2/2023
	ROVIDER OR SUPPLIER	ABILITATION	16	STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603		= =
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD 8E	(X5) COMPLETION DATE
F 755	Continued From p	age 111	F 7	55		
	practical nurse) #; When asked what medication is not scheduled to be a (name of pharmac the building) is the medications we n need two nurses the the (name of mac do, LPN #2 stated to get it and notify not here. When a LPN #2 stated, no where the Lyrical dates and the nur #2 stated she was unavailability of th that sometimes it	conducted with LPN (licensed 2, on 4/11/2023 at 3:14 p.m.  I the process was when a available at the time it is dministered, LPN #2 stated the cy machine with medications in a best thing. It has many of the eed. If it's a narcotic, then you o get it out of the machine.  I medication is not available in hine), what should the nurse to I you have to call the pharmacy the nurse practitioner that it is sked if Lyrica is in the machine, of it is not. LPN #2 was shown was not given on the above ses documented, on order. LPN is not made aware of the le Lyrica for R37. LPN #2 stated takes two days to get even the stat (right away)				
F 756 SS≃E	ASM (administrat administrator, AS and ASM #4, the made aware of the at 5:07 p.m.  No further information of the Drug Regimen Received Received Recei	ake up to 24 hours to get.  ive staff member) #1, the M #2, the director of nursing, regional nurse consultant, were e above concern on 4/11/2023  ation was obtained prior to exit. eview, Report Irregular, Act On )(1)(2)(4)(5)  Regimen Review. e drug regimen of each resident I at least once a month by a	F	756 1. The facility is unable to correct past noncompliance but currently has a designated pharmacist assigned and is making monthly visits to the facility and doing a		5/26/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495389	B. WING		04/12/2023
	ROVIDER OR SUPPLIER	SILITATION	11	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAUCK DR INCHESTER, VA 22603	1 0-11 (2.12.02.0
(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)	ILD BE COMPLETION
F 756			F 756	monthly Medication Regimen Review.	
	of the resident's med §483.45(c)(4) The p irregularities to the a facility's medical dire and these reports m (i) Irregularities including that meets the (d) of this section for (ii) Any irregularities during this review m separate, written regularity to attending physician director and director minimum, the resider and the irregularity to (iii) The attending physician (iiii) The attending physician the irregularity to (iiii) The attending physician irregularity has been action has been take be no change in the	harmacist must report any attending physician and the actor and director of nursing, ust be acted upon.  ude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug.  noted by the pharmacist ust be documented on a port that is sent to the and the facility's medical of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified.  In the pharmacist identified or reviewed and what, if any, and to address it. If there is to medication, the attending cument his or her rationale in		2. All residents could be affected by the alleged deficient practice. December 22 and January 2023 MRR will be pulled to ensure any recommendations were followed.  3. DON/Designee will retrieve the MMR from pharmacy consultant website monthly and will give to the provider to review and respond to the recommendations. DON will make the changes in PCC.	
	maintain policies an drug regimen review limited to, time framthe process and ste when he or she ider requires urgent action. This REQUIREMEN by:  Based on staff interreview, and clinical failed to complete a	acility must develop and d procedures for the monthly that include, but are not es for the different steps in ps the pharmacist must take atifies an irregularity that on to protect the resident.  IT is not met as evidenced view, facility document record review, the facility staff monthly medication regimen 2 residents in the survey		4. The results will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		495389	B. WING	i i	C 04/12/2023
	ROVIDER OR SUPPLIER	ABILITATION	110	REET ADDRESS, CITY, STATE, ZIP CODE LAUCK DR NCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
F 756		s #25, #29, and #20.	F 756		
	did not complete (MRR) in Deceml A review of R25's	25 (R25), the facility pharmacist a medication regimen review per 2022 or January 2023.  clinical record failed to reveal RR in December 2022 and			
	staff member) #1 director of nursing nurse consultant, concerns. ASM # pharmacist." She undergone a cha and lost their pha was without a ph She stated she w	7 p.m., ASM (administrative, the administrator, ASM #2, the g, and ASM #4, the regional were informed of these 1 stated: "We just got a stated the facility had nge of ownership on 12/1/22, rmacist. She stated the facility armacist until February 2023. rould check to make sure there or this resident in December y 2023.			
	couldn't find anyt February [2023].  A review of the fa Regimen Review consultant pharm review of each re clinical record at	cility policy, "Medication ," revealed, in part: "The acist performs a comprehensive sident's medication regimen and			
	2. For Resident	#29 (R29), the facility pharmacist			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY APLETED
		495389	B. WING		0	4/12/2023
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION		_	STREET ADDRESS, CITY, STATE, ZIP 110 LAUCK DR WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CEACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 756	did not complete a (MRR) in December A review of R29's devidence of an MR January 2023.  On 4/11/23 at 5:07 staff member) #1, the director of nursing, nurse consultant, we concerns. ASM #1 pharmacist." She sundergone a change and lost their pharm was without a pharm She stated she wowere no MRRs for 2022 and January.  On 4/12/23 at 9:24	medication regimen review or 2022 or January 2023.  clinical record failed to reveal R in December 2022 and  p.m., ASM (administrative he administrator, ASM #2, the and ASM #4, the regional vere informed of these stated: "We just got a tated the facility had ge of ownership on 12/1/22, macist. She stated the facility macist until February 2023. uld check to make sure there this resident in December	F 756	2 2 2	(CY)	
	3. For Resident #2: did not complete a (MRR) in January 2 A review of R29's 0 evidence of an MR	ion was received prior to exit.  0 (R20), the facility pharmacist medication regimen review 2023.  clinical record failed to reveal R in January 2023.  p.m., ASM (administrative the administrator, ASM #2, the				
	director of nursing, nurse consultant, v	and ASM #4, the regional vere informed of these stated: "We just got a				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495389	B. WING		C	
NAME OF DE	ROVIDER OR SUPPLIER	455365		STREET ADDRESS, CITY, STATE, ZIP CODE	04/12/2023	
WINCHESTER HEALTH & REHABILITATION			110 LAUCK DR WINCHESTER, VA 22603			
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 756	pharmacist." She sta undergone a change and lost their pharma was without a pharm She stated she would were no MRRs for th 2023.		F 750			
F 803 SS=D	Menus Meet Reside CFR(s): 483.60(c)(1)	n was received prior to exit.  nt Nds/Prep in Adv/Followed  -(7)  nd nutritional adequacy.	F 80	1. The facility is unable to correct past non-compliance.	05/26/23	
15 AR	residents in accorda guidelines.; §483.60(c)(2) Be pre §483.60(c)(3) Be foll §483.60(c)(4) Reflect reasonable efforts, the input received from groups; §483.60(c)(5) Be up §483.60(c)(6) Be residentian or other climiters.	owed;  ct, based on a facility's  he religious, cultural and resident population, as well as residents and resident		<ol> <li>All residents could be affected by the alleged deficient practice.</li> <li>The dietary manager and staff will be educated on following the published menu. A facility wide audit will be conducted to ensure menus are being followed or menus substituted per policy.</li> </ol>		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495389	B. WING		C 04/12/2023
NAME OF PE	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	7 7 11 12 12 12 12 12 12 12 12 12 12 12 12
WINCHES	TER HEALTH & REHA	BILITATION		110 LAUCK DR	TIS TELL TON
				WINCHESTER, VA 22603	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 803	construed to limit the personal dietary character this REQUIREMENT by:  Based on observation record review, and facility staff failed to one of 32 residents Resident #23.  The findings include For Resident #23 (provide the resident menu on 4/10/23.  On 4/10/23 at 12:3 wheelchair, with a stable that was in front contain any character the resident should On 4/10/23 at 12:3 evaluated the items.	ing in this paragraph should be ne resident's right to make oices.  NT is not met as evidenced tion, staff interview, clinical facility document review, the ofollow the published menu for in the survey sample,  e:  R23), the facility staff failed to at with the items on the lunch  1 p.m., R23 was sitting in a tray of food on the overbed ont of the resident. The tray did ocolate pudding. A review of R23 for this meal included that I get chocolate pudding.  4 p.m., OSM #7, a cook, so on R23's tray. OSM #7	F 80	Manager/Designee will audit 3 trays per meal for 8 weeks to ensure the published menu is being followed. The results of the audit will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the ongoing monitoring for compliance.	
	chocolate pudding.	not right. (R23) should have Somebody substituted i, but there should be on the tray."	(A)		
	services manager, stated the dietary a the tray line with th silverware, and col calling out what sh	p.m., OSM #8, the dining was interviewed. OSM #8 lide who stands on the side of e trays, condiments, d items, is responsible for ould be on the resident's plate. responsible for making sure	57.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495389	B, WING		C 04/12/2023		
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			1	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			
(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 APPROPRIED TO THE	D BE COMPLETION		
F 803	items like pudding a tray. She stated the unless the facility is stated: "I was stand what happened tood She stated (R23) lii stated the dietary a to touch the tray, a sure the correct iterresident.  On 4/11/23 at 5:07 staff member) #1, to director of nursing, nurse consultant, we concerns.  A review of the fact in part: "Menu item the religious, cultur the residents, when menus are posted and in print large e them."  No further informat Food in Form to McCFR(s): 483.60(d) Food a Each resident received.	are placed on the resident's menu should be followed to out of a particular Item. She ding right there. I don't know ay with (R23)'s lunch tray." Res chocolate pudding. She ide is usually the last person and is responsible for making ms are being served to the p.m., ASM (administrative he administrator, ASM #2, the and ASM #4, the regional were informed of these lity policy, "Menus," revealed, is and available snacks reflect al, and ethnic preferences of the resident areas, in positions mough for residents to read ion was provided prior to exit. Beet Individual Needs 3) and drink fives and the facility provides-	F 803	1. The facility is unable to correct past non-compliance.  2. All residents could be	5/26/23		
	This REQUIREME by: Based on observa	NT is not met as evidenced tion, staff interview, clinical facility document review, the		affected by the alleged deficient practice. A facility wide audit of therapeutic diets will be conducted to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495389	B. WING		C		
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABI	HITTER HITTER HITTER	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603				
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION		
residents in the surver.  The findings include:  For Resident #23 (R2 serve pureed spinach.  On 4/10/23 at 12:31 wheelchair, with a tratable in front of the repureed meat and passerving of spinach, wand stems were visib.  On 4/10/23 at 12:34 evaluated the items of stated: "No, this is not pureed."  A review of R23's phyfollowing: "3/7/23 Refollowing: "3/7/23 Refollowing: "3/7/23 Refollowing: "by the lunch meal that spinach had been run processor, but clearly get it to the correct point of the correct point of the lunch meal that spinach had been run processor, but clearly get it to the correct point of the correct point of the lunch meal that spinach had been run processor, but clearly get it to the correct point of the correct point	erve food at the insistency for one of 32 by sample, Resident #23.  23), the facility staff failed to in at lunch on 4/10/23.  25.m., R23 was sitting in a by of food on the overbed insident. The tray contained at a. The tray also contained a shich was not pureed. Leaves alle in the serving cup.  25.p.m., OSM #7, a cook, on R23's tray. OSM #7 of right. That spinach is not insident. Puree texture."  26.m., OSM #8, the dining as interviewed. OSM #8 and not been pureed enough the food of needed more moisture to be ureed texture.  26.m., ASM (administrative and aSM #4, the regional	F 805	ensure the correct diet is on the meal ticket.  3. The dietary manager and staff will be educated on preparing modified texture diets.  4. The Dietary Manager/Designee will audit 3 trays per meal for 8 weeks to ensure the consistency of the modified diet is correct. The results of the audit will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.			

	DE DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495389	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C 04/12/2023
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION		1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603		
(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 OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL! CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 805	revealed, in part: " prescribed by the the resident's treat accordance with h preferencesA 'th diet ordered by a prediction as part of clinical condition, the diet, or to alternative	age 119 Therapeutic diets are physician/practitioner to support the timent and plan of care and in is or her goals and erapeutic diet' is considered a physician, practitioner, or treatment for a disease or to modify specific nutrients in the texture of a diet."	F 805		
F 806 SS=D	Resident Allergies CFR(s): 483.60(d) Food a Each resident recision from S483.60(d)(4) Food allergies, intolerant S483.60(d)(5) Approximative value to resident meal choop that is initially different meal choop that is initially different meal choop that is initially different meal choop that is record that is initially different meal choop that is initially different meal choop that is initially different meal choop that is initially different meal choop that is initially different meal choop that is initially different meal choop that is initially that in the survey sample. The findings inclusion of the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that in the survey sample that it is not that in the survey sample that it is not the survey sample that it is not that in the survey sample that it is not the s	preferences, Substitutes (4)(5) and drink eives and the facility provides- d that accommodates resident aces, and preferences; dealing options of similar esidents who choose not to eat a served or who request a ice; ENT is not met as evidenced ation, staff interview, clinical d facility document review, the to serve food according to a acce for one of 32 residents in e, Resident #23.	F 806	<ol> <li>The facility is unable to correct past non-compliance.</li> <li>All residents could be affected by the alleged deficient practice. A facility-wide audit will be conducted to ensure residents' likes and dislikes are up to date.</li> <li>Dietary staff will be educated on substitutions to honor residents likes/dislikes, allergies, and preferences.</li> </ol>	5/26/23

STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION		O. 0938-0391 E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BUILDING		CON	PLETED	
	495389		B, WING			C
NAME OF P	NAME OF PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	4/12/2023
MINOUES	TER 11541 711 A ROLLAR	12 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		110 LAUCK DR		
WINCHES	TER HEALTH & REHAB	ILITATION	v	WINCHESTER, VA 22603		
(X4) IO		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		DATE
F 806	Cantinual Francis	- 400		1000		
F 800			F 806	Dictory .		
		p.m., R23 was sitting in a ay of food on the overbed		Manager/Designee will		5
		it of the resident. The tray		audit 3 trays per meal for 8		
		of chicken and pasta. A		weeks to ensure the		
	review of the meal tid	cket for R23 stated in two		substitutions to honor		85
	1 '	ked chicken. R23's family		residents likes/dislikes,		
	_	peside the resident. The		allergies and preferences		
	The second secon	d: "We keep telling them she  . She never has. But they		are being followed. The		78
	keep giving it to her.			results of the audit will be		1.2
	i de grang de de			reported to the QAPI		
		p.m., OSM #7, a cook,		Committee monthly x 3		
		on R23's tray. OSM #7		months. The QAPI		
		y. This is not right. We should		Committee is responsible		
	doesn't like chicken.	on the tray. I know (R23)	-1	for the on-going		421
	docorre into critottori.			monitoring for		
	On 4/10/23 at 2:50 p	.m., OSM #8, the dining	i	compliance.		
		as interviewed. She stated				
		y from the steam table line at				
		m sorry. I know (R23) does my fault. I shouldn't have	l'and and			
	served it. I don't know			i		
		Wilde Happonou.		Later to be a second of the se		*
	On 4/11/23 at 5:07 p	.m., ASM (administrative				
		e administrator, ASM #2, the				
		and ASM #4, the regional				
	nurse consultant, we concerns.	ere informed of these				3
	CONCOLLIS.					
	A review of the facilit	y policy, "Resident Food			125	
		ed, in part: "On admission				**

and/or re-admission the dietary representative or nursing staff will identify a resident's food

preferences...Resident dietary preferences will be reviewed periodically with the resident by the dietary team... When possible, staff will interview the resident and/or resident representative to determine current food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495389		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED			
		B. WING	C 04/12/2023				
	ROVIDER OR SUPPLIER	BILITATION	11	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 806		on history and life patterns	F 806				
F 812 SS=0	Food Procurement,S		F 812	The off-duty employee exited the building immediately.			
	approved or consider state or local authors (i) This may include from local producers and local laws or require (ii) This provision do facilities from using gardens, subject to safe growing and for (iii) This provision do (iii) This provision do	food items obtained directly s, subject to applicable State		2. All residents could be affected by the alleged deficient practice. A dietary department audit will be conducted by the administrator/designee to ensure dietary staff with beards are wearing a beard guard.			
	serve food in accord standards for food s This REQUIREMEN by: Based on observati document review, it	e, prepare, distribute and dance with professional service safety.  IT is not met as evidenced from staff interview, and facility was determined that the serve food in a sanitary		3. Dietary staff will be educated to wear a beard guard if they have a beard in the food preparation and serving area if they are on or off duty.  4. Administrator/designee	5/26/23		
	standing at the end		5	will monitor the dietary staff during meal service 3X week for 8 weeks to ensure sanitation is followed regarding wearing hair restraints, re.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE O	(X3) DATE SURVEY COMPLETED			
		495389	B. WING		C 04/12/2023	
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 812	employee, who has a beard guard.  On 4/10/23 at 12:2 member) #6 was send of the steam to being served. OSM mustache. OSM #6 stadropped somethin dining services may osm #8 stated: "Yes minutes. It's his data the kitchen is suppleard guard when OSM #8 stated: "Yes of acility at her requisite stated: "He cashouldn't have go partly my fault. He should have." She he usually wears at 10 of 4/11/23 at 5:07 staff member) #1, director of nursing nurse consultant, concerns.  A review of the face	25 p.m., OSM (other staff standing in the kitchen at the able line as lunch trays were M #6 had a full beard and 6 was not wearing a beard ated: "But it's my day off. I just g off for them." OSM #8, the anager was serving lunch trays. Yes, he is only here for a few ay off." When asked if anyone in cosed to wear a hair net and/or in proximity to the tray line, Yes. That is true."  10 p.m., OSM #8 was stated OSM #6 had come to the est to drop off a needed item. The ame past the line where he is estated when OSM #6 works, all the garb.  17 p.m., ASM (administrative the administrator, ASM #2, the in, and ASM #4, the regional were informed of these cillity policy, "Prevention of	F 812	beard guards. The results of the audit will be reported to the QAPI Committee monthly x 3 months. The QAPI Committee is responsible for the on-going monitoring for compliance.		
	"Dietary staff will v	Department," revealed, in part: wear hair restraints (e.g., or beard restraint) to prevent ng food."			<i>j</i> a	
	No further informa	ition was provided prior to exit.			N 52	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495389	B. WING		C 04/12/2023		
	ROVIDER OR SUPPLIER TER HEALTH & REHA	BILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION		
F 880 SS=E	infection prevention designed to provide comfortable environdevelopment and to diseases and infection for the facility must end control program. The facility must end control program a minimum, the following for the facility must end communicable staff, volunteers, volu	Control stablish and maintain an and control program e a safe, sanitary and anment and to help prevent the transmission of communicable stions.  In prevention and control stablish an infection prevention m (IPCP) that must include, at lowing elements:  In the for preventing, identifying, ating, and controlling infections at diseases for all residents, isitors, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards;  Item standards, policies, and program, which must include, to:  Item standards to identify cable diseases or hey can spread to other stility;  Item possible incidents of ease or infections should be stransmission-based precautions are event spread of infections;  Item standards policies and program, which must include, to:  Item standards policies, and program, which must include, to:  Item standards policies and program, which must include, to:  Item standards policies and program, which must include, to:  Item standards policies and program, which must include, to:  Item standards policies and program, which must include, to:  Item standards policies and program, which must include, to:  Item standards policies and program, which must include, to:  Item standards policies and program, which must include, to:  Item standards policies and program, which must include, to:  Item standards policies and program policies and program policies and program policies and program policies and program policies and program policies and policies	F 880	1. The facility is unable to correct past noncompliance. Infection tracking has been completed by the DON/IPC since 1-1-23  2. All residents could be affected by the alleged deficient practice. A root cause analysis was completed by the facility to identify Infection Control gaps and areas of opportunity.  3. Facility reviewed IC and Surveillance P&P and completed an ADHOC QAPI meeting to review F-tag 880. Facility will provide education on facility P&P for Infection Control and Surveillance to current licensed nurses, upon hire for new licensed nurses and annually. The DON/IPC and back-up IPC will complete Modules 1 and 4 of the CDC Infection Control Training for IPC	5/17/23		
	(iv)When and how resident; including		ļ				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495389			(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
WINCHESTER HEALTH & REHABILITATION  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (X5) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)  (X5) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQUILATORY OR LSC IDENTIFYING INFORMATION)  (X6) REGULATORY OR LSC IDENTIFYING INFORMATION)  (X6) REGULATORY OR LSC IDENTIFYING INFORMATION)  (X6) PREFIX TAG  (X7) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.  (V) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with residents or their food with residents or their food with residents or their food with residents or their food with residents or their food with residents or their food with residents or their food with residents or their food with residents or their food with residents or their			495389	B. WING		
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 880  Continued From page 124  (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.  (V) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.  S483.80(a)(4) A system for recording incidents identified under the facility.  PREFIX TAG  CRORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 880  Certifications and CMS Targeted Covid-19 Training for Frontline Staff and Management by 5-17-23.  4. The DON/IPC/designee will monitor, track and trend surveillance weekly and the results will be reported to the QAPI committee monthly X 3 months. The QAPI committee is responsible for the on-going monitoring for compliance.  S483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  PREFIX TAG  CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 880  Certifications and CMS Targeted Covid-19 Training for Frontline Staff and Management by 5-17-23.  4. The DON/IPC/designee will monitor, track and trend surveillance weekly and the results will be reported to the QAPI committee monthly X 3 months. The QAPI committee is responsible for the on-going monitoring for compliance.		TER HEALTH & REHA			110 LAUCK DR	0411212020
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (V) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.  §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.  §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR	JLD BE COMPLETION
§483.80(f) Annual review.  The facility will conduct an annual review of its IPCP and update their program, as necessary.  This REQUIREMENT is not met as evidenced by:  Based on staff interview and facility document review it was determined the facility staff failed to evidence infection tracking for 9 of 12 months reviewed.  The findings include:  The facility staff failed to evidence infection tracking for 4/1/2022 through 12/31/2022.  On 4/11/2023 at approximately 11:30 a.m., a	F 880	(A) The type and dedepending upon the involved, and (B) A requirement to least restrictive postic circumstances. (v) The circumstance must prohibit emploid disease or infected contact with resident contact will transmit (vi)The hand hygier by staff involved in §483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must had transport linens so infection. §483.80(f) Annual of the facility will confice for and update the This REQUIREMENT This REQUIREMENT The facility twas determined in the facility staff fail tracking for 4/1/202	aration of the isolation, a infectious agent or organism that the isolation should be the sible for the resident under the cess under which the facility byees with a communicable skin lesions from direct that or their food, if direct the disease; and the procedures to be followed direct resident contact.  Stem for recording incidents facility's IPCP and the the facility's IPCP and the the facility's IPCP and the the facility is IPCP and the facility of the incidence of th	F 880	Targeted Covid-19 Training for Frontline Staff and Management by 5-17-23.  4. The DON/IPC/designee will monitor, track and trend surveillance weekly and the results will be reported to the QAPI committee monthly X 3 months. The QAPI committee is responsible for the on-going monitoring for	

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NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP ( 110 LAUCK DR WINCHESTER, VA 22603	•	71212023	
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F 880	request was made member) #2, the	e to ASM (administrative staff director of nursing/infection the facility infection tracking logs	FE	380	X.		
	On 4/12/2023 at a (licensed practica with infection trac present. LPN #2	approximately 8:40 a.m., LPN I nurse) #2 provided a binder king from 1/1/2023 through the stated that they were looking for s in the previous director of	III			1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
	they did not have provide. ASM #2 were the ones the started working a ASM #2 stated th infections in their	10:10 a.m., ASM #2 stated that any other tracking logs to stated that the logs they had by had completed since they the facility a few months back, at they were notified of new morning meetings, in chart					
	they used the trac and track any trea that they used the monthly report wi	reviews. ASM #2 stated that cking sheets to locate residents ands in infections. ASM #2 stated information to compile a nich they reported in the QAPI e performance improvement)	Ξ			32	
	approved 6/15/20 "Surveillance re the occurrence of number and freque pidemics, monit detecting unusual control implication practitioner) coor surveillance using Surveillance Log.	"Infection Control Surveillance" 112 documented in part, afters to a system for recognizing if infections, recording their uency, detecting outbreaks and oring employee infections and I pathogens with infection ns. The ICP (infection control dinates the facilities infection g the [Name of facility] InfectionThe surveillance log should be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495389			(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER TER HEALTH & REHA	BILITATION	1	TREET ADDRESS, CITY, STATE, ZIP CODE 10 LAUCK DR VINCHESTER, VA 22603	
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F 880	administrator, ASM ASM #4, the region made aware of the	29 p.m., ASM #1, the I #2, the director of nursing and nal nurse consultant were above concern.	F 880		
F 943 SS=D	Abuse, Neglect, ar CFR(s): 483.95(c)(s) §483.95(c) Abuse, In addition to the frand exploitation refacilities must also that at a minimum §483.95(c)(1) Active neglect, exploitation	neglect, and exploitation. eedom from abuse, neglect, quirements in § 483.12, provide training to their staff educates staff on- vities that constitute abuse, on, and misappropriation of	F 943	1. CNA #3 received abuse and neglect education on 7/26/22 and 11/24/22. This documented training was not easily available during the survey. CNA was re-educated on Abuse and Neglect.	5/26/23
	§483.95(c)(2) Procof abuse, neglect, misappropriation of S483.95(c)(3) Demonstrated abuse procession of the February and the facility training for one of assistant) records.	f resident property nentia management and evention. INT is not met as evidenced erview and facility document staff failed to provide abuse one CNA (certified nursing reviewed.		2. All residents could be affected by the alleged deficient practice. The facility will complete an audit of all current staff to ensure all have had abuse and neglect training in the past year.  3. All staff will be educated on the facility policy and procedures for abuse prevention.	
		iled to evidence abuse training NA #3, who was hired on			2

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
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	12,1	495389	B. WING		04/12/2023
NAME OF PROVIDER OR SUPPLIER  WINCHESTER HEALTH & REHABILITATION			01 11	REET ADDRESS, CITY, STATE, ZIP CODE 0 LAUCK DR INCHESTER, VA 22603	
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F 943	staff member) #1,	age 127  9 p.m., ASM (administrative the administrator, and ASM #2, sing, were made aware of the	F 943	4. The HR Coordinator will monitor education on Abuse Prevention upon hire and annually. The results will be reported to the QAPI committee	
	On 4/13/23 at 12:2 member) #4, the histated she could right #3 was provided at the facility uses at the program chan December 2022. training program tautomatic notifica	22 p.m., OSM (other staff numan resources manager, not provide evidence that CNA abuse training. OSM #4 stated in online training program and ged when the facility was sold in OSM #4 stated she sets up the hen employees receive tions of certain trainings that are ted abuse training is one of the		monthly X 3 months. The QAPI committee is responsible for the ongoing monitoring for compliance.	
F 945 SS=D	CFR(s): 483.95(e) §483.95(e) Infecti A facility must inci prevention and co training that include policies, and procedescribed at §483. This REQUIREMI by: Based on staff in review, the facility control training for nursing assistant) The findings inclu The facility staff for	on control. Jude as part of its infection antrol program mandatory des the written standards, edures for the program as 3.80(a)(2). ENT is not met as evidenced terview and facility document or staff failed to provide infection or one of one CNA (certified or records reviewed.	F 945	1. CNA #3 received Infection Control Training.  2. All residents have the potential to be affected by the alleged deficient practice. The facility will complete an audit of all current staff to ensure all have had infection control training in the past year.  3. All staff will be educated on the facility policy and procedures for Infection Control.	5/26/23

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495389	B. WING	04/12/2023		
	ROVIDER OR SUPPLIER TER HEALTH & REHA	ABILITATION	1	STREET ADDRESS, CITY, STATE, ZIP CODE  110 LAUCK DR  WINCHESTER, VA 22603		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 945	hired on 9/12/88. On 4/12/23 at 1:39 staff member) #1, t	p.m., ASM (administrative the administrator, and ASM #2, ing, were made aware of the	F 945	4. The HR Coordinator will monitor education on Infection Control upon hire and annually. The results will be reported to the QAPI committee monthly x 3 months. The QAPI		
	member) #4, the histated she could no #3 was provided in #4 stated the facility program and the p facility was sold in stated she sets up employees receive certain trainings the	2 p.m., OSM (other staff uman resources manager, of provide evidence that CNA fection control training. OSM by uses an online training rogram changed when the December 2022. OSM #4 the training program then a automatic notifications of at are due. OSM #4 stated aining is one of the required		committee is responsible for the on-going monitoring for compliance.		
F 947 SS=D	Required In-Service CFR(s): 483.95(g) §483.95(g) Require aides. In-service training §483.95(g)(1) Be s	ed in-service training for nurse	F 947	The facility is unable to correct past non-compliance. CNA #3 received her 12 hours annual training for nurse aids.	5/26/23	
,	§483.95(g)(2) Inclutraining and reside §483.95(g)(3) Add determined in nurs and facility assess	hours per year.  ude dementia management ent abuse prevention training.  ress areas of weakness as se aides' performance reviews ment at § 483.70(e) and may al needs of residents as		All residents could be affected by the alleged deficient practice. The facility will complete an audit of all current CNAs to ensure all are up to date		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
495389			B, WING	04/12/2023	
NAME OF PROVIDER OR SUPPLIER WINCHESTER HEALTH & REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 110 LAUCK DR WINCHESTER, VA 22603	
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F 947	§483.95(g)(4) For note individuals with considerable address the care of This REQUIREMENTS: Based on staff interview, the facility sof annual training for nursing assistant) in The findings included The facility staff fall annual training was hired on 9/12/88.  On 4/13/23 at 12:22 member) #4, the hustated she could not #3 was provided 12 OSM #4 stated the program and the program	urse aides providing services ognitive impairments, also the cognitively impaired. IT is not met as evidenced rview and facility document taff failed to provide 12 hours or one of one CNA (certified ecords reviewed.	F 94	on receiving their 12 hours required training.  3. All CNA's will receive their annual 12 hours of required training.  4. The HR Coordinator will monitor education for the 12 hours required training for CNAs upon hire and annually thereafter. The results will be reported to the QAPI committee monthly x 3 months. The QAPI committee is responsible for the ongoing monitoring for compliance.	
				***	