STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495146	B. WING		C 08/24/2022
	ROVIDER OR SUPPLIER	SONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801	33/24/2322
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	An onsite abbreviated was conducted 08/23. Significant corrections compliance with 42 C Term Care requireme. Three complaints were survey. 1. VA00055966 with 6 substantiated with def 2. VA0005568 with for substantiated with def 3. VA 00054541 with substantiated with def 3. VA 00054541 with substantiated with def The census in this 117 time of the survey. The of two (2) closed recording two (2) closed recording two (2) closed recording two (2) closed recording the survey. The of two (2) closed recording the survey of two (3) closed recording the survey. The facility implement written policity implement writ	d Medciare-Medicaid survey /2022 through 08/24/2022. s are required for FR Part 483 Federal Long ints. e investigated during the one allegation was ficient practice. ur allegations was ficient practice. two allegations was ficient practice. 7 bed facility was 72 at the e survey sample consisted rds (Resident #1 and hty-three (23) current fident #3 through Resident fouse/Neglect Policies (3) 7 must develop and ficies and procedures that: and prevent abuse, on of residents and sident property, h policies and procedures in allegations, and	F 000	Develop/Implement Abuse/Neglect Polic CFR(s): 483.12(b)(1)-(3) 1.) Facility reviewed and updated procedure for Abuse, Negle Exploitation with implementation revision date, and name of who reviewed any policy revision(s). 2.) All residents with incidents, accident allegations of abuse have the potential to be affected by the depractice. 3.) The organization's administrative will be educated on updating and reviewing Abuse, Neglect, and Exploitation Policy.	cies olicy ect and n date, dents, ne eficient e team d
				4.) The Administrator or designee we monitor revised policy for implementation date, revision date name of who reviewed the policy revision(s) to ensure implementate x weekly x 6 weeks then monthly 3 months. All findings will be rep QAPI time 3 months to review for	ate, and y ation 2 y times ported to

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES	PRINTED: 09/02/2022 FORM APPROVED OMB NO. 0938-0391 continued intervention or amendment of the plan. 5.) Allegation of compliance: 9-20-2022.
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	Administrate- 9/7/2022
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the insother safeguards provide sufficient protection to the patients. (See instructions.) Exce following the date of survey whether or not a plan of correction is provided. For nursing days following the date these documents are made available to the facility. If deficient program participation.	ot for nursing homes, the findings stated above are disclosable 90 days homes, the above findings and plans of correction are disclosable 14
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: FHRJ	1 Facility ID: VA0016 If continuation sheet Page 1 of 97

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		(X3) DATE SURVEY COMPLETED			
		495146	B. WING_		*		C / 24/2022
	ROVIDER OR SUPPLIER	SONBURG		94 SOL	TADDRESS, CITY, STATE, ZIP CODE JTH AVENUE ISONBURG, VA 22801		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	Contract of the Contract of th	(X5) COMPLETION DATE
F 607	Abuse, Neglect and Epolicy presented by thimplementation date. The findings were: In response to a request the Administrator provabuse policy. On 8/25 provided a copy of the Neglect and Exploitatif found there was no impolicy revision date, and no ippolicy revision(s). At 12:30 p.m. on 8/24 that included the Adm Nursing, Regional Directory team. The Adrabuse, Neglect and Exif it was the facility's consisting one currently in place. Confirmed the policy dimplementation date. The policy, consisting paper bearing a "Choice also contained a foote 2022 The Compliance reserved." Asked if the from the Internet, the Rursing said the policy owner of the facility and the said the said the foote the facility and the said the policy owner of the facility and the policy of the facility and the	ew, facility document rise of a complaint ity failed to implement their exploitation policy. The refacility carried no rest from the survey team, rided a copy of the facility's responsible to the policy, titled Abuse, responsible to the policy replementation date, no remain a manner of who reviewed any restor of Nursing, and the responsible to the policy and asked right abuse policy. The red that the policy was the red	F6	507			

PRINTED: 09/02/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING			C 24/2022
	ROVIDER OR SUPPLIER	SONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 607		viewed the policy and also	F 60	707		
F 609 SS=D	neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, negl mistreatment, including source and misappro are reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not resure the administrator of the officials (including to adult protective servitor jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on staff intervi	violations (4) se to allegations of abuse, or mistreatment, the facility that all alleged violations ect, exploitation or ng injuries of unknown priation of resident property, ately, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and ces where state law provides term care facilities) in the law through established the results of all administrator or his or her lative and to other officials in the law, including to the State of 5 working days of the law, including to the State eged violation is verified to action must be taken.	F 60	Proporting of Alleged Violations CFR(s): 483.12(c)(1)(4) 1.) Residents 15, 9, 7, 2, 8, 11, 12, 19, 14, 6, 16, 13, 5, 17 a no adverse reactions. The pland responsible parties were with no further orders. 2 Facility's Administrator will a ensure all Facility Reportable were reported within the prior will complete education with administrator on reporting of violations. 4 The Administrator or designer Facility Reported incidents 2 weekly time 6 weeks then matimes 3 months. All findings reported to QAPI times 3 more review for continued interver amendment of the plan. 5 Allegation for compliance: 9-	nd 20 had hysician e notified, udit to e Incidents r 30 days. erations the facility alleged ee will audit times onthly will be enths to ation or	9-20-2022

Facility ID: VA0016

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495146	B. WING				C / 24/2022	
	ROVIDER OR SUPPLIER	SONBURG		9	STREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTH AVENUE HARRISONBURG, VA 22801	1 00	24/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	CH CORRECTIVE ACTION SHOULD BE COMPLE S-REFERENCED TO THE APPROPRIATE		
F 609	incident of missed mand/or procedures in incident of missed mand/or procedures in reported to the State after the date of occur. The findings were: On 6/27/2022, the State a complaint from the facility resident alleging resident alleging received alleging resident eceived alleging resident named in the Wing Front Unit did number of the did not all residents with the wing front Unit did number of the did not all residents with the wing Front Unit did number of the did not all residents with the wing Front Unit with medications, treatmed of 1. The list identifications, treatmed during the evening should be did not be did not all residents included the state of the did not all residents with the did not al	dility failed to report an edications, treatments, a timely manner. An edications, treatments, volving 19 residents was not Survey Agency until 17 days rrence. The Survey Agency received Responsible Party of a ng certain care issues. On dum to the complaint was dents on the A unit did not investigation, the survey residents, including the eoriginal complaint, on the A of receive medications wift on 7/9/2022. The did not receive nts, and/or procedures on the odid not receive nts, and/or assessments iff on 7/9/2022. The 18 e following: Idmitted with diagnoses that olic congestive heart failure, disease, atrial fibrillation, isorder, hyperlipidemia, prebral infarction,	F	609				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AD PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND I DIN OI	OGNINEOTICIT	IDENTI IOATION NOMBER.	A. BUILDII	NG_				
		495146	B. WING	WING			C 08/24/2022	
NAME OF D	201/1252 02 01 1221 152	455146	J B: WING_		TOTAL DODGE OF A TAKE TO CODE	08/	24/2022	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CHOICE H	EALTHCARE AT HARRIS	SONBURG			4 SOUTH AVENUE			
				Н	IARRISONBURG, VA 22801			
(X4) ID PREFIX TAG			ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 609	Continued From page 4 behavioral disturbance. According to the most		F	609				
		Set (MDS), a Quarterly						
		ssment Reference Date				ļ		
		he resident was assessed						
		nitive Patterns) as being						
		y impaired with a Summary						
	Score of 11 out of 15.							
	discharged from the f	acility on 7/15/2022.						
	According to a review	of the Medication						
		d (MAR) in Resident # 2's						
		alth Record (EHR), the						
	following medications							
		performed during the						
	evening shift on 7/9/2	022:						
	Aspercreme Lidocain	e Patch 4% - Apply to left						
	knee topically one tim	ne a day for pain and remove						
	7	atch was not signed off a			1			
	being removed on 7/9							
		5 mg (milligrams) - Give 7.5						
	mg by mouth at bedti	(4)						
		ablet 20 mg - Give 1 tablet						
		for hypercholesterolemia.						
		ipsule 100 mg - Give 1						
	capsule by mouth two	times a day for						
	constipation.	et 5 mg - Give 1 tablet by						
	mouth two times a da							
		et 15 mg - Give 15 mg by						
	mouth three times a							
		ply to rectum topically three						
	times a day for hemo							
	Check vital signs (ten							
	saturation) every shif							
		(right) great toe and second						
	toe at bedtime for DT	l (Deep Tissue Injury).						
	197	Extremities) elevated every						
	shift for increased ed	ema.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						(С
		495146	B. WING_			08/	24/2022
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				9	4 SOUTH AVENUE		
CHOICE H	EALTHCARE AT HARRIS	SONBURG		Н	IARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 609	every shift for HOH (H 2. Resident # 5 was a included atrial fibrillatidisorder, dementia with gastroesophageal refinuscle weakness, condeficit, chronic diastol and wedge compress lumbar vertebra. Accompany Market Mark	dmitted with diagnoses that ion, hypertension, anxiety ith behavioral disturbance, lux disease, generalized ignitive communication lic congestive heart failure, ion fracture of second ording to a Medicare 5-Day 6/15/2022, the resident was ion C (Cognitive Patterns) cognitively impaired with a out of 15. Tof the MAR in Resident # g medications, treatments, are not performed during the 022: Tablet 40 mg - Give 1 tablet for hyperlipidemia. Tag - Give 50 mg by mouth at with delirium. Tag - Give 1 tablet by depression with 50 mg to the sound of 15 mg - Give 1 tablet by antidepressant with 25 mg Tablet 40 mg - Give 1 tablet by antidepressant with 25 mg	F	609	DEFICIENCY)		
	reflux disease). Potassium Chloride L	illiliter) - Give 20 meq by					

A BUILDING A BUILDING A BUILDING B WING C 08/24/2022 NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 6 Propylene Glycol Solution 0.5% - Instill 1 drop in both eyes two times a day for dry eyes. Tylenol Extra Strength Tablet 500 mg - Give 500 mg by mouth two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 6 Propylene Glycol Solution 0.5% - Instill 1 drop in both eyes two times a day for dry eyes. Tylenol Extra Strength Tablet 500 mg - Give 500 mg by mouth two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.	С	
CHOICE HEALTHCARE AT HARRISONBURG (X4) ID PREFIX TAG (Bach Deficiency Must be preceded by Full REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 6 Propylene Glycol Solution 0.5% - Instill 1 drop in both eyes two times a day for dry eyes. Tylenol Extra Strength Tablet 500 mg - Give 500 mg by mouth two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.	2	
CHOICE HEALTHCARE AT HARRISONBURG (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 6 Propylene Glycol Solution 0.5% - Instill 1 drop in both eyes two times a day for dry eyes. Tylenol Extra Strength Tablet 500 mg - Give 500 mg by mouth two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 6 Propylene Glycol Solution 0.5% - Instill 1 drop in both eyes two times a day for dry eyes. Tylenol Extra Strength Tablet 500 mg - Give 500 mg by mouth two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.		
F 609 Continued From page 6 Propylene Glycol Solution 0.5% - Instill 1 drop in both eyes two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.		
F 609 Continued From page 6 Propylene Glycol Solution 0.5% - Instill 1 drop in both eyes two times a day for dry eyes. Tylenol Extra Strength Tablet 500 mg - Give 500 mg by mouth two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.	ETION	
Propylene Glycol Solution 0.5% - Instill 1 drop in both eyes two times a day for dry eyes. Tylenol Extra Strength Tablet 500 mg - Give 500 mg by mouth two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.		
both eyes two times a day for dry eyes. Tylenol Extra Strength Tablet 500 mg - Give 500 mg by mouth two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.		
Tylenol Extra Strength Tablet 500 mg - Give 500 mg by mouth two times a day for pain. Vital signs (temperature and O2 saturation) three times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.		
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times a day to affected area topically every day and evening shift for skin care. Remove Lidoderm patch at bedtime.		
and evening shift for skin care. Remove Lidoderm patch at bedtime.		
I V Para I Service American III and the Company of		
Vital signs (temperature and O2 saturation) three		
times a day. Venelex Ointment - Apply to affected area		
topically every day and evening shift for skin care.		
Resident # 6 was admitted with diagnoses that		
included osteoarthritis, anxiety disorder,		
hypertension, chronic pain syndrome,		
hyperlipidemia, morbid obesity, bacteremia,		
generalized muscle weakness, and dysphagia.		
According to the most recent MDS, a Quarterly Review with an ARD of 7/23/2022, the resident		
was assessed under Section C (Cognitive		
Patterns) as being cognitively intact with a		
Summary Score of 15 out of 15.		
According to a review of the MAR in Resident #		
6's EHR, the following medications, treatments, and/or procedures were not performed during the	i	
evening shift on 7/9/2022:		
Vital signs (temperature and O2 saturation) three times a day.		
Remove TED hose/compression stockings in PM		
as resident tolerates at bedtime.		
Nystatin Powder 10000 Unit/gm (Units per gram)		
- Apply to affected area topically every day and evening shift for Fungus Candida.		
Preparation H - Apply to hemorrhoids BID (two		
times a day) for 14 day every day and evening		
shift for hemorrhoids until 7/20/2022.		

MANIE OF PROVIDER OR SUPPLIER	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		W 100 COMM 100	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
CHOICE HEALTHCARE AT HARRISONBURG (X4) ID (X4) ID (X4) ID (X5) ID (X5) ID (X6) ID (X6			495146	B. WING			l .	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS READ CORRECTION (EACH DEPICEMENT VIA) SUMMARY STATEMENT OF DEFICIENCIES BY FULL REGOLATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 7 Sama Lotion 0.5% - Apply to inner thighs topically every day and evening shift for itching. Venelex Orithmet - Apply to heels and buttocks topically every day and evening shift for treatment. 4. Resident # 7 was admitted with diagnoses that included emphysema, cerebrovascular disease, renal dialysis, generalized muscle weakness, dysphagia, malaise, cellulitis of the left and right lower limbs, acute diastolic congestive heart failure, hypothyroidism, gastroesophageal reflux disease, chronic kidney disease, chronic respiratory failure, encephalopathy, and type 2 diabetes mellitus. According to a Medicare 5-Day MDS with an ARD of 8/12/2022; the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively intact with a Summary Score of 15 out of 15. According to a review of the MAR in Resident # 7's EHR, the following medications, treatments, and/or procedures were not performed during the evening shift on 7/9/2022: Atorvastatin Calcium Tablet 40 mg - Give 1 tablet by mouth at bedtime for cholesterol. Gabapentin Capsule 400 mg - Give 1 capsule by mouth at bedtime for neuropathy. Lactinex Tablet Chewable - Give 2 tablets by mouth two times a day for probiotic. Regian Tablet 5 mg - Give 1 tablet by mouth three times a day. Vital signs fulles, respiration, blood pressure) three times a day. Glucoscan (blood sugar check) before meals and at bedtime for times a day.	NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	L-1/LULL
PREFIX TAG REGULATORY OR ISC IDENTIFYING INFORMATION) F 609 Continued From page 7 Sarna Lotion 0.5% - Apply to inner thighs topically every day and evening shift for itching. Venelex Ointment - Apply to heels and buttocks topically every day and evening shift for treatment. 4. Resident # 7 was admitted with diagnoses that included emphysema, cerebrovascular disease, renal dialysis, generalized muscle weakness, dysphagia, malaise, cellulitis of the left and right lower limbs, acute diastolic congestive heart failure, hypothyroidism, gastroesophageal reflux disease, chronic kidney disease, chronic respiratory failure, encephalopathy, and type 2 diabetes mellitus. According to a Medicare 5-Day MDS with an ARD 6 #1/2/2022. the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively intact with a Summary Score of 15 out of 15. According to a review of the MAR in Resident # 7's EHR, the following medications, treatments, and/or procedures were not performed during the evening shift on 7/9/2022: Atorvastatin Calcium Tablet 40 mg - Give 1 tablet by mouth at bedtime for rehotestoral. Gabapertin Capsule 400 mg - Give 1 capsule by mouth at bedtime for rehotestoral. Reglan Tablet 5 mg - Give 1 tablet by mouth two times a day for probiotic. Reglan Tablet 5 mg - Give 1 tablet by mouth two times a day for probiotic. Reglan Tablet 5 mg - Give 1 tablet by mouth two times a day for probiotic. Vital signs (pulse, respiration, blood pressure) three times a day. Glucoscan (blood sugar check) before meals and at bedtime four times a day.	CHOICE H	EALTHCARE AT HARRIS	SONBURG					
Sarna Lotion 0.5% - Apply to inner thighs topically every day and evening shift for itching. Venelex Ointment - Apply to heels and buttocks topically every day and evening shift for treatment. 4. Resident # 7 was admitted with diagnoses that included emphysema, cerebrovascular disease, renal dialysis, generalized muscle weakness, dysphagia, malaise, cellulitis of the left and right lower limbs, acute diastolic congestive heart failure, hypothyroidism, gastroesophageal reflux disease, chronic kidney disease, chronic respiratory failure, encephalopathy, and type 2 diabetes mellitus. According to a Medicare 5-Day MDS with an ARD of 81/21022, the resident was assessed under Section C (Cognitive Patterns) as being moderately cognitively intact with a Summary Score of 15 out of 15. According to a review of the MAR in Resident # 7's EHR, the following medications, treatments, and/or procedures were not performed during the evening shift on 7/9/2022: Atorvastatin Calcium Tablet 40 mg - Give 1 tablet by mouth at bedtime for neuropathy. Lactinex Tablet Chewable - Give 2 tablets by mouth two times a day for probiotic. Reglan Tablet 5 mg - Give 1 tablet by mouth three times a day for peristaltis. Vital signs (pulse, respiration, blood pressure) three times a day, Glucoscan (blood sugar check) before meals and at bedtime four times a day for diabetes mellitus.	PREFIX	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	BE COMPLETION			
Insulin Lispro 100 Unit/ml solution pen-injector - Inject as per sliding scalesubcutaneously before		Sarna Lotion 0.5% - A every day and evenin Venelex Ointment - A topically every day and treatment. 4. Resident # 7 was a included emphysema renal dialysis, general dysphagia, malaise, colower limbs, acute dia failure, hypothyroidism disease, chronic kidnerespiratory failure, endiabetes mellitus. Acc MDS with an ARD of 8 assessed under Sectias being moderately of Summary Score of 15 According to a review 7's EHR, the following and/or procedures we evening shift on 7/9/20 Atorvastatin Calcium Toby mouth at bedtime for Gabapentin Capsule 4 mouth at bedtime for relactinex Tablet Chewamouth two times a day Reglan Tablet 5 mg - 0 times a day for perista Vital signs (pulse, respitate times a day. Glucoscan (blood sugat bedtime four times a lnsulin Lispro 100 Unit	apply to inner thighs topically g shift for itching. pply to heels and buttocks and evening shift for admitted with diagnoses that a cerebrovascular disease, lized muscle weakness, sellulitis of the left and right stolic congestive heart and a gastroesophageal reflux ey disease, chronic cephalopathy, and type 2 cording to a Medicare 5-Day 8/12/2022, the resident was on C (Cognitive Patterns) cognitively intact with a cout of 15. of the MAR in Resident # a medications, treatments, are not performed during the coze: Tablet 40 mg - Give 1 tablet for cholesterol. Hoo mg - Give 1 capsule by the cordinate of the co	F	609			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI	TIPLE CONSTRUCTION NG	l(X:	COMPLETED		
		495146	B. WING _	1		C 08/24/2022	
	ROVIDER OR SUPPLIER	SONBURG		STREET ADDRESS, CITY, STATE, ZIP COD 94 SOUTH AVENUE HARRISONBURG, VA 22801	DE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROFILE OF THE APPROPROF		N SHOULD BE	(X5) COMPLETION DATE			
F 609	amount of insulin give dependent on the res Midodrine HCL Table mouth four times a da Change water to bipa bedtime for bipap. Miconazole Nitrate Cabdominal folds topic yeast growth. Nystatin Powder 1000 folds, peri area topical shift. 5. Resident # 8 was a included hypertension dyspnea, malignant nor lung, hypo-osmola diabetes mellitus, mamalaise, and age related According to a Medicof 7/10/2022, the resisection C (Cognitive and long term memor impaired daily decision 8 was discharged to the According to a review 8's EHR, the following and/or procedures we evening shift on 7/9/20 Atorvastatin Calcium by mouth at bed time Fexofenadine HCL Taby mouth at bedtime Gabapentin Capsule mouth at bedtime for	en per sliding scale is ults of the Glucoscan.) It 10 mg - Give 1 tablet by any for heart rate. It p at night before use at ream 2% - Apply to ally two times a day for ally two times a day for ally every day and evening admitted with diagnoses that any diagnoses that any dizziness and giddiness, are oplasm of right bronchus lity, hyponatremia, type 2 lignant pleural effusion, atted cognitive decline. It are 5-Day MDS with an ARD dent was assessed under Patterns) as having short by problems with moderately on making skills. Resident # the hospital on 7/21/2022. If of the MAR in Resident # the moderate on the performed during the moderate of the m	F	609			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		495146	B. WING _				C / 24/2022
	PROVIDER OR SUPPLIER	SONBURG		STREET ADDRESS, CITY, STATE, ZIP COD 94 SOUTH AVENUE HARRISONBURG, VA 22801	Œ		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 609	Oxygen Therapy - Ox minute) via NC (nasa every shift for lung ca every shift for lung ca 6. Resident # 9 was a included anxiety disor generalized muscle with depressive disorder, a polyneuropathy, anen polyosteoarthritis, ost macular degeneration disorder. According to Quarterly Review with resident was assesse (Cognitive Patterns) a for daily decision maked According to a review 9's EHR, the following and/or procedures we evening shift on 7/9/20 Morphine Sulfate ER mg - Give 1 tablet by repain. Tamsulosin HCL Caps by mouth at bedtime for Docusate Sodium Caps by mouth every 12 ho Buspirone HCL Tablet three times a day for a Vital signs (temperatu times a day. Aquaphor - Apply to bi bedtime for dry skin. Calmoseptine Ointme coccyx topically every	g shift for skin protection. kygen at 2LPM (liters per I cannula) continuously incer to keep sats > 90% admitted with diagnoses that order, hypothyroidism, yeakness, hypertension, edema, chronic pain, mia, chronic kidney disease, reoporosis, age related in, myoclonus, and nightmare to the most recent MDS, a in an ARD of 7/1/2022, the red under Section C is having independent skills sing. If of the MAR in Resident # g medications, treatments, are not performed during the 022: Tablet Extended Release 15 mouth every 12 hours for sulle 0.4 mg - Give 0.4 mg for urinary frequency. I psule 100 mg - Give 100 mg urs for constipation. It - Give 20 mg by mouth anxiety. It - Give 20 mg by mouth anxiety. It - Give 3 aturation of three illateral arms/legs at int 0.44-20.6 % - Apply to	F 6	09			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495146	B. WING				C 24/2022
	ROVIDER OR SUPPLIER	RISONBURG		94 S	EET ADDRESS, CITY, STATE, ZIP CODE OUTH AVENUE RRISONBURG, VA 22801	1 00	2-7/2022
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	admitted with diagnorgastroesophageal reanxiety disorder, chidisease, altered memuscle weakness, of deficit, dementia with hallucinations, and reducere 5-Day MD the resident was assected (Cognitive Patterns) with a Summary Scorological Cognitive Patterns with a Summary Scorological Cognitive Patter	every shift. the survey sample was oses that included eflux disease, hypertension, ronic obstructive pulmonary intal status, generalized cognitive communication in behavioral disturbance, malaise. According to a S with an ARD of 5/25/2022, sessed under Section C as being cognitively intact ore of 15 out of 15. w of the MAR in Resident # ing medications, treatments, were not performed during the region of 15 out of 15 when the region of 15 in the region of 15 i	F	609			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		405446	B. WING				С
	DOLUBER OF CLIENCE	495146	B. WING_			08/	24/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CHOICE H	IEALTHCARE AT HARRIS	SONBURG			94 SOUTH AVENUE		
					HARRISONBURG, VA 22801		
(X4) ID	SA COLOR DE CONTRACTOR DE CONT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	The state of the s	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
					DEFICIENCY)		
F 609	Continued From page	:11	F6	309			_
	8/6/2022, the resident	was assessed under					
	Section C (Cognitive I						
		a Summary Score of 13 out					
	of 15.	-					
		of the MAR in Resident #					
		medications, treatments,					
	evening shift on 7/9/20	re not performed during the					
	evening shift on 1/9/20	022.					
	Melatonin Tablet 3 mg	g - Give 3 mg by mouth at					
	bedtime for insomnia.						
	Trazodone HCL Table	t 100 mg - Give 100 mg by					
	mouth at bedtime for i						
	Zinc Barrier Cream - A						
	buttocks/peri area eve	•					
	O2 at 2L via NC to kee						
		30 degrees at all times as					
-	resident) will allow eve	ery snift for comfort.					
	9. Resident # 12 in the	e survey sample was			, 1		
	admitted with diagnos						
	hypertension, dement						
	disturbance, anxiety d						
		s, gastroesophageal reflux					
		erosclerotic heart disease,			1		
		eakness, hyperlipidemia,				_	
	dysphagia, and type 2						
	_	recent MDS, a Quarterly					
		of 7/4/2022, the resident					
	was assessed under S Patterns) as being mo-						
		ary Score of 12 out of 15.					
	panoa mara oamm	a., 53010 01 12 out 01 10.					
	According to a review	of the MAR in Resident#					П
		medications, treatments,					
		e not performed during the					
	evening shift on 7/9/20)22:					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		SURVEY PLETED
		495146	B. WING_		- 1	C / 24/2022
	ROVIDER OR SUPPLIER	SONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
F 609	mouth three times a content of the part of	lay for neuropathy. Tablet 100 mg - Give 200 nes a day for dysuria, days. (NOTE: The duled for two days 7/8/2022 Tablet 10 mg - Give 1 tablet for allergies. on 0.1-0.3% - Instill 1 drop in a day for dry eyes. Solution 0.5-2.5 mg/3ml - ebulizer two times a day for ulization Solution 3% - 3 ml lizer two times a day for cg/act Aerosol - 2 puffs a day for COPD. ds to bilateral upper and es a day every day and haritis. ure, O2 saturation) three fit. ent every evening shift	F	609		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY
	-	495146	B. WING_				C /24/2022
	ROVIDER OR SUPPLIER	SONBURG		9	STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 609	mg one tablet one ti *Insulin Glargine Solu unit/ml, Inject 34 units for diabetes; *Carvedilol Tablet 6.2 two times a day for he *Tylenol Extra Strengt every 12 hours for pai *Guafenesin Liquid 10 mouth three times a d respiratory failure; *Lactobacillus Give 4* times a day for supple *Pregabaline Capsule mouth three times a d *Vital Signsthree tim monitoring; *Terbinafine Cream 19 topically every day and *Venelex Ointment Ap every day and evening Review of the July MA administration record) administration record) administration record) above physician order been given as ordered shift of 07/09/2022 11. Resident #14 was the following diagnose to: Chronic kidney dis encephalopathy, asthr	pated) delayed release 81 me a day for pain; tion Pen Injector 100 subcutaneously at bedtime 5 mg Give 1 tablet by mouth art failure; h 500 mg, Give two tablets n; 10 mg/5 ml, Give 20 ml by ay for cough, chronic tablets by mouth three ment; 75 mg Give 1 capsule by ay for pain; es a day every shift for 6 Apply to affected area d evening shift ply to affected area topically g shift. R (medication and TAR (treatment revealed that none of the ed meds or treatments had /carried out on the evening admitted to the facility with s, including but not limited ease stage 3, na, diabetes mellitus, nentia. A quarterly MDS 7/29/2022 assessed ely impaired with a	F	609			

	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			COMPLETED		
		495146	B. WING_			C 08/24/2022
	ROVIDER OR SUPPLIER	ISONBURG		STREET ADDRESS, CITY, STATE, ZIP 94 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 609	Continued From pag	ne 14	F	609		
	were not limited to: *Aspirin 325 mg one *Gabapentin 300 mg one time a day for no *Lipitor 20 mg Give 2 cholesterol; *Metformin 500 mg 0 times a day for diabe *Mucinex Extended Give 600 mg by mou congestion; *Senna Tablet 8.6 m two times a day for of *Albuterol Nebulizati ml)inhale orally via for shortness of brea *Finger stick blood s bedtime for dm (diab *Record Foley output diminished output no *Zinc Oxide 10% app every shift for presse *T and O2 (temperat for covid monitoring. Review of the July M none of the above p treatments had beer on the evening shift 12. Resident #15 wa the following diagnot to: personality disorder hemiplegic cerebral of 07/08/2022, asse	Give 1000 mg by mouth two etes; Release 12 hour 600 mg. auth two times a day for eg. Give one tablet by mouth constipation; ion Solution (2.5 mg/3 a nebulizer three times a day ath; ugar before meals and at betes mellitus); at QS (every shift). Alert MD if oted; ply to left buttock topically cure wound; ture and oxygen) every shift. MAR and TAR revealed that thysician ordered meds or a given/carried out as ordered				

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII		CONSTRUCTION	PLETED
		495146	B. WING_			C / 24/2022
	ROVIDER OR SUPPLIER	SONBURG		94	TREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE ARRISONBURG, VA 22801	,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page	15	F 6	609		
	not limited to: *Artificial tears1 dro dry eyes; *Melatonin 3 mg Give bedtime for sleep; *Phenobarbital Tablet mouth at bedtime for o *Phenytoin Sodium ex Give 3 capsules by mouth at bedtime for o *Trazadone 150 mg. O bedtime for depressio *Docusate 100 mg. Gi times a day for constip *Eye drops Allergy Re eyes two times a day for Potassium Chloride E capsules by mouth two hypokalemia; *Buspirone 10 mg. Giv times a day for anxiety *Acetaminophen 325 m four times a day for lov *Senna Lotion-Apply to a day for dry skin. Review of the July MA administration record) administration record) above physician order been given/carried out shift of 07/09/2022.	100 mg Give 1 tablet by convulsions; tended capsule 100 mg outh at bedtime for 0 mg. Give 2 tablets by convulsions; Give 0.5 tablet by mouth at n; ve 1 capsule by mouth two pation; lief Instill 1 drop in both for allergies; ER 10 meq. Give 4 or times a day for the 2 tablets by mouth three of; mg. Give 2 tablets by mouth wer back pain; or bilateral Lower legs twice the R (medication and TAR (treatment revealed that none of the led meds or treatments had as ordered on the evening				
		interviewed on 08/24/2022 a.m. regarding the missed				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMF	PLETED
		495146	B. WING				C 24/2022
	ROVIDER OR SUPPLIER	SONBURG		9	TREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD IS CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	remembered not gett "Yes, I remember, I wasked if she had experience or any ill effects medications. She state seizure, but I felt like didn't feel rightI told my meds, she didn't gnervous system was because of it." 14. Resident #16 was the following diagnosto: malignant neoplate pulmonary hypertensiannual MDS with an assessed Resident #a summary score of "Review of the physici were not limited to: *Dibucain ointment 1' every day and evenir *Vital Signs three tim *Udderly Smooth creday, every day and ehand/foot syndrome; *Zinc Barrier to ABD area every day and eprotection/prevention Review of the July Monone of the above physicistic protection of the deep on the evening shift of the same of the same of the same of the evening shift of the same of	ing her meds. She stated, was concerned." She was erienced a seizure that night, from not getting her ted, "No, I didn't have a I mightMy whole body just the next nurse I didn't get give them to me eithermy turned a different way s admitted to the facility with es including but not limited sm of the anus, heart failure, ion, and atrial fibrillation. An ARD of 07/07/2022 16 as cognitively intact with 15". an's orders included but Apply to rectum topically ge shift for rectal pain; es a day every shift; am to hands and feet twice a vening shift to prevent (abdominal folds) and perivening shift for AR and TAR revealed that tysician ordered meds or given/carried out as ordered	F	609			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING_			C 0 8/24/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		OLTILOLL	
CHOICE H	IEALTHCARE AT HARRIS	SONBURG		94 SOUTH AVENUE			
	CLIMANA DV CT	ATEMENT OF DESIGNATION		HARRISONBURG, VA 22801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 609	Continued From page	: 17	F 6	609			
	medications/treatmen	a.m. regarding the missed ts on 07/09/2022. She t remember the omission.					
	diagnoses that include macular degeneration hyperlipidemia, dysph depression, dementia anxiety. The most reconsessed Resident #1 impaired for daily decilong and short term more Resident #17's clinica 2022 physician orders assessments, medical Vital signs QS (every Wanderguard check pafety Buspirone HCI 15 MG times a day for anxiety	a, hypertension, lagia, Parkinson's disease, with behaviors, and lent MDS dated 08/16/2022 and having severely dision making and having semory problems. I record documented July that included the following tions and/or treatments. I shift) for protocol lacement every shift for lagive 1 tablet by mouth 3					
	time a day for dislipide Polyethylene Glycol 3: scoop by moth one tim mix with 6-8 oz liquid PreserVision AREDS mouth 2 times a day fo Seroquel Tablet 25 Mo times a day for depres Sinemet CR Tablet Ex tablet by mouth one tim Resident #17's MAR d	as of powder 17 GM. give 1 and a day for constipation Capsule give 1 capsule by or macular degeneration G give 1 tablet by mouth 2 asion Attended Release give 1 and a day for Parkinson's aid not include verification and a many condenses of the ent checked, nor					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	COMPLETED		
		405446	B. WING			1	C
NAME OF P	ROVIDER OR SUPPLIER	495146	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	08	24/2022
CHOICE H	IEALTHCARE AT HARR	ISONBURG			94 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	ordered/scheduled. 16. Resident #18 wadiagnoses that include hemiplegia, hyperlipidisorder, hypertensida anemia, aphasia, podiabetes. The most 08/01/2022 assesse impaired for daily decount 15. Resident #18's clinical 2022 physician order assessments, medical Air Mattress to bed, ensure air mattress of settings is appropriate Pressure Wound Apply Greers goo to for skin protection List below the CPAP Ramp (start/time) 5/3 and evening shift for Vital Signs q (every) every shift for covid particular and evening MASD). Gabapentin Capsule mouth two times a discovered to the control of the	evening of 07/09/2022 as s admitted to the facility with ded long-term use of insulin, idemia, depression, mood on, muscle weakness, lyneuropathy, and type 2 recent MDS dated d Resident #18 as severely cision making with a score of the long term of the long te	F	609			
	Levetiracetam Table mouth two times a da Metoprolol Tartrate T mouth two times a da	t 750 mg give 1 tablet by ay for seizures Tablet 25 mg give 1 tablet by					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495146	B. WING			1	С
NAME OF D	DOWNER OF GUIDNIES	433146	D. WING_			08	/24/2022
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CHOICE H	IEALTHCARE AT HARRIS	SONBURG		9	4 SOUTH AVENUE		
		JONES TO STATE OF THE PROPERTY		Н	ARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	(TAR) and medication (MAR) did not include assessments and treatordered nor document were administered on as ordered/scheduled 17. Resident #19 was diagnoses that include hypertension, bilaterat glaucoma, type 2 diabinsulin. The most receassessed Resident #1 for daily decision making memory problems. Resident #19's clinicated 2022 physician orders assessments and medicate with the company of	cent administration record administration record verification that the atments were completed as ted the above medications the evening of 07/09/2022 admitted to the facility with ed, hyperlipidemia, I cataracts, bilateral etes, and, long-term use of ant MDS dated 08/14/2022 9 as moderately impaired ing, having short term I record documented July that included the following dications. ats) three times a day Solution 2% instill 1 drop in day for glaucoma q (every) 0.5% Instill 1 drop in both for glaucoma nit/ml pen/injector - inject sly at bedtime for type 2	F	609	DEFICIENCY)		
	eyes at bedtime for gla Rhopressa Solution 0. eyes at bed time for gla	02% instill 1 drop in both					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495146	B. WING_			l	C 24/2022	
	ROVIDER OR SUPPLIER	SONBURG		9	TREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE IARRISONBURG, VA 22801		-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	03394-940	(X5) COMPLETION DATE	
F 609	documented the above administered on the electric ordered/scheduled. 18. Resident #20 was diagnoses that include heart disease, hyperlypothyroidism, GER weakness. The most 06/28/2022 assessed moderately impaired with a score of 12 out. Resident #20's clinica 2022 physician order assessments, medicate assessments, medicate assessments, medicate assessments. Temperature and Oxyshift) per facility protection for the facility protection of the facility protection of the facility and medicatio (MAR) and medicatio (MAR) did not include were removed as ord temperature/oxygen documented that about administered on the facility ordered/scheduled. On 08/24/2022, two are greatly assessed that the facility and medication (MAR) did not include were removed as ordered/scheduled. On 08/24/2022, two are greatly assessed that about a second control of the facility and the fa	empleted as ordered not be medications were evening of 07/09/2022 as a sadmitted to the facility with led intellectual disabilities, ipidemia, hypertension, RD, edema, and muscle recent MDS dated at Resident #20 as for daily decision making to of 15. Fall record documented July is that included the following ations, and treatments. Compression Stockings in the severy evening shift the year saturation QS (every bool in Tablet 5 mg give 1 tablet day for lipid control ment administration record in administration record in administration that ted hose lered, the stats were taken, nor ove medication was evening of 07/09/2022 as	F	609				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		495146	B. WING			08/	24/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CHOICE H	EALTHCARE AT HARRIS	SONBURG			94 SOUTH AVENUE		
					HARRISONBURG, VA 22801		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	~	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	=	(X5) COMPLETION
TAG	Englishment of the second of t	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA	A-100 - 100	DATE
					DEFICIENCY)		
F 609	Continued From page		F	609			is .
	diagnoses that includ						
	-	sion glaucoma, dysphasia,					
		oral disturbance, muscle tension. The most recent					
		22 assessed Resident #21	2				
	as severely impaired	for daily decision making					
	with a score of 2 out of	of 15.					
	Decident #041e elicies	d as sound also sound outside to the				*	
		al record documented July is that included the following					
	medications.	s that included the following					
		15 mg give 1 tablet by					
	mouth 3 times per day						
		5 mg give 1 tablet by mouth					
	3 times per day for an	-0.5% instill 1 drop in both					
	eyes two times a day	o.o /o modili / drop iii bodii					
		0.005% instill 1 drop in both					
	eyes at bedtime for gl				-		e
		5 MG. Give 0.5 mg by mouth					
	every 8 hours for anxi	still 1 drop in both eyes two					
	times a day for dry eye						
		ablet give 12.5 milligram by					11
	mouth two times a day						
		MG give 1 tablet by mouth					
	one time a day for dep	oression instill 1 drop in both eyes					
	two times a day for dr						
		apsule delayed release					
	Give 1 capsule by mo	uth one time a day for					
	GERD	000/ in alt 4 decided					
	Rhopressa Solution 0 eyes at bedtime for gla	.02% instill 1 drop in both					
		aucoma 50 MG give 0.5 tablet by					
	mouth two times a day						
		•					
	Resident #21's MAR of	did not document that the			9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495146	B. WING_				C 24/2022
	ROVIDER OR SUPPLIER	SONBURG		9	TREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE IARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	evening of 07/09/202: On 08/23/2022 at appressing was held with DON, the MDS (minin regional nurse consul (other staff) #1 who discussed was an incomplete of the discussed was an incomplete of the discussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift. On 8/23/2022, the Addiscussed was an incomplete of the 3-11 shift.	ere administered as on the 2 as ordered/scheduled. Proximately 2:15 p.m., a in the administrator, the num data set) nurse and the tant. During the meeting OS id the schedule for the potential that occurred on idents were not given their ints, or supplements during interest of the State Survey Agency mary of the occurrence, and should be submitted. The state Survey Agency was that intited. It was a FAX Cover Sheet p of 07/26/22 at 15:07 (3:07 two page FRI. According to PN (Licensed Practical inister medications to 19 evening shift on 7/9/2022. Spation, the number of d to 18.)	F	609			
	Responsible Party an	d Physician was notified on It Protective Services) on					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		2 2		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495146	B. WING				C 24/2022
	ROVIDER OR SUPPLIER	SONBURG		9	TREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		D. C.	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 609	Professions) on 7/26/as completed on 7/12 report included with the signed by the Administ On 08/23/2022 at appreneting was held with (Director of Nursing), Set) nurse, and the R During the meeting Of the schedule for the faroom. Specifically distoccurred on 07/09/202 given their medication supplements during the The Administrator stanurse here, the nurse relieve her wasn't on the here at 7:00 p.m. didn't give the eight on The DON and the Adranyone had notified the They both stated no. That was a Saturday for another staffing iss something about it, but extent until Monday. In office (Office of Licens Survey Agency). The as to when something Survey Agency.	(Department of Health 2022. The FRI was dated 7/2022. There was no final ne FRI. The FRI form was strator and dated 7/26/2022. Proximately 2:15 p.m., a note the Administrator, the DON the MDS (Minimum Data regional Nurse Consultant.) So (other staff) #1 who did recility was called in to the crussed was an incident that 22 when residents were not read and the streaments, or the 3-11 shift. The MDS (Minimum Data regional Nurse Consultant.) So (other staff) #1 who did recility was called in to the crussed was an incident that 22 when residents were not read an agency that was supposed to read the supposed to read an agency that was supposed to read the nurse that was here or nine o'clock meds." The nurse that was here or nine o'clock meds." The Administrator were asked if the read heard a little really didn't know the sent something to the sen	F	609			

PRINTED: 09/02/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		495146	B. WING		C 08/24/2022
NAME OF D	ROVIDER OR SUPPLIER	433140		STREET ADDRESS, CITY, STATE, ZIP CODE	06/24/2022
NAME OF P	ROVIDER OR SUPPLIER			94 SOUTH AVENUE	
CHOICE H	IEALTHCARE AT HARRIS	SONBURG		HARRISONBURG, VA 22801	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 677 SS=E	S483.24(a)(2) A reside out activities of daily I services to maintain appersonal and oral hydrogen and oral care for 1 of 25 in the provide incontinence the survey sample. For oral care as ordered in provided incontinence provided incontinence and oral care as ordered in provided incontinence and in	terview, staff interview and ew during a compliant lity staff failed to provide oral survey sample and failed to care for 2 of 25 residents in Resident #3 was not provided by the physician and was not e care. Resident 2 was not e care. admitted to the facility with led peripheral vascular etes, pain, anemia, stage 2 se, visual loss, dementia with be, depression, anxiety, egia, hypertension, eare, and GERD. mum data set (MDS) dated arterly and assessed erately impaired for daily a score of 12 out of 15. Inctional Status, the MDS 3 has being total dependent stance for toileting, transfers, d bathing; extensive	F 67		e done. their ds and gnee will sing ately gnee nence weeks finding 3 months ation or

Facility ID: VA0016

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495146	B. WING _				C 24/2022
	ROVIDER OR SUPPLIER	SONBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	bladder. Under Section Approach, the MDS of received nutrition via an observed laying in between the was interviewed about Resident #3 stated, "ywhere they weren't clettongue, but my daugh doctor and the nurses how often did staff prostated, "I think it's sup day." Resident #3 was experienced any more receiving the ordered	s incontinent for bowel and on K - Swallowing/Nutritional ocumented Resident #3 tube feeding. 35 a.m., Resident #3 was d in her room. Resident #3 t the complaint allegations. The can I did have a problem eaning my mouth and ter got it straight with the lift. Resident #3 was asked wide oral care. Resident #3 posed to be three times a s asked if she had a problems with not oral care. Resident #3 ter is here everyday and	F6	377			
	reviewed. Observed of physician orders was to perform mouth care mouth care mouth care wet toothe brush the roof of mouth not swallow, apply smand repeat, have resident Date: 12/01/202 Resident #3's care plaincluded a focus area included goals and interested/initiated on 10	the following order: "Nurse three times a day for brush and comb the tongue, th; resident to spit out, do all amount of toothpaste dent spit out excess salvia. 1." Ins were reviewed and for dental health that erventions that was 0/19/2020. Focus:					
	(related to) natural tee "(Resident #3) will be bleeding in the oral ca	free of infection, pain, or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495146	B. WING				C 24/2022
NAME OF D	ROVIDER OR SUPPLIER	400140			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	24/2022
NAME OF PI	ROVIDER OR SUPPLIER						
CHOICE H	EALTHCARE AT HARRIS	SONBURG			94 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE
F 677	Continued From page	26	F	677			
	s/sx of oral/dental pro Pain (gums, toothach in mouths, Lips crack missing, loose, broker	blems needing attention, e, palate), Abscess, Debris ed or bleeding, teeth n, eroded, decayed. Tongue ed, white, smooth). Ulcers					
	note from the Physicial dated 02/09/2022. The documented, " Chie Presenting Problem: patient's daughter is a white plaques on her edentulous with lower continues to demonst may be a function of a swallow. Secretions repatient's tongue does	ef Complaint/Nature of Evaluate tongue The upset that she has thick tongue. Patient is r lip protrusion. Patient trate hypersecretion, which a decreased ability to nanaged at this time. The have a thick, white, plaque, buth care has been applied					
	oral candida (oral thru Diflucan 200 mg via F Nystatin oral mouth s and swallow 100 units	essed and diagnosed with ush). The PA prescribed PEG tube for 7 days and olution with orders to swish s/ml and paint on the tongue days and continue mouth					
	asked for the any con investigations related the facility's complain documented on 02/08 daughter/RP reported oral care was not don	to Resident #3. A review of t/grievances follow-up 8/2022 Resident #3's I to the administrator that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(0) (0		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495146	B. WING_				C 24/2022
NAME OF P	ROVIDER OR SUPPLIER	() () () () () () () () () ()			STREET ADDRESS, CITY, STATE, ZIP CODE	00/	24/2022
					94 SOUTH AVENUE		
CHOICE H	EALTHCARE AT HARRIS	SONBURG			HARRISONBURG, VA 22801		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	K	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG	NEGOEATORT ONE	SO DENTI TING IN CRIMATION)	IAG		DEFICIENCY)	10	5,112
F 677	Continued From page	27	F	377			
	, •	ented the oral care was					
		orm documented Resident					
		ighter/RP that oral care was					
		ft (02/07/2022) and had not					
		e follow-up documented on					
		hift nurse (RN #1) who was					
		outine care for Resident #3					
		room to provide oral care,	,				
		was out of the room at the					
		eting and remained out of					
		N #1 left work for the day.					
		ented nurses were educated					
		d proper procedures for					
		ly record treatments as					
		pleted. The follow-up form					
		#3's mouth was observed					
	and the "tongue had a						1
	-						
	Resident #3's medicat	ion administration record					
	(MAR) was reviewed f	for February 2022. The					
	MAR documented on	02/08/2022 at 1400 (2:00					
		rse (RN #1) signed off			_		
	stating she had compl	eted the oral care as					
	ordered by the physici	an.			-		
		a.m., the scheduler (OS					
	•	determine the name of the					
,	_	cumented the oral care was					
		022 at 2:00 p.m. OS #1					
		RN #1 and stated she had					
		Resident #3's RP/daughter					
		#1 stated, "I remember the					
		s here working that day and					
		upset because she found					
		hrush in the Resident's			9	İ	
		S #1 continued and stated,				э	
	1	ter) told me that the second					l
		RN #2) told her that RN #1					
	had documented the o	oral care was done when it					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		(0
		495146	B. WING			08/	24/2022
	ROVIDER OR SUPPLIER	SONBURG		9	TREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE IARRISONBURG, VA 22801		
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	and said this probably this was falsification. (Resident #3) was at activities when RN #1 perform oral care. Re to her room before RI was never done. We signed off with the intention but she never did it and On 08/24/2022 at 9:3 interviewed about the "yes it was my fault. I the oral care was done but (Resident #3) was I went to complete the back to her room befor and I forgot to go back to show that the oral cwas asked if she reposition on the don't remember for so an in-service on oral of documenting after the provided and not befor The second shift incolonger employed by the interviewed. The facility presented provided "week of 2/2 documented: "Oral care to be provided (evening) CARE,	The daughter became upset y wasn't the first time and I later found out that the group meeting and other I went to the room to sident #3 never came back N #1 got off, so the oral care did found out that RN #1 ention of doing the oral care, and left for the day." 8 a.m. RN #1 was a incident. RN #1 stated, signed off on the MAR that he with intention of doing it, as at the group meeting when a oral care. She never came for I got off that afternoon k and strikeout on the MAR care wasn't done." RN #1 orted this to the second shift #2). RN #1 stated, "I laber. I would think I did, but I lare." RN #1 stated, "we had care and the importance of eatments and care are ore." I staff education on oral care	F	677			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495146	B. WING		4		C / 24/2022	
7	ROVIDER OR SUPPLIER HEALTHCARE AT HARRIS	SONBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 677	administration record, family requested and BEFORE signing off of before completed, this documentation." On 08/24/2022 at 12:2 were reviewed with the team that included the coordinator and corporation of the team that included the coordinator and corporation of the team that included the coordinator and corporation of the team that included the coordinator and corporation of the series of the team that included the coordinator and corporation of the series of the series of the series of the team that included the coordinator and corporation of the series The series of	led on TAR (treatment of for specific resident, this is should be completed on TAR. If you document is is considered falsifying 20 p.m., the above findings are facility's administration administrator, DON, MDS orate consultant. Ifficiency. 11:35 a.m., Resident #3 in bed in her room and was assisted with ADL care, hey don't have enough help. If takes forever for property day so they check to be and dry." Resident #3 ired assistance with a personal hygiene. If eas, I can only see out one of the time they come I'm proserved next to Resident ed package of incontinent in a saked if she used the lated, "yes, I wear them. But change me I soak through was asked if staff changed Resident #3 stated, "yes, d. Sometimes the hospice are when they come"		677				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495146	B. WING _			C 08/24/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRIS	SONBURG		STREET ADDRESS, CITY, STATE, ZIP 94 SOUTH AVENUE HARRISONBURG, VA 22801	CODE	
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD B THE APPROPRIA	
of bowel and bladder created on 10/19/202 remain free from skin incontinence and brie date." Interventions: wears briefs, check a An additional care pla Care Performance" dinterventions to assis transfers, bathing, be and dressing, each direquired 1-2 person picare. On 08/23/2022, the fa asked for the any coninvestigations related the complaint/grievar documented on 02/20 administrator was not granddaughter who a stated, "incontinent cisoon enough - not if pievery two hours. Patit Pads were 'soaking with Noted: urine odor was The follow-up documents assigned nurse (LPN a.m. shift report that I At 9:30 a.m., Resider checked on Resident changed. At 11:30 a. Resident #3 and asked changed and the resident reported she did not weather the side of the conference of the changed and the resident reported she did not weather the conference of the changed and the resident reported she did not weather the changed and the resident reported she did not weather the changed and the resident reported she did not weather the changed and the resident reported she did not weather the changed and the resident reported she did not weather the changed and the resident reported she did not weather the changed and the resident reported she did not weather the changed and the resident reported she did not weather the changed and the resident reported she did not weather the change of the	nterventions, "Incontinent and at risk for complications to." Goals: "(Resident #3) will a breakdown due to ef use through the review "BRIEF USE: (Resident #3) and change as needed" an focused on "ADL Self focumented goals and at Resident #3 with toileting, demobility, personal hygiene, ocumenting Resident #3 ohysical assistance for ADL acility's administrator was implaint/grievance. It to Resident #3. A review of ince follow-up form 0/2022 the facility's attified by Resident #3's arrived at 12:45 p.m. and are had not been provided obatient was being checked ent beddings were wet. Wet' as per grandmother. It is strong in room." ented Resident #3's #5) reported during the 7:00 Resident #3 had not voided. In the strong in the	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		101 11	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING				С
NAME OF B	00//050 00 0//00//55	493146	D. WING			08/	24/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CHOICE H	EALTHCARE AT HARRIS	SONBURG			94 SOUTH AVENUE		
560 BASE 19 19 10 10 10 10 10 10 10 10 10 10 10 10 10				- 1	HARRISONBURG, VA 22801		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI. TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
IAG	NEGOE WORLD	SO BENTI TING IN ONWATION,	IAG		DEFICIENCY)		
F 677	Continued From page	. 21		~~~	,		
1 0//	. •		-	677			
	sheets and did not no	tice a urine odor.					
	The follow up do support	and a different and the second and					
		ented the facility provided tion on incontinence care					
		e resident visually rather					
		esident and to note if there					
	were urine odors pres						
	incontinence care nee						
	moontmende dare nee	, dod.					1
	On 08/24/2022 at 9:15	5 a.m., CNA #4 was					
		the complaint allegations.					
	CNA #4 stated, "the n						
	THE RESIDENCE OF THE PROPERTY OF THE PARTY O	sident #3) if she was wet					
		't remember the exact time,					
	maybe 30 minutes to	an hour later, Resident #3's					
		f so I went to check on her					
	and she said she acci	dentally hit the call bell. I					
	asked her if she need	ed changing and she said					
	no. I should have visu	ally checked myself instead					
		ok her for her word because					
		was a little later that her					
		to visit and said the sheets					
		tress was soaked." CNA #4					
		ne observe when she was					
	Contract to the second	aughter that Resident #3					
	needed incontinence						
		et and it had soaked through					
		sheets, but the mattress					
		n like the granddaughter asked how often should the					
		CNA #4 stated, "at least					
	every 2 hours or more						
		dent. I know I should have			=		
		ent in the first time, but I	1				
		hat she had not voided at					
	that time."	nat one nad not volued at					
	and time.						1
	The first shift assigned	d nurse (LPN #5) was no					1
		e facility and could not be	100				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 10	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		405440	B. WING_		C	
NAME OF P	ROVIDER OR SUPPLIER	495146	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	08/24/20	022
	EALTHCARE AT HARRIS	SONBURG		94 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) MPLETION DATE
F 677	were reviewed with the team that included the coordinator and corpo was asked what was rounding, checks and The DON stated, "rouevery 2 hours with income."	20 p.m., the above findings ne facility's administration e administrator, DON, MDS prate consultant. The DON the expectation regarding providing incontinent care, anding should be at least continence care to be time or PRN (as needed) ividual resident."	F 6	77		
	during initial tour of the observed sitting in a was interviewed about facility. She stated, "There." When she was statement she said, "changed. I'm wet." She the back of her pants changed since six o'c fluid pill. I know it's a because they have to lunchtime and they calunch, they have to part of the observed by the same of the control of the contr	approximately 11:30 a.m., we facility Resident #4 was wheelchair in her room. She at her life and care at the They don't have enough help asked to elaborate on that Right now, I need to be ne lifted up her left leg and leg was wet. "I haven't been clock this morning. I take a lot to get me back in the bed o use the liftnow it's an't change you during ass out the trays." She was ng to the dining room for				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495146	B. WING			C 24/2022
	ROVIDER OR SUPPLIER	SONBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801	00/	24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	wet pants, it's too cold asked if she had been were dry if she would stated, "Oh yeah, I would cassigned to Resident approximately 11:45 at Resident #4 had been was in an activity whe she's back now but would change her after lunch Resident #4 was adm following diagnoses in hypertension, heart fa failure, hyperlipidemia annual MDS (minimum (assessment reference assessed Resident #4 summary score of "15"). A meeting was held woursing) the administrations was asked what the expect residents who were in "Everyone should be of checked every two hoo changed at the end of shift should make rour again after breakfast be again after lunch."	o, I'm not going with these if up there for that." She was a changed and her pants go to the dining room. She build go." g assistant) #1 who was #4 was interviewed at a.m. She was asked when a changed. She stated, "She in I went down thereI know the have to pass out trays. I'll in." itted to the facility with the including but not limited to: ilure, congestive heart a, and type 2 diabetes. An in data set) with an ARD the date) of 06/12/2022 was as as cognitively intact with a including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set) with an ARD the date of 06/12/2022 was as as cognitively intact with a including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set) with an ARD the date of 06/12/2022 was as as cognitively intact with a including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with an ARD the date of 06/12/2022 was as as cognitively intact with a including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with an ARD the date of 06/12/2022 was as a cognitively intact with a including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with an ARD the date of 06/12/2022 was as a cognitively intact with a including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with the date of 06/12/2022 was as a cognitively intact with the including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with the including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with the including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with the including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with the including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with the including but not limited to: ilure, congestive heart and type 2 diabetes. An in data set, with	F 67	77		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		495146	B. WING _				C 24/2022
NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFI) TAG	94 SOUT	ADDRESS, CITY, STATE, ZIP CODE ITH AVENUE SONBURG, VA 22801 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	(X5) COMPLETION DATE
F 684 SS=E	§ 483.25 Quality of car Quality of care is a furapplies to all treatment facility residents. Bas assessment of a resident residents receives accordance with professor practice, the compressor plan, and the resident review, and the resident review, and staff interfollow physician ordes the survey sample. First through # 21 were medications and/or travere not conducted at the findings include: On 08/23/2022 at appreciation was held with (Director of Nursing), nurse, and the Region During the meeting Of the scheduling for the room. Specifically disoccurred on 07/09/20 given their medication supplements during the tree. The nurse here. The nurse relieve her wasn't on	Indamental principle that and care provided to sed on the comprehensive lent, the facility must ensure a treatment and care in sessional standards of sessional session	F	3	 Residents 9, 7, 2, 8, 11,12,15, 14, 6, 16, 13, 5, 17, 21, 22 and md and responsible parties were notified, no further orders. LPN provided education on quality of and following physician orders weekly skin assessments. Director of Nursing will complet audit of physician orders and slassessments. The Director of Nursing or design provide education to Licensed equality of care following physici orders and weekly skin assessing. The Director of Nursing will audit physician's orders and skin assessments 2 times weekly times 3 months to review for continue intervention or amendment of the Allegation of compliance: 9-20- 	20 had re UM was of care and e an cin gnee will staff on an's ments. dit mes 6 onths. All API times ed ne plan.	9-20-2022

CENTERS FOR MEDICARE & MEDICAID SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495146	B. WING_			l .	C
NAME OF P	ROVIDER OR SUPPLIER	400140		9	STREET ADDRESS, CITY, STATE, ZIP CODE	08/	24/2022
	TOTION ON SON ELEM				94 SOUTH AVENUE		
CHOICE	IEALTHCARE AT HARRIS	SONBURG			HARRISONBURG, VA 22801		
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	Co. C.	(X5) COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
F 684	Continued From page	35	F6	684			
,		d, "The nurse that was here					
		0 p.m. to 7:00 p.m. The agency too, didn't get here					
		ne nurse that was here just					
	According to the As W	Vorked Schedule for			,		,
	07/09/2022, an "On ca						
		rse) #1 was listed. The DON xpectation of the on-call					
	nurse was. She stated	d, "They should have their					
	phone with them, ans- come in if needed."	wer it, and be available to				-	
	OS #1 was interviewe	d heginning at				v	
	approximately 2:40 p.	m. on 8/23/2022. She					
		scheduled to work 3:00 p.m. her she could only work					
		d to leave at 7:00. "She					
		at and I was trying to fill the					
		(Name of nurse working because the nurse who was					
	supposed to relieve he	er lives two hours away and					
	is always an hour or m	nore late for work."					
	A list of all residents w	ho did not receive					
		nts, and/or procedures on ested and provided by the					
	facility.	sted and provided by the					
		5 a.m. LPN #1, the On-Call			- ,		
	Nursing Supervisor, w she had gotten a call a	ras interviewed. She stated					
		urse who was working 3-7.					
	She said the nurse wh	no was relieving her wasn't			<i>2</i>		
		y an hour to an hour and a agency and they said she					
		s my first time on call and I					
				_			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495146	B. WING				C 24/2022
	ROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE HARRISONBURG, VA 22801	037	24/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD E TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE	
F 684	the schedule. (Name called me back and it relief still wasn't here her I (LPN # 1) was p come in. I called (Na back, she was mad, s relieving her) is alway after 10:00." LPN # 1 was asked w relieve the nurse who "If we have a call off a come in. I called the she was almost here going to be that late." A list of all residents medications, treatme 07/09/2022 was requifacility. The list ident Wing Front Unit who treatments, and/or as evening shift on 7/9/2 included the following. 1. Resident # 2 was included chronic dias atherosclerotic heart anemia, depressive of hypertension, gout, of generalized muscle w communication deficibehavioral disturbance recent Minimum Data Review with an Asse (ARD) of 4/28/2022, under Section C (Cog	er at home so I couldn't see of nurse working 3-7) was almost 9:00 p.m., her I texted (OS #1) and told robably going to have to me of nurse working 3-7) she said "(Name of nurse vs late. She got here a little why she didn't come in to o was working. She stated, and there's no one to fill it, I agency and they kept saying I didn't know she was who did not receive nts, and/or procedures on ested and provided by the did not receive medications, assessments during the 2022. The 18 residents didnitted with diagnoses that tolic congestive heart failure, disease, atrial fibrillation, disorder, hyperlipidemia, erebral infarction,	F	684			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION		SURVEY
		2200 1 2 2					С
		495146	B. WING	_		08	/24/2022
	PROVIDER OR SUPPLIER HEALTHCARE AT HARRIS			9	STREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTH AVENUE 14 ARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Score of 11 out of 15. discharged from the factorial discharged from the factorial discharged from the factorial discharged from the factorial discharged Electronic Heat following medications procedures were not pevening shift on 7/9/2. Aspercreme Lidocaine knee topically one timper schedule, the pat being removed on 7/9 Mirtazapine Tablet 7.5 mg by mouth at bedtime fravastatin Sodium Tablet mouth at bedtime for Docusate Sodium Calcapsule by mouth two constipation. Memantine HCL Tablet mouth three times a day Buspirone HCL Tablet mouth three times a divitch Hazel Pad - Apptimes a day for hemory Check vital signs (tem saturation) every shift Apply skin prep to R (rational distribution) every shift for increased ede Make sure resident has every shift for HOH (HCOMPLAINT DEFICIE)	Resident # 2 was acility on 7/15/2022. of the Medication d (MAR) in Resident # 2's alth Record (EHR), the treatments, and/or performed during the 022: e Patch 4% - Apply to left e a day for pain and remove ch was not signed off a //2022. omg (milligrams) - Give 7.5 me for depression. ablet 20 mg - Give 1 tablet for hypercholesterolemia. osule 100 mg - Give 1 times a day for ext 5 mg - Give 15 mg by any for anxiety. oly to rectum topically three rhoid. perature and O2 ight) great toe and second (Deep Tissue Injury). extremities) elevated every ima. s bilateral hearing aides in ard of Hearing).	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Contraction of the Participant in Contract and Indiana in the Contract of the	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			= 3.1=3.	A.015%			С
		495146	B. WING_			08/	24/2022
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
CHOICE II	EALTHCARE AT HARRIE	CONDURC		94	SOUTH AVENUE		
CHOICE H	EALTHCARE AT HARRIS	SONBURG		H.	ARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				(X5) COMPLETION DATE
F 684	disorder, dementia wigastroesophageal refimuscle weakness, condeficit, chronic diastorand wedge compress lumbar vertebra. According to a review 5's EHR, the following and/or procedures we evening shift on 7/9/2 Atorvastatin Calcium by mouth at bedtime Seroquel Tablet 50 m bedtime for demential Sertraline HCL Table mouth at bedtime for equal 75 mg. Sertraline HCL Table mouth at bedtime for to equal 75 mg. Artificial Tears Solution both eyes two times Famotidine Tablet 20 two times a day for Greflux disease). Potassium Chloride L (milliequivilants per mouth two times a day for Greflux disease).	ion, hypertension, anxiety ith behavioral disturbance, flux disease, generalized agnitive communication lic congestive heart failure, sion fracture of second fording to a Medicare 5-Day 6/15/2022, the resident was ion C (Cognitive Patterns) cognitively impaired with a out of 15. If of the MAR in Resident # g medications, treatments, ere not performed during the 2022: Tablet 40 mg - Give 1 tablet for hyperlipidemia. If g - Give 50 mg by mouth at with delirium. If 25 mg - Give 1 tablet by depression with 50 mg to to to 50 mg - Give 1 tablet by antidepressant with 25 mg On 0.2-0.21% - Instill 1 drop is a day for dry eyes. Image: Missing in the community of t	F	684			
	Tylenol Extra Strengt mg by mouth two time	h Tablet 500 mg - Give 500 es a day for pain.					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		35 8		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495146	B. WING			08	C / 24/2022
	ROVIDER OR SUPPLIER	SONBURG		9	STREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	times a day to affecte and evening shift for seemove Lidoderm para Vital signs (temperature times a day. Venelex Ointment - Altopically every day and 3. Resident # 6 was a included osteoarthritishypertension, chronichyperlipidemia, morbing eneralized muscle was assessed under seemonth and the	re and O2 saturation) three darea topically every day with care. It is at bedtime. It is and O2 saturation) three oply to affected area devening shift for skin care. It is anxiety disorder, pain syndrome, dobesity, bacteremia, eakness, and dysphagia. It is a Quarterly of 7/23/2022, the resident out of 15. In of the MAR in Resident # medications, treatments, re not performed during the out of 15. In of the MAR in Resident # medications, treatments, re not performed during the out of 15. In out	F	684			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				CX3) DATE SURVEY COMPLETED		
		495146	B. WING				24/2022		
	ROVIDER OR SUPPLIER	SONBURG		94	TREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE IARRISONBURG, VA 22801				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 684	included emphysema renal dialysis, general dysphagia, malaise, olower limbs, acute dia failure, hypothyroidist disease, chronic kidn respiratory failure, endiabetes mellitus. Ac MDS with an ARD of assessed under Sect as being moderately Summary Score of 18 According to a review 7's EHR, the following and/or procedures we evening shift on 7/9/2 Atorvastatin Calcium by mouth at bedtime Gabapentin Capsule mouth at bedtime for Lactinex Tablet Chew mouth two times a darkeglan Tablet 5 mg-times a day for perist Vital signs (pulse, resthree times a day. Glucoscan (blood sugat bedtime four times Insulin Lispro 100 Un Inject as per sliding simeals and at bedtime amount of insulin gividependent on the restaute in the signs of the sin	admitted with diagnoses that a, cerebrovascular disease, alized muscle weakness, cellulitis of the left and right astolic congestive heart m, gastroesophageal reflux ey disease, chronic acephalopathy, and type 2 acording to a Medicare 5-Day 8/12/2022, the resident was acion C (Cognitive Patterns) cognitively intact with a 5 out of 15. If of the MAR in Resident # g medications, treatments, are not performed during the 2022: Tablet 40 mg - Give 1 tablet for cholesterol. 400 mg - Give 1 capsule by neuropathy. If out of tablet by mouth three	F	684					

A95146 B. WING NAME OF PROVIDER OR SUPPLIER CHOICE HEALTHCARE AT HARRISONBURG B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE 94 SOUTH AVENUE	
CHOICE HEALTHCARE AT HARRISONBURG	PROVIDER OR SUPPL
CONTRACTOR SECTION OF THE PROPERTY OF THE PROP	HEALTHCARE AT
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(EACH DE
mouth four times a day for heart rate. Change water to bipap at night before use at bedtime for bipap. Miconazole Nitrate Cream 2% - Apply to abdominal folds topically two times a day for yeast growth. Nystatin Powder 100000 Unit/gm - Apply to skin folds, peri area topically every day and evening shift. 5. Resident # 8 was admitted with diagnoses that included hypertension, dizziness and giddiness, dyspnea, malignant neoplasm of right bronchus or lung, hypo-osmolally, hyponatremia, type 2 diabetes mellifus, malignant pleural effusion, malaise, and age related cognitive decline. According to a Medicare 5-Day MDS with an ARD of 77/10/2022, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired daily decision making skills. Resident # 8 was discharged to the hospital on 7/21/2022. According to a review of the MAR in Resident # 8's EHR, the following medications, treatments, and/or procedures were not performed during the evening shift on 7/9/2022: Atorvastatin Calcium Tablet 80 mg - Give 1 tablet by mouth at bed time for hyperlipidemia. Fexofenadine HCL Tablet 180 mg - Give 1 tablet by mouth at bed time for playerlipidemia. Fexofenadine HCL Tablet 180 mg - Give 1 tablet by mouth at bed time for playerlipidemia. Fexofenadine HCL Tablet 180 mg - Give 1 tablet by mouth at bed time for playerlipidemia. Fexofenadine HCL Tablet 180 mg - Give 2 capsules by mouth at bed time for flayerlipidemia. Fexofenadine HCL Tablet 180 mg - Give 2 capsules by mouth at bed time for flayerlipidemia. Fexofenadine HCL Tablet 180 mg - Give 2 capsules by mouth at bed time for flayerlipidemia. Fexofenadine HCL Tablet 180 mg - Give 2 capsules by mouth at bed time for neuropathy. Venelex Ointment - Apply to buttocks topically every day and evening shift for skin protection. Oxygen Therapy - Oxygen at 2LPM (liters per minute) via NC (nasal cannula) continuously every shift for lung cancer to keep sats > 90%	mouth four time Change water bedtime for bip Miconazole Ni abdominal folcy yeast growth. Nystatin Powd folds, peri area shift. 5. Resident # included hyper dyspnea, maligor lung, hypodiabetes mellit malaise, and a According to a of 7/10/2022, the Section C (Cogand long term impaired daily 8 was discharged According to a 8's EHR, the for and/or procedure vening shift of Atorvastatin Caby mouth at bed Fexofenadine I by mouth at bed Gabapentin Camouth at bedtin Venelex Ointmevery day and Oxygen Theral minute) via NC

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDI		COMPLETED			
						(С	
		495146	B. WING_			08/	24/2022	
	ROVIDER OR SUPPLIER	SONBURG		9	TREET ADDRESS, CITY, STATE, ZIP CODE 4 SOUTH AVENUE IARRISONBURG, VA 22801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ON SHOULD BE E APPROPRIATE		
F 684	Continued From page 6. Resident # 9 was a included anxiety disorder generalized muscle with depressive disorder, a polyneuropathy, aner polyosteoarthritis, ost macular degeneration disorder. According to Quarterly Review with resident was assesse (Cognitive Patterns) a for daily decision maked According to a review 9's EHR, the following and/or procedures we evening shift on 7/9/2 Morphine Sulfate ER mg - Give 1 tablet by pain. Tamsulosin HCL Cap by mouth at bedtime to Docusate Sodium Caby mouth every 12 hoses	admitted with diagnoses that order, hypothyroidism, veakness, hypertension, edema, chronic pain, mia, chronic kidney disease, reoporosis, age related in, myoclonus, and nightmare to the most recent MDS, a man ARD of 7/1/2022, the ed under Section C is having independent skills sting. Tof the MAR in Resident # g medications, treatments, ere not performed during the 2022: Tablet Extended Release 15 mouth every 12 hours for urinary frequency, psule 100 mg - Give 100 mg ours for constipation.	990.000	584			DATE	
	times a day. Aquaphor - Apply to be bedtime for dry skin. Calmoseptine Ointme coccyx topically even	ent 0.44-20.6 % - Apply to y shift for dermatitis. Check functioning every						
	7. Resident # 10 in the admitted with diagnost							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495146	B. WING_			C 08/24/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		00/24/2022	
CHOICE H	HEALTHCARE AT HARRIS	SONBURG		94 SOUTH AVENUE HARRISONBURG, VA 22801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)			
F 684	anxiety disorder, chrodisease, altered ment muscle weakness, codeficit, dementia with hallucinations, and made Medicare 5-Day MDS the resident was asse (Cognitive Patterns) a with a Summary Score According to a review 9's EHR, the following and/or procedures we evening shift on 7/9/20 Senna Tablet 8.6 mg-bedtime for constipation Vital signs (pulse, respective times a day. Weekly skin assessment every even (NOTE: 7/9/2022 was Nystatin Cream 10000 application transdermarsh. 8. Resident # 11 in the admitted with diagnose muscle weakness, pol gastroesophageal reflusciatica, obesity, hypedisease, type 2 diabet congestive heart failur to the most recent Anra 8/6/2022, the resident Section C (Cognitive Ferror of the most recent Cognitive Ferror of the most recent Anra 8/6/2022, the resident Section C (Cognitive Ferror of the most recent Cognitive Ferror of the most recent Cognitive Ferror of the most recent Anra 8/6/2022, the resident Section C (Cognitive Ferror of the most recent Anra 8/6/2022, the resident Section C (Cognitive Ferror of the most recent Anra 8/6/2022, the resident Section C (Cognitive Ferror of the most recent Anra 8/6/2022, the resident Section C (Cognitive Ferror of the most recent Anra 8/6/2022, the resident Section C (Cognitive Ferror of the most recent Anra 8/6/2022, the resident Section C (Cognitive Ferror of the most recent Anra 8/6/2022, the resident Section C (Cognitive Ferror of the most recent Anra 8/6/2022).	lux disease, hypertension, nic obstructive pulmonary al status, generalized gnitive communication behavioral disturbance, alaise. According to a with an ARD of 5/25/2022, essed under Section C as being cognitively intact e of 15 out of 15. of the MAR in Resident # medications, treatments, re not performed during the coze: Give 1 tablet by mouth at on. Diration, blood pressure) ent/Weekly summary ening shift every Saturday. a Saturday.) O Unit/gm - Apply 1 ally two times a day for e survey sample was es that included generalized tyneuropathy, ux disease, lumbago and rension, chronic kidney es mellitus, diastolic e, and malaise. According nual MDS with an ARD of was assessed under	F 6	684			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3 3		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495146	B. WING_			1	C 24/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	LHILULL
		and approximate toward and		9	4 SOUTH AVENUE		
CHOICE H	EALTHCARE AT HARRIS	SONBURG		H	IARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 684	Continued From page	e 44	F 6	684			
	9's EHR, the following	of the MAR in Resident # g medications, treatments, ere not performed during the 2022:					
	Melatonin Tablet 3 mm bedtime for insomnia Trazodone HCL Table mouth at bedtime for Zinc Barrier Cream - / buttocks/peri area ev O2 at 2L via NC to ke HOB (Head of Bed) > res(ident) will allow even be seen and the seen and the seen and the seen are seen as a seen allowed by the seen and the seen are seen as a seen allowed by the seen allowed by the seen and the seen are seen as a seen allowed by the see	g - Give 3 mg by mouth at et 100 mg - Give 100 mg by insomnia. Apply to bilateral ery shift. eep sats >89%. 30 degrees at all times as very shift for comfort. he survey sample was ses that included tia without behavioral disorder, depressive is, gastroesophageal reflux herosclerotic heart disease, veakness, hyperlipidemia, 2 diabetes mellitus. it recent MDS, a Quarterly of 7/4/2022, the resident Section C (Cognitive					
	According to a review 9's EHR, the following and/or procedures we evening shift on 7/9/2 Gabapentin Capsule mouth three times a control Phenazopyridine HC	w of the MAR in Resident # g medications, treatments, ere not performed during the 2022: 100 mg - Give 2 capsules by			·		

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI		(X3) DATE SURVEY COMPLETED			
		495146	B. WING			1	C / 24/2022
	ROVIDER OR SUPPLIER	SONBURG	•	STREET ADDRESS, CITY, STATE, ZIP CODE 94 SOUTH AVENUE HARRISONBURG, VA 22801			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	bladder spasms for 2 medication was sched and 7/9/2022.) Montelukast Sodium by mouth at bedtime f Artificial Tears Solutio both eyes two times a Ipratropium-Albuterol 3ml inhale orally via necopp. Sodium Chloride Nebi inhale orally via nebul COPD. Symbicort 160-4.5 mo inhale orally two times Occusoft lid scrub pad lower eye lids two times evening shift for bleph	days. (NOTE: The duled for two days 7/8/2022 Fablet 10 mg - Give 1 tablet for allergies. n 0.1-0.3% - Instill 1 drop in day for dry eyes. Solution 0.5-2.5 mg/3ml - ebulizer two times a day for dulization Solution 3% - 3 ml dizer two times a day for eg/act Aerosol - 2 puffs a day for COPD. Is to bilateral upper and des a day every day and diaritis. re, O2 saturation) three to the days of the same desired and the same day every evening shift	F	684			
	the following diagnose to: hypertension, left I diabetes mellitus, and 5-day MDS (minimum (assessment reference hospital admission) as severely impaired with of "7". Review of the physicia not limited to:	admitted to the facility with es including but not limited ower quadrant pain, type 2 depression. A medicare data set) with an ARD e date) of 08/15/2022 (post esessed Resident #13 as a cognitive summary score n orders included but were eated) delayed release 81					

CENTERS FOR MEDICARE & MEDICAID SERVICES

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495146	B. WING				C 24/2022
	ROVIDER OR SUPPLIER	SONBURG		9	STREET ADDRESS, CITY, STATE, ZIP CODE 14 SOUTH AVENUE HARRISONBURG, VA 22801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 684	*Insulin Glargine Soluunit/ml, Inject 34 units for diabetes; *Carvedilol Tablet 6.2 two times a day for he *Tylenol Extra Streng every 12 hours for pa *Guafenesin Liquid 1 mouth three times a crespiratory failure; *Lactobacillus Give 4 times a day for supple *Pregabaline Capsule mouth three times a crespiratory failure; *Lactobacillus Give 4 times a day for supple *Pregabaline Capsule mouth three times a crespiratory failure; *Lactobacillus Give 4 times a day for supple *Pregabaline Capsule mouth three times a crespiratory failure; *Lactobacillus Give 4 times a day for supple *Pregabaline Capsule mouth three times a crespiratory failure; *Venelex Ointment Alevery day and evening the supple sup	one time a day for pain; ation Pen Injector 100 is subcutaneously at bedtime is subcutaneously at the subcutaneously and subcutaneously is subcutaneously at the subcutaneously is subcutaneously is subcutaneously in subcutan	F	684			