STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0076	A. BUILDING: _____ B. WING _____	07/14/2016

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 7/12/16 through 7/14/16. Significant Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 180 bed certified facility was 132 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #21) and 8 closed record reviews (Residents #22 through #29).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-250. Resident assessment and care planning. cross reference to F278. 12VAC5-371-140. Policies and procedures. Based on staff interview and facility document review, it was determined that the facility staff failed to obtain a Virginia State Police background check within 30 days of hire for one of 25 employee record reviews, OSM (other staff member) #24 (an occupational therapist). OSM #24 was hired on 12/10/15. A Virginia State Police background check was not completed for OSM #24 until 7/13/16. The findings include: OSM #24 was hired on 12/10/15. Review of OSM	F 001	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F278 Cross reference to 12VAC5-371-250/12VAC5-371-140 1. Virginia State background check on OSM #24 was completed on 7/13/2016	8/17/16

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

Electronically Signed | 08/01/16

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F 001	Continued From page 1 #24's employee record revealed a nationwide background check completed on 12/2/15; however, a Virginia State Police background check was not completed until 7/13/16. On 7/14/16 at 7:56 a.m., an interview was conducted with OSM #11 (human resources). OSM #11 stated OSM #24 was hired before she (OSM #11) began employment at the facility. OSM #11 was asked the facility process for completing background checks on new employees. OSM #11 stated she makes an employment offer contingent upon background checks and reference checks. OSM #11 stated she completes a Virginia State Police background check and a third party vendor runs a federal background check before the employee begins employment. At this time, OSM #11 stated a federal background check was completed for OSM #24 on 12/2/15 but a Virginia State Police background check was not completed until 7/13/16. On 7/14/16 at 11:54 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #5 (the corporate nurse consultant) were made aware of the above findings. The facility policy titled, "Criminal History Checks" documented, "POLICY: For the safety of our patients and to comply with state laws, all employees are subject to criminal history record checks. PROCEDURE: 2. A federal and nation-wide background must be requested. The background must be reviewed prior to orientation. The Regional Human Resources Manager should be consulted for backgrounds with significant history, other than minor traffic violations...3. The Virginia State Police Record Request must also	F 001	with no disqualifying criminal records to work at the Facility. 2. An audit of all current staff files will be completed to ensure that there is no missing State background check. Any noted missing State background check will be completed immediately and result acted upon accordingly. 3. The Regional Human Resource Manager to conduct re-education with Facility□s Human Resource Manager in the following area: a) Required back ground checks for potential employees 4. Human Resource Manager to audit background checks on newly appointed staff on an ongoing basis monthly x2 months and quarterly x3 quarters. F322 Cross reference to 12 VAC 5-371-250G 1. Resident #25 was discharged on 12/14/2015. 2. All current patients with feeding tubes will be audited to ensure that they have treatment orders for daily dry dressing change to the stoma or cleaning around the feeding tube incision site. A physician order will be obtained and implemented accordingly for any noted missing feeding tube treatment order. 3. Re-education of nursing staff in the following areas: a. Nursing management protocols for feeding tube insertion site b. Standard treatment orders for feeding tube 4. The DON/Designee will audit 10% of current patients with feeding tube to ensure that they have treatment order for	

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F 001	Continued From page 2 be requested from the Central Criminal Records Exchange, from Virginia State Police, within 30 days of hire..." No further information was presented prior to exit. 12 VAC 5 - 371 - 250 G cross references to F 322 Resident Rights 12VAC5-371-150C cross reference F156 Management and Administration 12VAC5-371-110B2 cross reference F167 Maintenance & Housekeeping 12VAC5-371-370A cross reference F252 Infection Control 12VAC5-371-180A,C7 cross reference F441 12VAC5-371-200B. Director of Nursing Cross reference to F-281 12VAC5-371-140. Policies and procedures Cross reference to F-329 12VAC5-371-220. Nursing services Cross reference to F-329 12VAC5-371-240C. Physician services Cross reference to F-386 F309 cross reference to 12VAC5-371-220 CFR 502 cross references to 12VAC5-371-301 A 12VAC5-371-220H. Nursing Services cross referenced to F157. 12VAC-371-130B. Resident Rights cross referenced to F157. 12VAC-371-360E. Clinical Records cross referenced to F514. 12VAC-371- 340 A cross references to Federal	F 001	their feeding tube incision site. The audit will be performed on an ongoing basis weekly for one month, then monthly for two months, and then quarterly for two more quarters. Any deviation will be corrected accordingly and then forwarded to the QA committee 5. Date of compliance is 8/17/2016. F156 Cross reference to 12VAC5-371-150C 1. The facility posted the contact information for Medicare, Medicaid, the Ombudsman, and the State Agency on 7/25/2016 in an area easily visible and accessible by the patients. 2. A walking review of the facility will be completed to assess other possible areas to display the Medicare, Medicaid, the Ombudsman, and the State Agency for patients who mostly stayed on the Units. The above information will be posted at any identified suitable location(s) in the building besides where they are currently displayed for additional accessibility. 3. Re-education/remediation session will be completed by the Vice President of Operation to include: a) Administrator and Discharge Planning staff in the area of patients□ access to pertinent State client advocacy agency groups, such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, the Medicaid fraud control unit, and other relevant information on filing a complaint concerning residents abuse, neglect, and misappropriation of resident□s property. 4. Administrator/Discharge	

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F 001	Continued From page 3 Tag F 371.	F 001	Planning/Designee to perform an ongoing auditing of the continuing display of pertinent State client advocacy agency groups accessible locations within the facility weekly for one month, then monthly for two months, and then quarterly for two more quarters. Any observed deviation will be forwarded to the QA committee for recommendation. 5. Date of compliance is 8/17/2016. F 167 Cross reference to 12VAC5-371-110B2 1. The missing first five pages of the 8/27/2015 survey results were replaced in the survey binder on 7/14/2016 and placed in a location accessible by the patients for possible review. 2. An audit of all of the whole Survey binder was completed on 7/14/2016 to ascertain that no additional pages besides the first five pages were missing. No additional missing page(s) were noted. 3. Re-education will be completed with the Administrator in the following area: a. Maintenance of complete previous survey results in an area known to and accessible by the patients for possible review 4. Administrator/Designee will audit the displayed survey binder to ensure that it is complete and accessible to the patients at all times for one week x1 month, then monthly for two months, and quarterly for two more quarters. Any noted missing pages will be immediately replaced and trend forwarded to the QA for recommendation. 5. Date of compliance is 8/17/2016.	

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F 001	Continued From page 4	F 001	F252 Cross reference to 12VAC5-371-370A 1. The bedside tables missing door pulls were replaced in resident rooms # 8B, #22B, # 24A, #75A & B, and #86A on 7/27/2016. The four and half feet broken and cracked tile in room # 27B, in the B-side of the room, was replaced on 7/27/2016. Room #86B missing floor tile was replaced on 7/27/2016. Unpainted trim around the HVAC unit in room #34B was painted on 7/20/2016. Room #41 missing plaster on the outside corner of the bathroom was repaired on 7/29/2016. The two holes in the wall behind head of bed in Resident room #48A repaired on 7/27/2016. The pitted and chipped wall behind the head of bed in room #77A was repaired on 7/28/2016. The outside areas of the bathroom wall in room 82 that was not sanded and painted was sanded and painted on 7/20/2016. The three areas that were not sanded and painted in room #90 were sanded and painted on 7/20/2016. 2. All rooms will be audited to assess the presence of any wall with patches, areas of wall not sanded, missing plaster, holes in wall, broken/cracked tile, and bedside table missing door pulls. Any noted presence of the above identified problems will be immediately repaired or replaced as applicable. 3. Re-education of the staff in the following areas: a. Maintenance Department: Recurrent auditing of facility infrastructures (including its building, furniture, equipment, etc.) to assess need for replacement or repair b. Other Departments staff: Reporting	

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F 001	Continued From page 5	F 001	observed maintenance need(s) in the Facility to the Maintenance Department 4. The Maintenance Department Manager/Designee to audit rooms so as to assess for repair needs weekly for one month, then monthly for two months, and then quarterly for two more quarters. Any noted repair needs will be addressed accordingly and findings forwarded to the QA committee. 5. Date of compliance is 08/17/2016. F 441 Cross reference to 12VAC5-371-180A, C7 1. Air conditioning vents in the clean laundry room were cleaned on 7/14/2016. 2. All current residents are at risk. All air conditioning vents in the Facility will be assessed to ascertain that they are not covered with dust and dirt. Any air conditioning vents noted to have dust and dirt will be cleaned immediately. 3. Re-education of the Housekeeping/Maintenance and other Facility staff will be conducted in the following areas: a. Housekeeping Department staff daily auditing and cleaning of air conditioning vents as applicable b. Reporting of noted air conditioning vents with dust and dirt to the Housekeeping Department 4. House Keeping Manager/Designee will audit all of the air conditioning vents in the Facility daily x4 weeks, weekly x1 month, and then monthly x3 months to ensure that they are free from dust and dirt. Any abnormal findings will be corrected accordingly and then forwarded to the QA committee.	

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F 001	Continued From page 6	F 001	5. Date of compliance 8/17/2016 F281Cross Reference to 12VAC5-371-200B Past non-compliance requiring no plan of correction F 329 Cross reference to 12VAC5-371-140/12VAC5-371-220 1. Resident #26 discharged on 8/15/2015. Resident #11 Irbesartan blood pressure medication was discontinued by MD in agreement with Hospice/responsible party on 7/20/2016 due to intermittent recurrent episodes of hypotension and low heart rate. Low BP and heart rate is yet to be recorded since 7/20/2016. 2. Review of all current patient□s physician order sheet (POS), admitted to the facility on and after 8/7/2015, will be completed to ascertain that no diabetes oral medication was ordered for any one of them without the diagnosis of diabetes mellitus. Review of recorded blood pressure and heart rate readings in the last 30 days, starting from 7/1/2016, for all current patients with the diagnosis of hypertension will be completed. This is to ascertain that no blood pressure medication was given to any patient with a low blood pressure as specified by their baseline. MD/RP will be notified accordingly for any recorded abnormal finding(s) 3. Re-education of all nurses in the following areas: a. Reconciliation of discharge medication list(s) for newly admitted or readmitted patients to the Facility	

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F 001	Continued From page 7	F 001	b. Accurate physician/nurse practitioner order review for new admissions/readmissions to the Facility c. Standard nursing management protocols for the administration of oral hypertension medications d. Observing the 5 rights when transcribing of medication orders and administering them. 4. The DON/Unit Managers or Designee will audit all new admissions□ POS against their corresponding discharge medications list on an ongoing basis to ensure that it is accurate and has no diabetes mellitus (DM) oral medication for patient without the diagnosis of DM. Furthermore, the DON/Unit Managers/Designee will audit 10% of the total inpatients with the diagnosis of hypertension to ensure that none of them have recorded low BP/HR readings and corresponding hypertension medication administration at the same time. The audit will be weekly for one month, then monthly for two months, and quarterly for two more quarters. Any abnormal findings will be rectified accordingly and then forwarded to the QA committee for further quality improvement recommendation 5. Date of compliance is 8/17/2016. F386 Cross reference to 12VAC5-371-240C 1. Resident #26 discharged on 8/15/2015. 2. Review of all physician order sheet (POS) for current patients assigned to Resident #26 physician, who were admitted to the facility on and after	

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F 001	Continued From page 8	F 001	8/7/2016, will be completed to ascertain that no diabetes oral medication was ordered for any one of them who does not have a diagnosis of diabetes mellitus. Any discrepancy noted will be reviewed by the said physician for rectification accordingly. 3. Re-education will be completed with the nurses and physicians□/nurse practitioners in the following areas: a. Reconciliation of discharge medication list(s) for newly admitted or readmitted patients to the Facility b. Physician/nurse practitioner order review for new admission/readmission to the Facility c. Observing the 5 rights of medication orders when transcribing and administering them. 4. The DON/Unit Managers in consultation with the Medical Director/Designee will audit 10% of all new admissions□ POS against their corresponding discharge medications list on an ongoing basis to ensure that it is accurate and has no diabetes oral medication for patient without the diagnosis of DM weekly x4 weeks, and then monthly x 3 months. Any abnormal findings will be corrected and then forwarded to the QA committee for further resolution. 5. Date of compliance is 08/17/2016. F 309 Cross reference to 12VAC5-371-2201. Resident # 7□s pain management program was adjusted and is effective at this time. Resident # 28 was discharged 1/27/2016. We were unable to locate BP□s for Resident # 6 on 3/24/16. Transcribing nurse entered the	

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F 001	Continued From page 9	F 001	order as a no documentation required order on 3/4/2016. Affected nurse re-educated on order entering into the point click care on 8/1/2016. Resident # 6□s physician was notified of the error on 8/1/16 and no further orders were obtained. No fall noted for resident #18 on 5/6/2016. Resident #18 instead noted with a fall on 6/6/2016 with care plan revised on the same day of 6/6/2016. No neuro-checks documentation was, however, located for the fall on 6/6/2016. Resident # 18 did not have neuro-checks ordered on 5/6/16. 2. An audit of residents on pain management, neuro-checks and vital signs will be completed to verify compliance. Those found to be incomplete will be corrected accordingly. 3. Education will be undertaken with the following staff: a) Unit Managers/Supervisors/RNs/LPNs in the area of assessment, documentation and follow-through on pain management, documentation and assessment of vital signs and neuro-checks 4. DON/Unit Managers will audit residents needing pain management for effectiveness and modifications, residents needing neuro-checks and ordered vital signs weekly x 4 weeks and then monthly x 3 months. Results of the audit will be forwarded to the QA committee. 5. Date of compliance 8/17/16. F502 Cross reference to 12VAC5-371-301A 1. Resident # 6□s physician was contacted and a TSH was ordered for	

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F 001	Continued From page 10	F 001	8/1/16. Resident # 4□s physician was contacted and a CBC, CMP, Lipids and Liver Function test were ordered for 8/1/16. Resident # 10 had a CBC, CMP, and TSH completed 7/20/16. 2. An audit of current residents with lab orders will be conducted to verify that labs were completed as ordered. Any lab orders found incomplete will be corrected accordingly. 3. Education will be undertaken with the following staff: a. Unit Managers/Supervisors/RNs/LPNs in the area of transcribing, verifying, obtaining lab results and physician notification 4. DON/Unit Managers will audit residents with lab orders weekly x 4 weeks, and then monthly x 3 months. Results of the audits will be forwarded to the QA committee 5. Date of compliance 8/17/16. F 157 Cross reference to 12VAC5-371-220H/12VAC-371-130B 1. Resident # 6□s weight order was discontinued on 6/5/16. The resident□s physician was notified of the missing weights during the time period noted. Resident # 24 was discharged on 5/30/16. Resident # 11□s blood pressure medication was discontinued on 7/20/16 due to recurrent hypotensive episodes. 2. An audit of residents with changes of condition requiring physician notification will be completed. Those found to be incomplete will be corrected accordingly. 3. Education will be undertaken with the following staff: a) Unit Managers/Supervisors/RNs/LPNs	

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F 001	Continued From page 11	F 001	in the area of identifying changes in condition and notification of physicians 4. Unit Managers will audit residents with changes in condition on a daily basis and notify the physicians as required. The DON will audit 10% of residents with changes of condition weekly x 4 weeks and then monthly x 3 months. Results of the audit will be forwarded to the QA committee. 5. Date of compliance 8/17/16. F514 Cross reference to 12VAC-371-360E 1. Resident # 11□s blood pressure medication (lrbesartan) was discontinued on 7/20/16. Resident # 25 was discharged 12/14/15. 2. An audit of current resident on blood pressure medications will be conducted to verify that there is no antihypertensive medications administration for patients with recorded low BP and heart rate. There are currently no residents with tracheostomies in the Facility. An audit of residents with suction orders will be conducted to verify correct documentation. Any noted anomaly will be corrected accordingly 3. Education will be undertaken with the following staff: A. Unit Managers/Supervisors/RNs/LPNs in the area of administration of blood pressure medications, documentation and physician notification when BP is too low. B. Unit Managers/Supervisors/RNs/LPNs in the area of tracheostomy care, suctioning and documentation. 4. DON/Unit Managers will audit 10% of current residents with blood pressure	

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F 001	Continued From page 12	F 001	medications for appropriate administration and documentation weekly x 4 weeks, and then monthly x 3 months. DON/Unit Managers will also audit residents with tracheostomies and receiving suctioning for appropriate completion and documentation weekly x 4, then monthly x 3 months. Results of the audits will be forwarded to the QA committee. 5. Date of compliance 8/17/16. F371 Cross reference to 12VAC-371-340A 1. The affected staff hairnet was immediately adjusted to properly restrain all her hair on 7/12/2016. 2. All current residents are at risk. Dining staff in-serviced on proper hair restrain donning on July 12, 2016. In addition, the Facility purchased a mirror on July 29, 2016 and placed it next to the handwashing station in the cook prep area, so that staff can check for all hair being properly restrained in hairnet. 3. In-service education will be conducted to all facility staff on proper hairnet donning when entering the kitchen. 4. Dining Services Manager will monitor on an ongoing basis appropriate hair restraint of all staff entering the kitchen daily x2 weeks, weekly x1 month, and then monthly x3 months. Any observed noncompliance will be corrected accordingly and then forwarded to the QA committee for additional quality improvement recommendation. 5. Date of compliance is 8/17/2016.	