STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495286		C 09/14/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JAMES RIVER CONVALESCENT CENTE	540 ABERTHAW AVENUE NEWPORT NEWS, VA 23601

(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/12/17 through 09/14/2017. Corrections are required for compliance with 42 CRF Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One (1) complaint was investigated during this survey. The census is this 154 bed facility was 138 at the time of survey. The survey sample consisted of 21 current Resident reviews (Resident #1 through #21) and 4 closed record reviews (Resident #22 through #25).	F 000		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441		10/10/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/27/2017

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

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F 441	Continued From page 1 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 2 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and staff interviews the facility staff failed to maintain an infection control program to provide a safe, sanitary environment to prevent the development and transmission of disease and infection for 1 of 25 residents (Resident #17) and in the survey sample. The findings included: The facility staff failed to use a barrier and disinfect the over bed table after being used to check Resident #17's blood sugar and administering insulin. Resident #17 was originally admitted to the facility on 11/13/15. Diagnoses for Resident #17 included but not limited to Type 2 Diabetes (1). Resident #17's Comprehensive Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/11/2017 coded the resident with a 09 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), moderate cognitive impairment. In addition, the MDS coded Resident #17 requiring total dependence of one with dressing and bathing, extensive assistance to two with transfers, extensive assistance of one with bed mobility, eating, toilet use and personal hygiene. Resident #17 was coded occasional incontinent of bowel and bladder. On 09/12/17 at approximately 4:35 p.m., during medication pass and pour, LPN #1 went to	F 441	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an omission that the deficiency exist or that we are in agreement of them. It is an affirmation that corrections to the area cited has been made and that the facility is in compliance with participation requirement. The dates of completion serve as my allegation of compliance. 1. Nurse #1 was reeducated on the proper technique in providing a clean barrier during insulin administration, blood glucose monitoring, and proper infection control techniques. 2. RN's and LPN's will be monitored for appropriate techniques in infection control as it pertains to blood glucose monitoring, and insulin administration. 3. The Director of Clinical Performance/designee will re-educate RN's and LPN's on "Prevention of Spread of Infection". The in-service will include a review of proper techniques in blood glucose monitoring and administration of insulin to include ensuring a clean barrier on which to rest the equipment. 4. The Director of Nursing/designee will perform 10 random observation audits weekly for 6 weeks on nurses performing blood glucose monitoring. Audits will	

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F 441	Continued From page 3 Resident #17's room caring a small white plastic basket containing alcohol pads, 2 x 2 gauzes, lancets, test strips and glucometer. LPN #1 placed the container on the over bed table; the table was noted to be without a barrier. The LPN cleaned resident's finger with an alcohol pad; pricked her finger with a lancet then placed the lancet on the over table. The LPN then used the glucometer to obtain the resident's blood sugar. After the blood sugar was obtained, the glucometer was placed on the over bed table. The LPN removed her gloves and put on another pair of gloves then injected 3 units of Humalog (2) insulin into her right upper arm. After the insulin injection, LPN #1 placed the used insulin syringe on the over bed table. The LPN removed all items off the over bed table and placed all supplies back into the medication cart. An interview was conducted with LPN #1 on 07/12/17 at approximately 4:30 p.m., who stated, "I should have used a barrier on the over bed table and the table should have been wiped down after use." An interview was conducted with the Director of Nursing (DON) on 09/12/17 at approximately 5:05 p.m., who stated a barrier should have been used before putting the items used for the blood sugar checks and the table should have cleaned before and after use." The DON also stated, "The used lancet should have been put in the sharps container and glucometer should not have been placed on the resident's over bed table after being used without the use of a barrier." The facility administration was informed of the finding during a briefing on 09/14/17 at 1:50 p.m. The facility did not present any further information	F 441	cover proper technique and infection control practices while performing blood glucose monitoring and the DON/designee will maintain a record of the observations. RN's and LPN's requiring additional training will be identified and re-educated. The DON/designee will review the audit results for any patterns or trends and report any findings to our Quality Assurance Performance Improvement Committee on a quarterly basis.	

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F 441	Continued From page 4 about the findings.	F 441		