DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED 02/08/2017
FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495404	A BUILDING ---------- B WING	02/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS. CITY. STATE. ZIP CODE
THE GLEBE	250 GLEBE ROAD DALEVILLE, VA 24083

(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 1/31/17 through 02/02/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 32 certified bed facility was 32 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents #1 through #9 and #14) and 4 closed record reviews (Residents #10 through #13)

F 164 SS=D 483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS

483.10
(h)(l) Personal privacy includes accommodations. medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(h)(3)The resident has a right to secure and confidential personal and medical records.

(i) The resident has the right to refuse the release of personal and medical records except as provided at
§483.70(i)(2) or other applicable federal or state laws.

§483.70
(i) Medical records.
(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the

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F 000 Plan of Correction: This Plan of Correction is our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly.

F 164

F 164 483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL SS=D PRIVACY/CONFIDENTIALITY OF RECORDS

After notification by inspector, the ADON and Nurse Supervisor educated and reviewed with all nursing and certified nursing assistants, the resident rights as outlined in the regulation, 483.10, (h) (l) Personal privacy includes accommodations. Medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups... To ensure all residents are supported in their rights under 483.10(h)(l), the facility will provide ongoing staff training by the DON/Director of Clinical Services/or designee during new hire process, 30 and 90 day staff performance review as well as annually during resident rights in service.

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ellen A Haney-Dandleme LNHA | TITLE: Administrator | (X6) DATE: 2-16-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correct1ng 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 164 Continued From page 1
records, except when release is-

(i) To the individual, or their resident representative where permitted by applicable law;

(ii) Required by Law;

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;

(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview and clinical record review, it was determined the facility staff failed to provide privacy (did not close window shades or the bathroom door) during incontinence care and a skin assessment for 1 of 14 residents (#5.)

Findings:

Facility staff failed to provide privacy for Resident #5 (by not closing window shades or the bathroom door) during incontinence care and a skin assessment Resident #5's clinical record was reviewed on 1/31/17 at 3:00PM.

The resident was admitted to the facility on 1/9/17 for physical therapy after a fall at her home resulted in multiple fractures Resident #5's

F 164

F 164 483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL SS=D PRIVACY/CONFIDENTIALITY OF RECORDS Continued:

The POC will be implemented no later than February 20, 2017. The outlined POC will be monitored for effectiveness through a weekly ADL observation audit of 5% of census, by the DON/Director of Clinical Services/ or designee. The results of the weekly audit will be reviewed by the LNHA and adopted as part of the agenda in the Quarterly Quality Improvement committee. The QQIC committee will review and determine ongoing need for the POC based on results of no less than 100% accuracy during the ADL audit process for (2) consecutive quarters.

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F 164	Continued From page 2 diagnoses included a seizure disorder, hypertension, a wedge compression fracture of thoracic vertebra and a fracture of one rib. Resident #5's latest MDS (minimum data set) assessment, dated 1/17/17, coded the resident's cognitive status as unimpaired. The resident required the assistance of at least one nursing staff member for all the activities of daily living but was able to eat independently. The resident did require assistance for toileting and was frequently incontinent. The resident's CCP (comprehensive care plan) implemented on 1/9/17 the resident with an alteration in bladder/bowel elimination related to decreased mobility. The staff interventions included "Provide privacy during elimination as able while maintaining safety." Resident #5's physician's orders, signed and dated electronically on 1/27/17 included an order for Desitin 13% topical cream. The physician ordered the cream be applied on each of three shifts and as needed at every void change. The cream was for a "raw red rash at Peri/vaginal area." On 2/1/17 at 2:00 PM Resident #5 was interviewed by a member of the survey team. The resident told the surveyor she had a very bad rash and a sore bottom from having to lie in feces for long periods of time. She agreed to let the surveyor examine her skin. On 2/1/17 at 3:45PM LPN I accompanied the surveyor to examine the resident's skin. LPN I took a tube of Desitin 13% creme with her so she could apply it during the assessment.	F 164		

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F 164	Continued From page 3	F 164		

LPN I rolled the resident into the bathroom in her wheelchair and assisted her to stand at the side of the toilet She then pulled the resident's pants down and removed her brief.

LPN I did not close the bathroom door or the window shade during this time. The surveyor observed the resident's bare buttocks were exposed and visible to the outside window from the area inside the bathroom.

After assessing Resident #5's skin and buttocks, LPN I turned the resident and helped her onto the toilet She then exited the bathroom to get a dry brief from the resident's closet

The surveyor then asked the resident if the staff closed the blinds and shut the bathroom door to provide privacy when providing her incontinence care. Resident #5 stated, Sometimes they do and sometimes they don't"

On 2/2/17 at 10:45 AM the administrator and DON were informed of the surveyor's observations and the concerns about privacy. No

additional information was provided prior to the survey team exit

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 01/31/17 through 02/02/17. Corrections are required for compliance with Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow The census in this 32 certified bed facility was 32 at the time of the survey. The survey sample consisted of 10 current Resident reviews (Residents #1 through #9, and #14) and 4 closed record reviews (Residents# 10 through #13).	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 The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. 12 VAC 5-371-360 J: Cross reference to F-164.	F 001		

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