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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495386		03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT BOTETOURT COMMONS	290 COMMONS PARKWAY 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	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 3/1/16 through 3/3/16 Corrections are required for compliance with the following Federal Long Term Care requirements The Life Safety Code survey/report will follow The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 15 current Resident reviews (Residents 1 through 14 and 19) and 4 closed record reviews (Residents 15 through 18)		This plan of correction constitutes our Credible Allegation of Compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws.	
F 226 SS=B	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property This REQUIREMENT is not met as evidenced by Based on staff interview and facility document review, the facility staff failed to obtain sworn statements for 3 of 25 new hires and obtain license verification for 2 of 25 new hires. The findings included: The physical therapist with a hire date of 2/17/16, licensed physical therapist assistant and occupational therapist with a hire date of 10/1/15 did not have signed sworn statements in their employee file prior to the survey. The administrator was notified of the above findings on 3/2/16 at approximately 7:15 pm in the conference room. The administrator presented copies of signed	F 226	The license and verification for the two (2) employers identified during the survey was completed 3/3/16 and are new on file The sworn statements for the three (3) employees identified during the survey were obtained 3/3/16 and are now on file An audit was conducted 3/3/16 on all other contracted employee files in relation to sworn statements and license verification, and were found to be in compliance The Human Resource Coordinator and/or designee will conduct an audit monthly for a minimum of three (3) months to ensure that all employee files including contracted staff are in compliance with the requirement for sworn statements and license verification. Findings of audits will be reported to the QA Committee who will determine the need or duration of future audits.	4/17/16

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mitchell P. Davis
TITLE: Executive Director
(X6) DATE: 3/28/2016

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 226	Continued From page 1 sworn statements by the above documented new hires dated for 3/3/16. The administrator stated " We just switched companies in which we contract those services with, the people have been here but they began working for a different group of employers. " Also, the physical therapist with a hire date of 2/17/16 and the licensed physical therapist with a hire date of 10/1/15 did not have their professional license verified by facility staff prior to the start of the survey on 3/1/16. There were no license verifications in the employee files when reviewed by the surveyor on 3/2/16 at 6 pm in the conference room. The administrator was notified on 3/2/16 at approximately 7:15 pm, of the physical therapist with hire date of 2/17/16 and the licensed physical therapist assistant with a hire date of 10/1/15 had no license verification in their employee files. The administrator presented copies, to the surveyor on 3/3/16 at approximately 7:30 am, of the license verifications for the physical therapist and licensed physical therapist assistant. These verifications at the top of the page stated " License Lookup ...Last updated on 03/02/2016 " According to the facility ' s policy titled " Employment Standards " it stated, " It is the policy that the facility will hire only those individuals that are best suited to perform their assigned task within the guidelines and rules set forth by the state and federal government. " No further information was provided to the surveyor prior to the exit conference on 3/3/16.	F 226		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278	Resident #14 MDS with ARD 2/10/16 was corrected 3/25/16 to reflect the active diagnosis.	

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A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure minimum data set (MDS) assessments were accurate for 6 of 19 residents (Resident #14, Resident #3, Resident #8, Resident #4, Resident #9, and Resident #15).
The findings included:
1. The facility staff failed to accurately code the significant change/5 day assessment for active diagnoses and failed to code falls on the quarterly

F 278

Resident #14 MDS with ARD 1/14/16 was corrected 3/25/16 to reflect the 12/2/15 fall.

Resident #3 MDS with ARD 2/20/16 section C and D was unable to be corrected IDT was educated 3/2/16

Resident #8 MDS with ARD 2/2/16 was corrected 3/3/16 to reflect the 1/2/16 fall and section V was corrected to include the date and location of the CAA.

Resident #4 MDS with ARD 1/20/16 was corrected 3/3/16 for section V to include the date and location of the CAA

Resident #9 MDS with ARD 1/14/16 was corrected 3/3/16 for section V to include the date and location of the CAA.

Resident #15 MDS with ARD 10/13/15 was corrected 3/25/16 for section V to include the date and location of the CAA

An audit of sections C, D, I, J and V was completed for the most recent MDS assessments for other current residents and corrections were made as applicable.

An inservice was completed with the IDT to include accurate completion and coding of sections 3/2/16 per assigned discipline according to the RAI guidelines The MDS Coordinators or designees will audit a minimum of two (2) completed MDS assessments

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F 278	Continued From page 3 MDS for Resident #14. a. The clinical record of Resident #14 was reviewed 3/3/16. Resident #14 was admitted to the facility 12/11/14 and readmitted 2/3/16. Diagnoses included but were not limited to acute and chronic respiratory failure, chronic blood loss, acute on chronic renal failure, and generalized weakness. The significant change/5 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/10/16 assessed Resident #14's cognitive summary score as 03 out of 15 in Section C. Resident #14 was observed on 3/2/16 at 5:00 p.m. Resident #14 was in bed, head of bed elevated, and receiving oxygen at 3 liters per nasal cannula. Resident #14 was observed on 3/3/16 at 8:30 a.m. Resident #14 was in bed, head of bed elevated, receiving oxygen at 3 liters per nasal cannula, and being fed breakfast by a certified nursing assistant. Resident #14's significant change/5 day MDS was reviewed in its entirety on 3/3/16. Section I Active Diagnoses did not include respiratory failure. The surveyor interviewed the assistant director of nursing on 3/3/16 at 9:00 a.m. The ADON stated if the respiratory failure was acute then that probably wasn't coded because the failure hopefully would clear up. The surveyor provided the physician visit progress note dated 2/4/16. Diagnoses and assessments listed were chronic blood loss, acute on chronic renal failure, chronic kidney disease, acute and chronic respiratory failure (acute-on-chronic), and generalized muscle weakness. The ADON stated after reviewing the progress note that respiratory failure should have been coded. b. The surveyor reviewed the quarterly minimum data set (MDS) assessment with an assessment	F 278	for accuracy of all sections weekly for eight (8) weeks. Findings of such audits will be reported to the QA Committee who will determine the need or duration of future audits	4/17/16

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reference date (ARD) of 1/14/16. Resident #14 was assessed with a cognitive summary score of 05 out of 15 in Section C Summary Score. Section G Functional Status assessed Resident #14 to need extensive assistance of 1 person for bed mobility and transfers. Toilet use was assessed to be limited assistance of 1 person.
The surveyor reviewed the December 2015 through March 2016 departmental notes. The 12/2/15 8:03 p.m. departmental note read "At 4:25 pm (afternoon), pt. (patient) was observed lying on the bathroom floor with his w/c (wheelchair) unlocked and behind him. Pt. stated he was self transferring to toilet and forgot to lock his wheelchair. Wheelchair noted to not have brakes locked. Pt. was also in socked feet with no shoes."
Section J Health Conditions and specifically, Section J1700-J1900, was not marked to reveal the fall that occurred 12/2/15. The surveyor discussed the fall and the coding with the assistant director of nursing on 3/3/16 at 9:00 a.m. She reviewed both the note and the quarterly MDS and stated the fall should have been coded.
The surveyor informed the administrator, the director of nursing, and the assistant director of nursing of the above concern on 3/3/16 at 12:10 p.m.
No further information was provided prior to the exit conference on 3/3/16.
2. The facility staff failed to code Section C (Cognitive Patterns) and Section D (Mood) on Resident #3's admission minimum data set (MDS) assessment.
The clinical record of Resident #3 was reviewed 3/1/16 and 3/2/16. Resident #3 was admitted to the facility 2/13/16 with diagnoses that included but not limited to Clostridium difficile colitis (C.

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F 278	Continued From page 5 Diff), muscle weakness, congestive heart failure, osteoarthritis, chronic kidney disease, and urinary retention. The admission minimum data set (MDS) with an assessment reference date (ARD) of 2/20/16 for Resident #3 was reviewed 3/1/16. Section C Cognitive Patterns had dash marks from C0100 through C1600. Section D Mood had dash marks from D0100 through D0650 The surveyor interviewed registered nurse #4 on 3/2/16 at 10:15 a.m. R.N. #4 was asked to review Resident #3's admission MDS for accuracy. She stated Section C and Section D had dash marks. She stated the dash marks are used when the interviews are done on or after the ARD (assessment reference date). R.N. #4 stated the activity staff were responsible for Section C and Section D. The surveyor interviewed the activity director on 3/2/16 at 11:25 a.m. The activity director stated she does Section C, Section D, and Section F. The activity director reviewed the admission MDS and stated she didn't recall doing those sections. She stated she prints the "MDS Command Center Calendar" for a schedule of the MDSs that are due. The activity director provided the surveyor with the February 2016 calendar. On February 20, Resident #3 was entered with an "A" beside of the entry. A=admission. The activity director stated she guessed she didn't do it. The surveyor informed the administrator and the director of nursing of the failure of the facility to accurately code Section C and Section D on Resident #3's admission MDS on 3/2/16 at 3:50 p.m. and informed the administrator, the director of nursing, and the assistant director of nursing of the above finding on 3/3/16 at 12:10 p.m. The ADON reviewed the electronic clinical record to see if an interview had been completed. She	F 278		

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stated an interview for Resident #3 had not been completed.
No further information was provided prior to the exit conference on 3/3/16.
3. The facility staff failed to accurately code a fall for Resident #8 that occurred 1/2/16 on the quarterly minimum data set and failed to complete Section V for nutrition to include where information was found.
The clinical record of Resident #8 was reviewed 3/2/16. Resident #8 was admitted to the facility 10/27/15 with diagnoses that included but not limited to Parkinson's disease, hypertension, diabetes mellitus type 2, and atherosclerotic heart disease.
a. The quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/2/16 assessed Resident #8 with a cognitive summary score of 02 out of 15 in Section C. Section G Functional Status assessed Resident #8 to require extensive assistance of two people for bed mobility and transfers.
While reviewing the departmental notes for Resident #8, the note of 1/2/16 4:27 a.m. read "Resident was observed in floor near his bed. No injury noted and VS (vital signs) were obtained and recorded. Resident was able to move all extremities without any pain. Will continue to monitor and record any noted changes."
The surveyor reviewed Section J Health Conditions and specifically J1700 through J1900 Fall History. There were no recorded falls for Resident #8.
The surveyor interviewed registered nurse #3 on 3/2/16 at 11:00 a.m. R.N. #3 reviewed the coding on the MDS and reviewed the departmental note and stated the fall had not been coded.
The surveyor informed the administrator and the director of nursing of the inaccurate coding on the

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quarterly assessment for resident #8 on 3/2/16 at 3:50 p.m.
No further information was provided prior to the exit conference on 3/3/16.
b. The facility staff failed to complete Section V Care Area Assessment (CAA) Summary accurately for Resident #8. The facility staff had not identified the date and location of the CAA information used to determine the care plan for nutrition.
The surveyor reviewed Resident #8's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/3/2015 on 3/2/16. Resident #8 was assessed with a cognitive summary score of 15 in Section C. Section V Care Area Assessment (CAA) Summary was reviewed. The location and date of CAA documentation was incomplete for the triggered care area of nutrition. There was no date of the nutritional assessment.
The surveyor reviewed the admission "Medical Nutritional Therapy Assessment" dated 11/4/15. The nutritional assessment was dated after the ARD date of 11/3/15.
The surveyor informed the administrator and the director of nursing of the above finding on 3/2/16 at 3:50 p.m.
No further information was provided prior to the exit conference on 3/3/16.
4. For Resident #4, the facility staff failed to document the date in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment to indicate where the information related to the CAA could be found.

Resident #4 had been admitted to the facility 10/25/07. Diagnoses included, but were not limited to, anxiety disorder, chronic obstructive

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pulmonary disease, schizophrenia, heart failure, hypertension, constipation, and anemia.

Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD (assessment reference date) of 01/20/16 had scored the Resident 0 out of a possible 15 points.

The facility staff had checked section V of the MDS assessment to indicate they would care plan the following care areas. Cognitive loss/dementia, visual function, communication, ADL (activities of daily living) functional/rehabilitation potential, urinary incontinence, psychological well-being, behavioral symptoms, activities, falls, nutritional status, dental care, pressure ulcer, and psychotropic drug use.

The directions under section V read "Indicate in the Location and Date of CAA documentation column where information related to the CAA can be found..."

The facility staff had not documented the dates where the information of the CAA documentation could be found for visual function, communication, ADL functional/rehabilitation potential, urinary incontinence, activities, falls, dental care, pressure ulcer, and psychotropic drug use.

On 03/02/16 at approximately 10:15 a.m. the missing dates were shown to RN (registered nurse) #1. RN #1 reviewed section V with the surveyor and acknowledged the missing dates.

On 03/02/16 at approximately 3:45 p.m. during a meeting with the administrator and DON (director

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of nursing) the administrative staff was notified of the missing dates on section V of the Residents annual MDS assessment.

No further information regarding this issue was provided to the survey team prior to the exit conference.

5. For Resident #9, the facility staff failed to document the date in section V (care area assessment (CAA) summary) of the Residents annual MDS (minimum data set) assessment to indicate where the information related to the CAA could be found.

Resident #9 had been admitted to the facility 10/17/14. Diagnoses included, but were not limited to, encephalopathy, hypertension, dementia, and heart failure.

Section C (cognitive patterns) of the Residents annual MDS assessment with an ARD (assessment reference date) of 01/14/16 scored the Resident 14 out of a possible 15 points.

The facility staff had checked section V of the MDS assessment to indicate they would care plan the following care areas. Cognitive loss/dementia, ADL functional/rehabilitation potential, urinary incontinence, psychological well-being, mood state, falls, nutritional status, pressure ulcer, and psychotropic drug use.

The directions under section V read "Indicate in the Location and Date of CAA documentation column where information related to the CAA can be found..."

The only care area that had the dates where the

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information could be found was nutritional status.

On 03/02/16 at approximately 3:45 p.m. during a meeting with the administrator and DON (director of nursing) the administrative staff was notified of the missing dates on section V of the Residents annual MDS assessment.

No further information regarding this issue was provided to the survey team prior to the exit conference.

6. For Resident #15, the facility staff failed to document the date in section V (care area assessment (CAA) summary) of the Residents significant change in status MDS (minimum data set) assessment to indicate where the information related to the CAA could be found.

Resident #15 had been admitted to the facility 03/04/15. Diagnoses included, but were not limited to, metabolic encephalopathy, anxiety disorder, diabetes, hypertension, and dementia.

Section C (cognitive patterns) of the Residents significant change in status MDS assessment with an ARD (assessment reference date) of 10/13/15 had a documented summary score of 1 out of a possible 15 points.

The facility staff had checked section V of the MDS assessment to indicate they would care plan the following care areas. Cognitive loss/dementia, visual function, communication, urinary incontinence, psychological well-being, mood state, activities, falls, nutritional status, and pressure ulcer.

The directions under section V read "Indicate in

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F 278	Continued From page 11 the Location and Date of CAA documentation column where information related to the CAA can be found..." The facility staff had not documented the date where the information could be found for nutritional status. On 03/03/16 at approximately 12:20 p.m. during a meeting with the administrator, DON (director of nursing), and ADON (assistant director of nursing) the administrative staff were notified of the missing date on the MDS assessment. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 278		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, and clinical record review, the facility staff failed to assess and treat 9 of 19 Residents for bowel management issues (Residents #5, #13, #15, #14, #8, #6, #16, #1, and #11) and failed to follow physicians orders for 1 of 19 Residents (Resident #19).	F 309		

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The findings included.

1 For Resident #5, the facility staff failed to assess and treat the Resident for bowel management issues. The Residents clinical record indicated the Resident did not have a BM (bowel movement) from 02/08/16-02/13/16.

Resident #5 was admitted to the facility 10/07/14. Diagnoses included but were not limited to, constipation, convulsions, hypertension, chronic obstructive pulmonary disease, and dysphagia.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/07/16 included a documented summary score of 13 out of a possible 15 points. Section G (functional status) was coded 3/2 for toilet use indicating the Resident required extensive assistance of one person. Section H (bladder and bowel) was coded with a 2 to indicate the Resident was frequently incontinent of bowel. Section I (active diagnoses) included constipation.

The Residents POS (physician order sheet) indicated that for the month of February 2016 Resident #5 had physician orders for miralax powder 17 grams everyday for constipation, docusate sodium 100 mg every 12 hours for constipation, and senna 8.6 mg-docusate 50 mg take 2 by mouth every day as needed for constipation. A review of the Residents eMAR (electronic medication administration record) indicated that the Resident had received the miralax and docusate sodium as ordered. There was no documentation to indicate the Resident had received the as needed medication

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Resident #9 order was clarified 3/2/16 to include "May administer medication with food or a snack"

DON and ADON completed an audit of all current in house residents 3/2/16. All residents with medication orders to administer with food were clarified 3/2/16 to "Administer with food or snack."

Resident #1,5,6,8,11,13,14, 15 and 16 bowel movement documentation in medical records were unable to be corrected.

DON, ADON and nursing administration completed review of last documented bowel movement and bowel sound assessment on all current in house residents 3/2/16. No problems identified.

Inservices were initiated 3/2/16 and will be provided to all nursing staff to include:

*Policy and procedure on administering medications with food and/or snack.

*Policy and procedure on accurate documentation in the electronic medical record of bowel movements of each resident.

The DON, ADON and Charge Nurses will audit EMAR orders for medications with foods and snack and observe medication pass monthly at a minimum of three (3) months to ensure compliance during the medication pass.

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senna-docusate in February 2016.

The Residents POS also included the order "11-7 nurse to review smart charting/BM documentation EVERY Monday and Thursday and notify MD (medical doctor) if any bowel management issues identified."

A review of the Residents eTAR (electronic treatment administration record) indicated the 11-7 nursing staff had placed a check mark on the eTAR on Monday and Thursday for the entire month of February 2016.

A review of the Residents BM history for February 2016 indicated that Resident #5 had a BM on 02/08/16 and did not have another BM until 02/13/16.

The surveyor was unable to locate any information to indicate the physician had been notified of any bowel management issues or that the as needed medication had been administered.

During an interview with Resident #5 on 03/02/16 at approximately 1:00 p.m. the surveyor asked the Resident if he had any problems with constipation. Resident #5 stated that he did now.

On 03/03/16 at approximately 12:20 p.m. the survey team meet with the administrator, DON (director of nursing), and ADON (assistant director of nursing). During this meeting the administrative team was notified of the above. The DON verbalized to the survey team that the night shift nurse (11-7) was supposed to review the BM sheets, could talk with the Resident, and if needed should make a referral to the physician.

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The DON, ADON and Charge Nurses will audit "The no BM report" for any non compliance with follow up no less than five (5) days a week for eight (8) weeks.

Findings of audits will be reported to the QA Committee who will determine the need or duration of future audits. 4/17/16

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The DON stated the facility did not use standing orders and they tried not to let the Residents go longer than 3 days without a BM. The DON then stated after 3 days they should be doing an intervention with the physician.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #13, the facility staff failed to assess and treat the Resident for bowel management issues. The Residents clinical record indicated the Resident did not have a BM (bowel movement) from 02/07/16-02/12/16.

Resident #13 had been admitted to the facility 10/04/12. Diagnoses included, but were not limited to, constipation, diabetes, atrial fibrillation, chronic kidney disease, dementia hypertension, and hypothyroidism.

Section C (cognitive patterns) of the Residents quarterly review MDS (minimum data set) assessment with an ARD (assessment reference date) of 12/24/15 had a documented summary score of 0 out of a possible 15 points. Section G (functional status) was coded 3/2 for toilet use indicating the Resident required extensive assistance of one person. Section H (bladder and bowel) was coded to indicate the Resident was always incontinent of bowel. Section I (active diagnoses) was coded to indicate the Resident had an active diagnosis of constipation.

A review of the Residents BM history for February 2016 indicated that Resident #13 had a BM on 02/07/16 and did not have another BM until 02/12/16.

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The Residents POS included the order "11-7 nurse to review smart charting/BM documentation EVERY Monday and Thursday and notify MD if any bowel management issues identified."

A review of the Residents eTAR (electronic treatment administration record) indicated the 11-7 nursing staff had placed a check mark on the eTAR on Mondays and Thursdays for the entire month of February 2016.

For the month of February 2016 Resident #13 had a physician order for senna-docusate 8.6 mg/50 mg by mouth q (every) hs (bedtime/hour of sleep) prn (as needed). There was no documentation on the eMAR (electronic medication administration record) to indicate this medication had been given.

The surveyor was unable to locate any information to indicate the physician had been notified of any bowel management issues.

On 03/03/16 at approximately 12:20 p.m. the survey team meet with the administrator, DON (director of nursing), and ADON (assistant director of nursing). During this meeting the administrative team was notified of the above. The DON verbalized to the survey team that the night shift nurse (11-7) was supposed to review the BM sheets, could talk with the Resident, and if needed should make a referral to the physician. The DON stated the facility did not use standing orders and they tried not to let the Residents go longer than 3 days without a BM. The DON then stated after 3 days they should be doing an intervention with the physician.

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No further information regarding this issue was provided to the survey team prior to the exit conference

3 For Resident #15, the facility staff failed to assess and treat the Resident for bowel management issues. The Residents clinical record indicated the Resident did not have a BM (bowel movement) from 11/15/15-11/24/15, 11/26/15-12/06/15, 12/07/15-12/13/15, and from 12/14/15-12/25/15.

Resident #15 was admitted to the facility 03/04/15 and had expired at the facility on 12/26/15. Diagnoses included, but were not limited to, anxiety disorder, diabetes, hypertension, and metabolic encephalopathy.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/13/15 included a documented summary score of 1 out of a possible 15 points. Section G (functional status) was coded 3/2 for toilet use indicating the Resident required extensive assistance of one person. Section H (bladder and bowel) was coded to indicate the Resident was occasionally incontinent of bowel.

A review of the Residents BM history for November and December 2015 indicated that the Resident had a BM on 11/15/15 and did not have another BM until 11/24/15. Had a BM on 11/26/15 and did not have another BM until 12/06/15. Had a BM on 12/07/15 and did not have another BM until 12/13/15 and had a BM on 12/14/15 and did not have another BM until 12/25/15

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The Residents POS included the order "11-7 nurse to review smart charting/BM documentation EVERY Monday and Thursday and notify MD if any bowel management issues identified."

A review of the Residents eTAR's (electronic treatment administration records) indicated the 11-7 nursing staff had placed a check mark on the eTAR on Mondays and Thursdays for the months of November and December 2015.

The surveyor was unable to locate any information to indicate the physician had been notified of any bowel management issues.

On 03/03/16 at approximately 12:20 p.m. the survey team meet with the administrator, DON (director of nursing), and ADON (assistant director of nursing). During this meeting the administrative team was notified of the above. The DON verbalized to the survey team that the night shift nurse (11-7) was supposed to review the BM sheets, could talk with the Resident, and if needed should make a referral to the physician. The DON stated the facility did not use standing orders and they tried not to let the Residents go longer than 3 days without a BM. The DON then stated after 3 days they should be doing an intervention with the physician.

No further information regarding this issue was provided to the survey team prior to the exit conference.

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4. The facility staff failed to implement bowel management protocol when Resident #14 did not have bowel movements for 3 days.
The clinical record of Resident #14 was reviewed

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3/3/16. Resident #14 was admitted to the facility 12/11/14 and readmitted 2/3/16. Diagnoses included but were not limited to acute and chronic respiratory failure, chronic blood loss, acute on chronic renal failure, and generalized weakness. The significant change/5 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/10/16 assessed Resident #14's cognitive summary score as 03 out of 15 in Section C. Section G Functional Status coded Resident #14 to need limited assistance of 1 person for toilet use. Section H Bowel and Bladder assessed Resident #14 to be frequently incontinent of bowel.
The February 2016 physician orders read in part "11-7 nurse to review smart charting/BM (bowel movement) documentation EVERY Monday and Thursday and notify MD (medical doctor) if any bowel management issues identified."
The February 2016 electronic treatment administration record (eTAR) was reviewed. An entry on the eTAR read exactly as the physician order was written. Check marks and initials were present for 2/4/16, 2/8/16, 2/11/16, 2/15/16, 218/16, 2/22/16, 2/25/16 and 2/29/16. The surveyor reviewed the bowel movement documentation accessed through "Smart Charting." There were no bowel movements documented from 2/11/16 through 2/18/16.
The surveyor requested the assistant director of nursing for help in locating bowel movements for Resident #14. The ADON reviewed the bowel movement documentation and stated bowel movement documentation "fires off" to C.N.A.s (certified nursing assistants) from the activities of daily living constant. She stated the certified nursing assistant chart bowel movements. The 11-7 nurse checks the documentation and if the resident has not had a bowel movement, the

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nurse would notify the physician. The ADON stated the facility was going through a transition but nurses should be checking for bowel movements.
The surveyor informed the administrator, the director of nursing and the assistant director of nursing of the above finding on 3/3/16 at 12:10 p.m. The DON stated the nurses need to look at the bowel movement documentation. "If nothing documented, ask the resident. If that resident can tell you, that's ok. If they can't tell you, call the MD. There needs to be an intervention after 3 days."
No further information was provided prior to the exit conference on 3/3/16.
5. The facility staff failed to implement bowel management protocol when Resident #8 did not have bowel movements for 3 days.
The clinical record of Resident #8 was reviewed 3/2/16. Resident #8 was admitted to the facility 10/27/15 with diagnoses that included but not limited to constipation, Parkinson's disease, hypertension, diabetes mellitus type 2, and atherosclerotic heart disease.
The quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/2/16 assessed Resident #8 with a cognitive summary score of 02 out of 15 in Section C. Section G Functional Status assessed Resident #8 to require extensive assistance of two people for bed mobility, transfers and toilet use. Section H. Bowel and Bladder assessed Resident #8 to be incontinent of bowel occasionally.
The surveyor reviewed the smart charting for bowel movements for January 2016 through March 2016. There was no documentation that Resident #8 had bowel movements from 1/11/16 through 1/18/16 and from 2/5/16 through 2/12/16.

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The column for bowel movements was checked "no" for each of the previous dates. The January 2016 and February 2016 electronic treatment administration records had no recorded bowel movements.
The surveyor informed the director of nursing of the bowel movement concern on 3/2/16 at 12:00 noon.
The director of nursing informed the surveyor 3/2/16 at 1:00 p.m. that Resident #8 had been assessed, regular bowel sounds had been heard in all four quadrants of the abdomen. Resident #8 was not distended and had no complaints of pain when palpated. C.N.A. reported Resident #8 had a bowel movement 3/2/16.
The surveyor informed the administrator and the director of nursing of the above concern on 3/2/16 at 3:50 p.m. The director of nursing stated for the bowel movements, education had to be done.
The surveyor informed the administrator, the director of nursing and the assistant director of nursing of the above finding on 3/3/16 at 12:10 p.m. The DON stated the nurses need to look at the bowel movement documentation. "If nothing documented, ask the resident. If that resident can tell you, that's ok. If they can't tell you, call the MD. There needs to be an intervention after 3 days."
6. The facility staff failed to implement bowel management protocol when Resident # 6 did not have bowel movements for 3 days.
The clinical record of Resident #6 was reviewed 3/2/16. Resident #6's diagnoses included but were not limited to multiple sclerosis, paralytic ileus, paraplegia, volvulus, anemia, anxiety, depression, insomnia, irritable bowel syndrome, constipation, functional intestinal disorders, and colostomy.
Resident #6's quarterly minimum data set (MDS)

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assessment with an assessment reference date (ARD) of 2/5/16 assessed the resident with a summary score of 00 out of 15. Section G Functional Status assessed Resident #6 to be totally dependent on two persons for toilet use. Section H Bowel and Bladder was coded "9"-not rated, resident had an ostomy or did not have a bowel movement for the entire 7 days. H0100 Appliances was checked for an ostomy.
Resident #6's current comprehensive care plan dated 5/14/15 identified constipation as a problem with approaches: initiate standing orders for constipation on the third day if no bowel movement. Record bowel movement every shift. Colostomy bag care as needed. Colostomy output every shift.
The January 2016 physician orders, the February 2016 physician orders, and the March 2016 physician orders read in part "11-7 nurse to review smart charting/BM (bowel movement) documentation EVERY Monday and Thursday and notify MD (medical doctor) if any bowel management issues identified and colostomy care every shift."
The January 2016 electronic treatment administration record (eTAR), the February 2016 eTAR, and the March 2016 eTAR were reviewed. An entry on the eTAR read exactly as the physician orders were written for colostomy care and 11-7 nurse to review smart charting /BM documentation EVERY Monday and Thursday and notify MD if any bowel management issues. Colostomy care was checked and initialed for each day in January, February, and through March 3, 2016 and for each shift. 11-7 nurse checked the smart charting on 1/4/16, 1/7/16, 1/11/16, 1/14/16, 1/18/16, 1/21/16, 1/24/16, 1/28/16, 2/1/16, 2/4/16, 2/8/16, 2/11/16, 2/15/16, 2/18/16, 2/22/16, 2/25/16, 2/29/16, and 3/3/16.

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The surveyor reviewed the bowel movement documentation accessed through "Smart Charting". There were no bowel movements documented from January 2016 through March 3, 2016. The bowel movement documentation read "No matching records found."
The surveyor informed the administrator, the director of nursing and the assistant director of nursing of the above concern on 3/3/16 at 12:10 p.m. The DON stated the nurses need to look at the bowel movement documentation. "If nothing documented, ask the resident. If that resident can tell you, that's ok. If they can't tell you, call the MD. There needs to be an intervention after 3 days."
No further information was provided prior to the exit conference on 3/3/16
7 The facility staff failed to implement bowel management protocol when Resident #16 did not have bowel movements for 3 days.
The clinical record of Resident #16 was reviewed 3/3/16. Resident #16 was re-admitted to the facility 12/18/15 with diagnoses that included but not limited to osteomyelitis of lumbar vertebra, hypertension, constipation, heartburn and type 2 diabetes mellitus.
Resident #16's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/25/15 assessed the resident with a cognitive summary score of 12 out of 15. Section G Functional Status assessed Resident #16 to need extensive assistance of one person for toileting. Section H Bowel and Bladder assessed Resident #16 to be continent of bowel.
Current comprehensive care plan, dated 12/18/15, identified constipation as a problem with approaches to give medications as ordered, initiate standing orders for constipation on the third day of no bowel movement, and record

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bowel movement every shift.
The December 2015 and January 2016 physician orders read in part "11-7 nurse to review smart charting/BM (bowel movement) documentation EVERY Monday and Thursday and notify MD (medical doctor) if any bowel management issues identified."
The December 2015 and January 2016 electronic treatment administration records (eTAR) were reviewed. An entry on the eTAR read exactly as the physician orders were written. Check marks and initials were present for 12/21/15, 12/24/15, 12/28/15, 12/31/15, 1/4/16, 1/8/16, and 1/11/16.
The surveyor reviewed the bowel movement documentation accessed through "Smart Charting." There were no bowel movements documented from 12/18/15 through 1/1/16 and 1/10/16 through 1/13/16.
The surveyor informed the administrator, the director of nursing and the assistant director of nursing of the above concern on 3/3/16 at 12:10 p.m. The DON stated the nurses need to look at the bowel movement documentation. "If nothing documented, ask the resident. If that resident can tell you, that's ok. If they can't tell you, call the MD. There needs to be an intervention after 3 days."
No further information was provided prior to the exit conference on 3/3/16.
8. The facility staff failed to implement a bowel management protocol for Resident #1 when Resident #1 did not have bowel movements for 3 days.
Resident #1 was readmitted to the facility on 7/30/15 with the following diagnoses of, but not limited to high blood pressure, diabetes, thyroid disorder, anxiety, urinary tract disorder and constipation.
Resident #1's MDS (Minimum Data set, an assessment protocol) with an ARD (Assessment

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Reference Date) of 11/5/15 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 14 out of a total of 15. Resident #1 was also coded as being occasionally incontinent of bowel and bladder and required extensive assistance of 2 staff members for bathing.
A review of Resident #1 ' s clinical record was performed on 3/1/16. The January and February 2016 physician orders read in part " 11-7 nurse to review smart charting/BM (bowel movement) documentation EVERY Monday and Thursday and notify MD (medical doctor) if any bowel management issues identified. "
The January and February 2016 eTAR (electronic treatment administration record) was reviewed. Check marks and initials were present for the following dates: 1/3/16, 1/7/16, 1/11/16, 1/14/16, 1/18/16, 1/21/16, 1/25/16, 1/28/16, 2/1/16, 2/4/16, 2/8/16, 2/11/16, 2/15/16, 2/18/16, 2/22/16, 2/25/16 and 2/29/16. The surveyor reviewed the smart charting of Resident #1 for January and February 2016 and found no bowel movements documented for 1/1/16 through 1/5/16, 1/10/16 through1/19/16, 1/20/16 through 1/25/16, 1/27/16 through 1/31/16, 2/1/16 through 2/5/16, 2/6/16 through 2/14/16, 2/15/16 through 2/23/16 and 2/25/16 through 2/29/16.
On 3/2/16 at approximately 2 pm, the director of nursing was notified of the above documented findings. The director of nursing reviewed the bowel movement documentation and stated that the " CNA ' s document the resident having bowel movements on their daily living care charting. The nurses are to review this every Monday and Thursday night on 11-7 shift. If there are no bowel movements documented, the nurses will ask the resident if the resident has had a bowel movement if the resident able to tell the nurse, and if no bowel movements then they

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are to notify the physician of this. Either way, the nurses are to notify the physician of no bowel movements if a resident has had no bowel movements for 3 days."
The administrator and director of nursing were notified of the above documented findings on 3/3/16 at 12:10 pm in the conference room. The director of nursing stated that this was being looked at throughout the facility and changes would be taking place regarding this matter.
No further information was provided to the surveyor prior to the exit conference on 3/3/16.
9 The facility staff failed to implement a bowel management protocol for Resident #11 when Resident #11 did not have bowel movements for 3 days.
Resident #11 was admitted to the facility on 2/16/16 with the following diagnoses of, but not limited to high blood pressure, dementia, depression, weakness, upper respiratory infection and constipation. Resident #11's MDS (Minimum Data set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/29/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 00 out of a total of 15. Resident #11 was also coded as being always incontinent of bowel and bladder and required extensive assistance of 2 staff members for bathing.
A review of Resident #11's clinical record was performed on 3/3/16. The February and March 2016 physician orders read in part "11-7 nurse to review smart charting/BM (bowel movement) documentation EVERY Monday and Thursday and notify MD (medical doctor) if any bowel management issues identified."
The February and March 2016 eTAR (electronic treatment administration record) was reviewed. Check marks and initials were present for the

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F 309	Continued From page 26 following dates: 2/18/16, 2/22/16, 2/25/16, 2/28/16 and 3/3/16. The surveyor reviewed the smart charting of Resident #11 for February and March 2016 and found no bowel movements documented for 2/22/16 through 2/26/16 and 2/27/16 through 3/2/16. On 3/3/16 at 10 am, the director of nursing was notified of the above documented findings. The director of nursing reviewed the bowel movement documentation and stated that the " CNA ' s document the resident having bowel movements on their daily living care charting. The nurses are to review this every Monday and Thursday night on 11-7 shift. If there are no bowel movements documented, the nurses will ask the resident if the resident has had a bowel movement if the resident able to tell the nurse, and if no bowel movements then they are to notify the physician of this. Either way, the nurses are to notify the physician of no bowel movements if a resident has had no bowel movements for 3 days. " The administrator and director of nursing were notified of the above documented findings on 3/3/16 at 12:10 pm in the conference room. The director of nursing stated that this was being looked at throughout the facility and changes would be taking place regarding this matter. No further information was provided to the surveyor prior to the exit conference on 3/3/16. 10. The facility staff failed to administer Resident # 19 ' s medication as ordered by the physician. Resident #19 was readmitted to the facility on 9/16/15 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, diabetes, blood clot and gout. On the quarterly MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 3/2/16, Resident #19 was coded as having a BIMS (Brief Interview for	F 309		

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	495386		03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRINGTON PLACE AT BOTETOURT COMMONS	290 COMMONS PARKWAY DALEVILLE, VA 24083

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F 309 Continued From page 27

F 309

Mental Status) score of 3 out of a total score of 15. The resident was also coded as requiring extensive assistance by 1 staff member for dressing, personal hygiene and bathing.
On medication pass with licensed practical nurse (LPN) #1 on 3/2/16 at 8:40 am, LPN #1 gave the following medication to Resident #13: Mobic 7.5 mg 1 tablet by mouth. The resident was given water to take the medication with as observed by the surveyor.
The physicians ' orders for March 2016 were reviewed. It stated " Mobic 7.5 mg (milligram) by mouth every day for pain. Take with food. " The packaging from the pharmacy had a label on it that stated " Take with food. "
The surveyor asked LPN #1 what time the resident has breakfast on the morning of 3/2/16. LPN #1 stated that the resident went to the dining room about 7:30 am and ate breakfast at that time. The surveyor asked LPN #1 to read over the order for the medication Mobic. LPN #1 stated, " I didn ' t give it with any food. "
The director of nursing and administrator was notified of the above documented findings on 3/2/16 at approximately 4:30 pm in the end of the day conference.
The director of nursing informed the surveyor on 3/3/16 that a full audit of all residents receiving medications with food were captured and the staff was in service on the aspect of administering medications with food when it was ordered to do so.
No further information was provided to the surveyor prior to the exit conference on 3/3/16.

F 371 483.35(i) FOOD PROCURE,
SS=F STORE/PREPARE/SERVE - SANITARY

F 371

The facility must -

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F 371	Continued From page 28 (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon staff interview and facility document review, the facility staff failed to document tray line temperatures for each meal in the facility kitchen. The findings included: Upon review of documentation of the facility kitchen on 3/1/16, it was noted by the surveyor that the tray line temperatures for the following dates were left blank: 1/15/16 breakfast and lunch, 2/4/16 dinner, 2/12/16 breakfast and lunch, 2/20/16 breakfast and lunch and 2/26/16 lunch. The dietary manager was asked by the surveyor for a copy of the policy and procedure on obtaining and documenting tray line temperatures. A " Tray Line Checklist " was provided to the surveyor which stated the following: " ...Food should be put on steam table no more than ½ hour prior to the start of service and should be at 135 degrees or hotter. Temperatures should be taken and recorded ... " The regional dietary manager was notified of the above documented findings on 3/2/16 at approximately 8 am in the conference room. The surveyor asked what the expectation of the staff was in regards to obtaining and documenting tray line temperatures. The regional dietary	F 371	The missing tray line temperatures noted during survey was unable to be corrected Inservices were initiated 3/2/16 and will be provided to all dietary staff to include; *Policy and procedure on tray line checklist An audit of documentation of tray line temperatures was completed 3/2/16 and are current to date The dietary manager and/or designee will audit tray line temperature logs for any non compliance with follow up no less than five (5) days a week for eight (8) weeks Findings of audits will be reported to the QA Committee who will determine the need or duration of future audits RECEIVED MAR 30 2016 VDH/OLC	4/17/16

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F 371 Continued From page 29

F 371

manager stated " They should be taken before each meal when the food is placed on the tray line and then recorded on these sheets daily. " At approximately 2 pm on 3/2/16, the dietary manager gave the surveyor an in service record which stated for " all food temps (temperatures) are to be obtained prior to the meal service and documented on tray line checklist ... " The dietary manager stated that in services had begun with all staff as of 3/2/16 at 1040 am. The administrator and director of nursing were notified of the above findings on 3/2/16 at approximately 4 30 pm in the conference room No further information was provided to the surveyor prior to the exit conference on 3/3/16

F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

F 431

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to

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F 431 Continued From page 30
have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by.
Based on observation and staff interview, the facility staff failed to dispose of an expired medication on 1 of 2 units (Blue Ridge).

The findings included:

The medication room on the Blue Ridge unit included an expired bottle of zinc sulfate

During initial tour of the facility on 03/01/06 beginning at approximately 2:55 p.m. the surveyor and the ADON (assistant director of nursing) entered the medication room on the Blue Ridge unit.

The shelf in this medication room included numerous bottles of unopened medication. This shelf included 1 bottle of 100 tabs of zinc sulfate with an expiration date of 11/2015.

The ADON was shown the bottle and acknowledged the expiration date. The ADON removed the bottle from the supply.

F 431
The unopened expired Zinc was immediately removed from the medication storage shelf on 3/1/16

DON and ADON completed an audit on both medication rooms and medication carts 3/1/16 No other expired medications were noted

Inservices will be provided to all RN and LPNs to include:

*Policy and procedure on the storage of medications and supplies

The DON, ADON and Charge Nurses will make rounds pf medication rooms and medication carts to monitor for non compliance no less than three (3) days a week for eight (8) weeks

Findings of audits will be reported to the QA Committee who will then determine the need or duration of future audits 4/17/16

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F 431 Continued From page 31

The administrator and DON (director of nursing) were notified of the expired medication during a meeting with the survey team on 03/02/16 at approximately 3:45 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 441 483.65 INFECTION CONTROL, PREVENT
SS=D SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) 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.
(3) The facility must require staff to wash their

F 431

F 441

The aide was stopped immediately from exiting resident room on initial tour 3/1/16 per ADON
The aide was re-educated
3/1/16 in regards to the facilities policy and procedure on isolation

DON and ADON completed an audit on all current inhouse residents 3/1/16
No other residents are on specified isolation precautions at this time

Inservices will be provided to all staff to include:

*Policy and procedure on specified isolation precautions.

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F 441	Continued From page 32 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control guidelines for 1 of 19 residents (Resident #3). The findings included: The facility staff failed to follow infection control guidelines when entering Resident #3's room. Resident #3 was on contact isolation. The staff failed to don personal protective equipment before entering Resident #3's room. The clinical record of Resident #3 was reviewed 3/1/16 and 3/2/16. Resident #3 was admitted to the facility 2/13/16 with diagnoses that included but not limited to Clostridium difficile colitis (C. Diff), muscle weakness, congestive heart failure, osteoarthritis, chronic kidney disease, and urinary retention. The admission minimum data set (MDS) with an assessment reference date (ARD) of 2/20/16 for Resident #3 was reviewed 3/1/16. Section C Cognitive Patterns had dash marks from C0100 through C1600. Section D Mood had dash marks from D0100 through D0650. The current comprehensive care plan dated 2/29/16 read "Infection C-Diff. Goal: Will be free from infection by next review. Meds	F 441	The DON, ADON and Charge Nurses will make rounds on any isolation rooms to monitor for any non-compliance no less than three (3) days a week for eight (8) weeks Findings of isolation rounds will be reported to the QA Committee who will determine the need or duration of future audits.	4/17/16

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F 441	Continued From page 33 (medications)/TX (treatment) as ordered. Isolation as ordered." The surveyor toured the 400 and 500 halls of the Blue Ridge unit on 3/1/16 beginning at 2:55 p.m. with the director of nursing then finished hall 600 with the assistant director of nursing (ADON). When the surveyor and the assistant director of nursing toured Resident #3's room, the surveyor observed a sign on the door that read "Contact Precautions" and three stacked drawers at the entrance to the room that contained personal protective equipment (PPE) to use for isolation. While receiving information about Resident #3, a certified nursing assistant (C.N.A.) entered the room. C.N.A. #1 entered the room and began adjusting Resident #3's oxygen tubing. She was not observed to stop and don personal protective equipment prior to entering Resident #3's room. The assistant director of nursing spoke to C.N.A. #1 about infection control guidelines and the need to use PPE when taking care of Resident #3. The surveyor interviewed the ADON after her discussion with the certified nursing assistant. She stated C.N.A. #1 should have gowned and dressed out before entering Resident #3's room. The surveyor requested the facility policy on infection control. The surveyor interviewed C.N.A. #1 on 3/1/16 at 5:10 p.m. She stated she was nervous but had been taught about the use of PPE. She stated she thought she would be in Resident #3's room for just a second. The surveyor reviewed the infection control policy on Clostridium Difficile on 3/1/16. The policy read in part under policy interpretation and implementation "10.Healthcare workers and visitors will wear gloves and gowns when entering the room of a resident with C. difficile infection." The surveyor informed the administrator and the	F 441		

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

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F 441	Continued From page 34 director of nursing of the above concern during a meeting on 3/2/16 at 3:50 p.m No further information was provided prior to the exit conference on 3/3/16.	F 441		

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PRINTED: 03/23/2016
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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F 000	Initial Comments	F 000		
	An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 3/1/16 through 3/3/16 Corrections are required for complainace with the following Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow			
	The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 15 current Resident reviews (Residents 1 through 14 and 19) and 4 closed record reviews (Residents 15 through 18)			
F 001	Non Compliance	F 001		
	The facility was out of compliance with the following state licensure requirements			
	This RULE: is not met as evidenced by: A Biennial State Licensure Inspection was conducted 3/1/16 through 3/3/16. The facility was not in compliance with the following Virginia Nursing Home Rules and Regulations:			
	12 VAC 5-371-140 (A, D, 12, E.2, E.3): cross reference to F- 226. 12 VAC 5-371-14-250 (D, E): cross reference to F- 278. 12 VAC 5-371-220 A: cross reference to F- 309. 12 VAC 5-371-340 (A): cross reference to F-371 12 VAC 5-371-300 (J.3): cross refermece to F-431 12 VAC 5-371-180 (A,B C): cross reference to F-441.			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael P. [signature] | TITLE: Executive Director | (X6) DATE: 3/28/2016