<table>
<thead>
<tr>
<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<tbody>
<tr>
<td>(X1) ID</td>
<td>495086</td>
<td>A BUILDING</td>
<td>03/12/2015</td>
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<tr>
<td>NAME OF PROVIDER OR SUPPLIER</td>
<td>KINDRED TCC AND REHABILITATION-BAY POINTE</td>
<td>B WING</td>
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<tr>
<td>STREET ADDRESS, CITY, STATE, ZIP CODE</td>
<td>1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454</td>
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<tr>
<th>F 000 INITIAL COMMENTS</th>
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<tr>
<td>An unannounced Medicare/Medicaid standard</td>
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<td>survey was conducted 3/10/15 through 3/12/15.</td>
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<td>Two complaints were investigated during the</td>
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<td>survey. Corrections are required for</td>
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<tr>
<td>compliance with the following 42 CFR Part</td>
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<td>483 Federal Long Term Care requirements.</td>
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<td>The census in this 145 certified bed facility</td>
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<td>was 100 at the time of the survey. The survey</td>
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<td>sample consisted of 22 resident reviews: 18</td>
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<td>current residents (Residents #1 through #17 and</td>
<td></td>
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<tr>
<td>#21) and 4 closed record reviews (Residents</td>
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<td>#18 through #20 and #22).</td>
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<tr>
<td>F 278 483.20(g) - (j) ASSESSMENT</td>
<td>F 278</td>
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<tr>
<td>SS=D ACCURACY/COORDINATION/CERTIFIED</td>
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<td>The assessment must accurately reflect the</td>
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<td>resident's status.</td>
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<td>A registered nurse must conduct or coordinate</td>
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<td>each assessment with the appropriate</td>
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<td>participation of health professionals.</td>
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<td>A registered nurse must sign and certify that</td>
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<td>accuracy of that portion of the assessment.</td>
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<td>Under Medicare and Medicaid, an individual</td>
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<td>who willfully and knowingly certifies a</td>
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<td>material and false statement in a resident</td>
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<td>assessment is</td>
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<td>This Plan of Correction is the center's</td>
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<td>credible allegation of compliance.</td>
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<td>Preparation and/or execution of this plan of</td>
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<td>correction does not constitute admission or</td>
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<td>agreement by the provider of the truth of the</td>
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<td>facts alleged or conclusions set forth in the</td>
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<td>statement of deficiencies. The plan of</td>
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<td>correction is prepared and/or executed solely</td>
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<td>because it is required by the provisions of</td>
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<td>federal and state law.</td>
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| LABORATORY DIRECTOR OR PROVIDER/SUPPLIER/      | TITLE                                      |
| REPRESENTATIVE'S SIGNATURE                     |                                            |
| (X8) DATE                                    |                                            |
|                                               |                                            |

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 discloseable 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 discloseable 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.

FORM CMS-2567(02-09) Previous Versions Obsolete
Event ID: QEEQ11
Facility ID: VA0022
If continuation sheet Page 1 of 24
F 278 Continued From page 1

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 clinical record review, observation, resident interview, staff interview, and review of the facility's policy, the facility staff failed to accurately code the indwelling urinary catheter (including suprapubic catheter and nephrostomy tube) on the Minimum Data Set (MDS) assessments for 2 of 22 residents (Resident #6 and #3), in the survey sample.

The facility staff dashed (-) "H0100A" on the MDS assessments for Residents #6 and #3 instead of checking use of an indwelling catheter over the 7 days look back period.

The findings included:

Resident #6 was originally admitted to the facility 11/23/13 and readmitted 1/1/15. The current diagnoses are neurogenic bladder, stroke, paraplegia, anemia, hypertension, and pressure ulcer of the buttock.

The quarterly MDS assessment with an
F 278 Continued From page 2

assessment reference date of 2/20/15 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15/15 indicating no problems in cognitive skills for daily decision making.

In section "H" (Bladder and Bowel) the resident was coded with dashes at "H0100A" and not rated, resident had a catheter (Indwelling, condom), urinary ostomy, or no urine output for the entire 7 days at "H0300".

Section "H" of the MDS 3.0 RAI (Resident Assessment Instrument) Manual contains instructions on coding suprapubic catheters. Page H-1 defines a suprapubic catheter as:
SUPRAPUBIC CATHETER  An indwelling catheter that is placed by a urologist directly into the bladder through the abdomen. This type of catheter is frequently used when there is an obstruction of urine flow through the urethra.
Page H-2 contains instructions on correct coding of Section H:
Coding Instructions Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances A-D were used in the past 7 days.
- H0100A, indwelling catheter (including suprapubic catheter and nephrostomy tube)
- H0100B, external catheter
- H0100C, ostomy (including urostomy, ileostomy, and colostomy)
- H0100D, intermittent catheterization
- H0100Z, none of the above

Coding Tips and Special Populations
Suprapubic catheters and nephrostomy tubes should be coded as an indwelling catheter (H0100A) only and not as an ostomy (H0100C).
The care plan dated 1/2/15 read, Problem: ... has a suprapubic catheter due to neurogenic bladder/paraplegic. Goal: ...will not develop any complications associated with catheter use through next review 5/20/15. Interventions: Administer/monitor effectiveness of medications as ordered. Change drainage bag per policy. Monitor for signs/symptoms of discomfort on urination and frequency. Labs as ordered and report results to physician. Resident has 16 French with 30 cubic centimeter balloon suprapubic catheter.

Resident #6 was observed in the wheelchair on 3/11/15 dressed in black sweats. Resident #6 stated the suprapubic catheter had been leaking the night before and the nurse had come in and changed it. Clear amber urine was observed draining into a bedside drainage bag seated on the footrest of the wheelchair. Resident #6 was asked by the surveyor if an indwelling catheter was in use during the entire month of February 2015. Resident #6 stated the suprapubic catheter was in use the entire month of February 2015.

An interview was conducted with the MDS coordinator on 3/12/15 at approximately 3:35 p.m. The MDS coordinator stated Resident #6 did have an indwelling catheter in place during the look back period 2/14/15 - 2/20/15 but the facility had received instructions from Medicare to dash “H0100A” on the MDS assessment if the resident had a diagnosis of neurogenic bladder or obstructive uropathy. The surveyor asked the
MDS coordinator to provide the document from Medicare which gave the facility the directives on coding the MDS for indwelling catheters. The MDS coordinator presented a document titled Quick Catch Nursing Center Division Case Management Kindred Healthcare dated 9/16/14.

The Administrator stated on 3/12/15 at approximately 3:38 p.m. the facility does not have a policy for coding the MDS; they follow the Resident Assessment Instrument (RAI).

The RAI MDS 3.0 manual states at chapter 3 page 4:
Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing System (ASAP).

- A dash value means an item has not been assessed. This most often occurs when a resident is discharged before an item has been assessed.
- Dashed values allow an assessment to be submitted when an assessment is required for payment purposes.
- There are 4 date items (A2400C, O0400A6, O0400B6, O0400C6) that use a dash-filled value to indicate the event has not yet occurred...
2. The facility staff failed to accurately code Resident #3's Minimum Data Set (MDS) for the use of an indwelling urinary catheter.

Resident #3 was admitted to the nursing facility on 11/25/13 with diagnoses that included multiple sclerosis, chronic respiratory failure with tracheostomy (trach), paraplegia, chronic osteomyelitis, neurogenic bladder with an indwelling suprapubic urinary catheter, morbid obesity, high blood pressure, gastroesophageal reflux disease (GERD) and urostomy tube.

The most recent Minimum Data Set (MDS) was a quarterly dated 1/27/15 and coded Resident #3 with a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident had no problems in cognitive skills for daily decision making. Resident #3 was coded with a "9" in section H0300. Urinary Continence, not rated, resident had an ostomy or no urine output for the entire 7 days. In section H0100. Appliances, there were dashes in the box beside A. Indwelling catheter (including suprapubic catheter and nephrostomy tube) and Z. (None of the above).

Resident #3 had a care plan dated 2/10/15 for a suprapubic catheter due to a neurogenic bladder diagnosis.

During the entire survey, on 3/10/15 through 3/12/15, Resident #3 was observed to have a suprapubic catheter.

An interview was conducted with the MDS.
F 278  Continued From page 6  

F 278

coordinator on 3/12/15 at approximately 3:35 p.m. Two surveyors were present during the interview. The MDS coordinator stated the facility had received instructions from Medicare to dash " H0100A" on the MDS assessment if the resident had a diagnosis of neurogenic bladder or obstructive uropathy. The surveyor asked the MDS coordinator to provide the document from Medicare which gave the facility the directives on coding the MDS. The MDS coordinator presented a document titled Quick Catch Nursing Center Division Case Management Kindred Healthcare dated 9/18/14.

On 3/12/15 at approximately 4:15 p.m. the above findings were shared with the Administrator, Director of Nursing and corporate representative. No additional information was provided to the survey team.

F 281

483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on observations during a medication pass, clinical record review, staff interviews and facility documentation the facility staff failed to ensure professional standards of quality were met during the administration of medications for 1 of 22 residents (Resident #14) in the survey sample. Registered Nurse (RN) #2 poured liquid Colace (a stool softener) medication in and out of its multi-dose bottle, using a 30 milliliter (ml) medicine cup, until she acquired the prescribed amount and administered it to the resident.

F 281  

1. RN #2 was provided a one to one in-service by the DNS on the correct procedure for pouring liquid medication.

2. Residents with liquid medications administered by nursing staff have been identified as having the potential to be affected.

3. SDC (Staff Development Coordinator) and DNS have in-serviced Licensed Nurses on procedure for pouring liquid medication. SDC, DNS, Nurse Supervisor will randomly observe three Licensed Nurses a week pouring liquid medication during medication administration pass to validate the correct procedure is being followed. During their probationary period, newly hired licensed nurses will be in-serviced on procedure for pouring liquid medication.

4. Results of the audits will be reviewed by the DNS or SDC in the center's monthly Quality Assurance and Performance Improvement Meeting for a minimum three months or until the Quality Assurance and...
Continued From page 7

dose.

The findings included:

Resident #14 was re-admitted to the nursing facility on 2/14/15 with diagnoses that included constipation.

Resident #14 had physician’s orders dated 2/15/15 for Colace 50 milligrams (mg) 5 ml twice a day (BID).

During a medication pass observation on 3/11/15 at 9:00 a.m., RN #3 poured liquid Colace medication in and out of its multi-dose bottle, using a 30 ml medicine cup, until she acquired 5 ml.

An interview was conducted with the Director of Nursing (DON) on 3/11/15 at 11:00 a.m. She stated the overage of a poured medication should be discarded and never poured back into a multi-dose bottle of any type of medication.

The above aforementioned observation was shared with the Administrator, Corporate nurse and revisited with the DON on 3/12/15 at 4:30 p.m. No further information was provided to the survey team.

The facility’s policy and procedure entitled “Oral Medication Administration” dated 4/28/09 indicated the following:

“If medication is a multi-dose bottle, removes bottle cap from multi-dose bottle and places cap upside down on work surface. Holds bottle with label against palm of hand while pouring. Pours liquid medication at eye level. Pours the desired volume of liquid so that base of meniscus is level..."
F 281 Continued From page 8
with line on the scale. Discards any excess liquid into a sink. Wipes the lip and neck of the bottle with a paper towel and recaps the bottle."

Potter and Perry 7th Edition Chapter 35 page 721
Administering Oral Medications
To prepare liquids:
2) Hold multi-dose bottle with label against palm of hand while pouring.
3) Hold medication cup at eye level, and fill to desired level on scale. Make sure scale is even with fluid level at its surface or base of meniscus, not edges. Draw up volumes less than 10 mL in syringe without needle. Rationale: (Ensures accuracy of measurement. Use of syringe is more accurate for small doses of medication.)
4) Discard any excess liquid into sink. Wipe lip and neck of bottle with paper towel. Rationale: (Prevents contamination of bottle's contents and prevents bottle cap from sticking.)

F 309 483.25 PROVIDE CARE/SERVICES FOR
SS=D 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 observations during a medication pass, clinical record review, staff interview and facility documentation, the facility staff failed to ensure physician's orders were in place for the

F 309 483.25 PROVIDE CARE/SERVICES FOR
SS=D 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 observations during a medication pass, clinical record review, staff interview and facility documentation, the facility staff failed to ensure physician's orders were in place for the
F 309 Continued From page 9

delivery of care for 1 of 22 residents (Resident #14) in the survey sample. Resident #14 did not have a current physician’s order for the medication multivitamin with minerals.

The findings included:

Resident #14 was re-admitted to the nursing facility on 2/14/15 with diagnoses that included multiple sclerosis, muscle weakness, swallowing problems, paraplegia, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), high blood pressure, neurogenic bladder, mood disorder, dementia, constipation, diabetes and unspecified psychosis.

Resident #14 most recent Minimum Data Set (MDS) was a re-entry dated 2/14/15 and coded the resident with short term memory and moderately impaired in the skills needed for daily decision making.

The care plan dated 2/16/15 indicated the resident was on multiple medications for his medical conditions. They were to be administered per physician’s orders.

Observations during a medication pass on 3/11/15 at 9:00 a.m. revealed there was no current signed physician’s order for the multivitamin that was administered to Resident #14. The order printed on the Physician’s Order Sheet (POS) for March 2015 dated 2/15/15 for Therapy M (a multivitamin with minerals) was circled and “D/C” was written over it. Registered Nurse (RN) #3 who was administering medication at the time stated the facility used the over the counter stock (OTC) multivitamin with minerals and even though it was the same medication, it clarifying physician’s orders as needed to ensure medication is being administered per physician’s order.

4. Results of the audits will be reviewed by the DNS or SDC in the center’s monthly Quality Assurance and Performance Improvement Meeting for a minimum three months or until the Quality Assurance and Performance Improvement Committee deems compliance is sustained ongoing. The Quality Assurance and Performance Improvement Committee will make recommendations and determine the need for further auditing to ensure compliance is sustained ongoing.
F 309 Continued From page 10

needed to print out "multivitamin with minerals". When asked why she did not get the pharmacy to correct the wording instead of writing discontinued over the Therapy M she stated, it was happening all over the building with other residents and she expected it to correct itself. On 3/12/15, the March POS had written at the bottom of the second page "3/11/15 MVI with minerals one tab by mouth (PO) daily, with the 3/11/15 crossed through and "2/14/15" written over it.

On 3/12/15 at 11:00 a.m., the Director of Nursing (DON) was asked where the order came from for the MVI with minerals and she stated, "It was obtained after (this surveyor's name) brought it to our attention, but I never told her to cross through and put 2/14/15. I made her put 3/11/15 as the actual date the order was obtained."

The facility's policy and procedures entitled "Physician's Orders" dated 11/21/12 indicated physician's orders are administered only upon clear, complete and signed order of a person lawfully authorized to prescribe.

On 3/12/15 at approximately 4:30 p.m., the aforementioned observations were shared with the Administrator, the Corporate Nurse and re-visited with the DON. No further information was provided to the survey team.

F 323 483.25(h) FREE OF ACCIDENT SS=D HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.

This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

1. RN #3 and the Licensed Nurse Orientee observing RN#3 were provided a one to one in-service by the DNS related to maintaining resident safety by properly storing medications securely in the medication cart when leaving the medication cart unattended.

2. Residents residing in the center have the potential to be affected.

3. DNS or SDC in-serviced Licensed Nurses on to maintaining resident safety by properly storing medications securely in the medication cart when leaving the medication cart unattended. DNS, SDC or Nurse Supervisor will randomly observe three nurses a week perform medication administration pass for three residents to validate medications are properly stored in the medication cart when leaving the medication cart unattended. During their probationary period, newly hired Licensed Nurses will be in-serviced to maintaining resident safety by properly storing medications securely in the medication cart when leaving the
F 323  Continued From page 11

This REQUIREMENT is not met as evidenced by:
Based on observations during a medication pass, staff interview and facility documentation, the facility staff failed to ensure the facility remained as free of hazards as possible on one of two units in the nursing facility. Seven cards of medications were left on top of the medication cart out of sight of the two nurses who entered a room to administer medications and provide care to a resident.

The findings included:

During a medication pass observation on 3/11/15 at 9:00 a.m., Registered Nurse (RN) #3 left 7 cards of medications on the medication cart while she entered a resident's room to administered the resident by the window medications. The orientee with RN #3 was also in the room obtaining a blood pressure and assisting the RN to reposition the resident.

During the 8 minutes the two nurses were in the room, a resident was standing the entire time at the medication cart waiting for his medications. Several resident and staff also passed the medication cart. When brought to her attention, she stated it was her practice to put all medications away after pouring medications and prior to entering a resident's room. She was aware there was a resident at the medication cart when she was pouring another resident's medications and told him she would be back to give him his medications.

medication cart unattended 4.9.15

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

4. Results of the audits will be reviewed by the DNS or SDC in the center's monthly Quality Assurance and Performance Improvement Meeting for a minimum three months or until the Quality Assurance and Performance Improvement Committee deems compliance is sustained ongoing. The Quality Assurance and Performance Improvement Committee will make recommendations and determine the need for further auditing to ensure compliance is sustained ongoing.
On 3/11/15 at 11:00 a.m. the aforementioned observation was brought to her attention. She stated she expected medications not to be left on an unattended medication cart because it was a safety issue and a privacy issue.

On 3/12/15 at approximately 4:30 p.m., the aforementioned observations were shared with the Administrator, the Corporate Nurse and the DON. No further information was provided to the survey team.

The facility’s policy and procedure entitled Accident/Hazard Risk Assessment dated 2/28/14 indicated environmental hazards included but was not limited to access to chemicals, toxic’s or other hazards such as housekeeping chemicals and supplies and medications...The facility provides an environment free from hazards over which they have control to reduce the risk of avoidable accidents by residents and employees.

The facility must ensure that residents receive proper treatment and care for the following special services:
- Injections;
- Parenteral and enteral fluids;
- Colostomy, urostomy, or ileostomy care;
- Tracheostomy care;
- Tracheal suctioning;
- Respiratory care;
- Foot care; and
- Prostheses.

1. Resident #3 tracheostomy care is being performed per policy. DNS provided LPN #3 a one to one in-service with return demonstration on tracheostomy care.

2. Residents with tracheostomies have been identified as having the potential to be affected.

3. DNS or SDC provided Licensed Nurses an in-service on performing tracheostomy care per policy. DNS, SDC or Nurse Supervisor will randomly observe three nurses a week performing tracheostomy care to validate care is performed per policy. During their orientation period, newly hired Licensed Nurses will be inserviced on an in-service on performing tracheostomy care per policy.

4. Results of the audits will be reviewed by the DNS or SDC in the center’s monthly Quality Assurance and Performance Improvement Meeting for a minimum three months or until the Quality Assurance and Performance Improvement
F 328 Continued From page 13
This REQUIREMENT is not met as evidenced by
Based on observations, clinical record review, staff and resident interview and facility documentation, the facility staff failed to ensure proper respiratory care was provided for 1 of 22 residents (Resident #3) in the survey sample. Resident #3 was not provided tracheostomy care in accordance with the standards of nursing practice.

The findings included:

Resident #3 was admitted to the nursing facility on 11/25/13 with diagnoses that included multiple sclerosis, chronic respiratory failure with tracheostomy (trach), paraplegia, chronic osteomyelitis, neurogenic bladder, morbid obesity, high blood pressure, gastroesophageal reflux disease (GERD) and urostomy tube.

The most recent Minimum Data Set (MDS) was a quarterly dated 1/27/15 and coded Resident #3 with a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident had no problems in cognitive skills for daily decision making. The resident was coded with special treatments to include a tracheostomy with trach care, oxygen therapy and suctioning.

A tracheostomy is an opening or stoma in the trachea through the anterior neck at the level just below the vocal cords. It is created during a surgical tracheostomy procedure (Kornusky, Jennifer and Capie, J.K. August 23, 2013, Tracheostomy care: Providing. Glendale: cinahl Information Systems).
F 328  Continued From page 14

The care plan dated 2/10/15 identified Resident #3 had a tracheostomy. The goal the staff set for the resident was that there would be no signs or symptoms of infection through target date of 4/27/15. Some of the interventions the staff would use to accomplish this goal included universal precautions and daily tracheostomy care and as needed.

On 3/12/15 at 11:15 a.m. tracheostomy (trach) care was observed by licensed practical nurse (LPN) #3. Prior to starting the procedure, the LPN stated she was the one other staff, other than the respiratory therapist, that performed trach care and was very familiar with the process and had performed the care for other trach residents, as well. She proceeded to place two tracheostomy kits on a blue Chux (brand name) pad along with a bottle of hydrogen peroxide, a bottle of normal saline and six packages of trach sponges. The LPN opened one of the trach kits, removed and donned a set of blue colored sterile gloves. She filled one side of the kit's reservoir with peroxide and proceeded to dip 4x4 sponge gauze pads, squeeze out the peroxide and clean the resident's skin under the left and right side of the trach ties and replaced the pads under both sides. The trach ties were visibly soiled with a brown substance. She removed the old soiled trach sponge, obtained more 4x4 gauze sponges, dipped them in hydrogen peroxide several times as she washed above and below the trach stoma without changing her gloves. She removed the old disposable inner cannula from the outer cannula with the same gloves, opened a package with a new sterile disposable inner cannula and replaced it inside the outer cannula. Using the same gloves, she opened a packaged trach sponge and placed it under the flange next the
stoma. The LPN left copious amounts of gray tan crusted secretions around the stoma, on and in the crevices of the outer cannula. The LPN was asked what she used the sterile gloves for, to which she responded, "I used them to clean around the trach." LPN #3 kept the same sterile gloves on throughout the entire trach care process. Throughout the procedure she also readjusted the resident's gown and covers using the same gloves.

On 3/12/15 at 1:45 p.m., an interview was conducted with Registered Nurse (RN) #2. She stated she was responsible for training licensed nurses to include tracheostomy care. She stated she expected regular gloves to be used when removing soiled dressing and the sterile gloves to be used when removing the inner cannula and when cleaning the stoma site, as well as replacing the inner cannula. She also said changing gloves and hand hygiene in between was an expected practice to prevent cross contamination to what the nurse was attempting to clean, as well as other surfaces. According to the RN, it was not appropriate to dip back into the reservoir of hydrogen peroxide with soiled gloves and continue cleaning the site. She was able to produce an inservice record with sign in sheet where LPN #3 had attended.

On 3/12/15 at 2:25 p.m., RN #2 and the Respiratory Therapist (RT) stated they went over the trach care procedure with LPN #3 early in the day because they knew she was going to be observed performing trach care by a surveyor. The RT stated she thought she understood the procedure well when she went over it with her, but did not see her perform hands on.
F 328 Continued From page 16

On 3/12/15 at 2:35 p.m., RN #2 went back to Resident #3 with this surveyor and observed Resident #3’s trach and stoma site. RN #2 apologized to Resident #3 and stated, “This is not done correctly and we will have to do it again. She (referring to LPN #3) left a lot of secretions around your stoma which could block your breathing and create infection. The ties will be changed too because they looked soiled.”

On 3/12/15 at 3:00 p.m., the Director of Nursing (DON) stated she was specifically training LPN #3 on trach care and would be setting up house wide mandatory re-training for all licensed nurses.

According to the facility’s policy and procedure entitled “Tracheostomy Care” dated 2/28/14 it indicated tracheostomy care involved performing stoma site care and cleaning and replacing the tracheostomy tube inner cannula. Although the procedure is performed primarily to control the build up of secretions that can potentially obstruct the artificial airway, it is also necessary to maintain the integrity of the skin at the stoma site; which is prone to inflammation (i.e., stomatitis) and healthcare-acquired infection. The policy also supported RN #2’s statements regarding the procedure for trach care.

On 3/12/15 at approximately 4:30 p.m., the aforementioned observations were shared with the Administrator, the Corporate Nurse and the DON. No further information was provided to the survey team.

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

The facility must establish and maintain an
F 441 Continued From page 17

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 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 observations, clinical record review.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 441

week pouring liquid medication during medication administration pass to validate the correct procedure is being followed.

During their probationary period, newly hired Licensed Nurses will be in-serviced on performing tracheostomy care per policy and the procedure for pouring liquid medication.

4. Results of the audits will be reviewed by the DNS or SDC in the center's monthly Quality Assurance and Performance Improvement Meeting for a minimum three months or until the Quality Assurance and Performance Improvement Committee deems compliance is sustained ongoing. The Quality Assurance and Performance Improvement Committee will make recommendations and determine the need for further auditing to ensure compliance is sustained ongoing.
F 441 Continued From page 18

staff interviews and facility documentation, the facility staff failed to ensure infection control measures were provided to prevent the possible transmission of infection for 2 of 22 residents (Resident #3 and #14) in the survey sample.

1. Resident #3 was not provided tracheostomy care to prevent the possible transmission of infection.

2. The licensed nurse poured liquid Colace (a stool softener) medication in and out of its multi-dose bottle using a standard 30 ml medication cup until she obtained the correct dose amount. This practice had the potential for contaminates to go back into the bottle of Colace.

The findings included:

1. The licensed nurse poured liquid Colace medication in and out of its multi-dose bottle using a standard 30 ml medication cup until she obtained the correct dose amount. This practice had the potential for contaminates to go back into the bottle of Colace.

The findings included:

Resident #3 was admitted to the nursing facility on 11/25/13 with diagnoses that included multiple sclerosis, chronic respiratory failure with tracheostomy (trach), paraplegia, chronic osteomyelitis, neurogenic bladder, morbid obesity, high blood pressure, gastroesophageal reflux disease (GERD) and urostomy tube.

The most recent Minimum Data Set (MDS) was a
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<td>quarterly dated 1/27/15 and coded Resident #3 with a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), which indicated the resident had no problems in cognitive skills for daily decision making. The resident was coded with special treatments to include a tracheostomy with trach care, oxygen therapy and suctioning.</td>
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A tracheostomy is an opening or stoma in the trachea through the anterior neck at the level just below the vocal cords. It is created during a surgical tracheostomy procedure (Komusky, Jennifer and Caple, J.K. August 23, 2013. Tracheostomy care: Providing. Glendale: cinahl Information Systems).

The care plan dated 2/10/15 identified Resident #3 had a tracheostomy. The goal the staff set for the resident was that there would be no signs or symptoms of infection through target date of 4/27/15. Some of the interventions the staff would use to accomplish this goal included universal precautions and daily tracheostomy care and as needed.

On 3/12/15 at 11:15 a.m. tracheostomy (trach) care was observed by licensed practical nurse (LPN) #3. Prior to starting the procedure, the LPN stated she was the one other staff, other than the respiratory therapist, that performed trach care and was very familiar with the process and had performed the care for other trach residents, as well. She proceeded to place two tracheostomy kits on a blue Chux (brand name) pad along with a bottle of hydrogen peroxide, a bottle of normal saline and six packages of trach sponges. The LPN opened one of the trach kits, removed and donned a set of blue colored sterile gloves. She
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<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<td>495086</td>
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<td>03/12/2015</td>
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<td>B. WING</td>
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**NAME OF PROVIDER OR SUPPLIER**  
KINDRED TCC AND REHABILITATION-BAY POINTE

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
1148 FIRST COLONIAL RD  
VIRGINIA BEACH, VA 23454

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<th>(X4) ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
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<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
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<tbody>
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<td>PREFIX</td>
<td>(EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)</td>
<td>PREFIX</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSSED REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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**F 441** Continued From page 20

filled one side of the kit's reservoir with peroxide and proceeded to dip 4x4 sponge gauze pads, squeeze out the peroxide and clean the resident's skin under the left and right side of the trach ties and replaced the pads under both sides. The trach ties were visibly soiled with a brown substance. She removed the old soiled trach sponge, obtained more 4x4 gauze sponges, dipped them in hydrogen peroxide several times as she washed above and below the trach stoma without changing her gloves. She removed the old disposable inner cannula from the outer cannula with the same gloves, opened a package with a new sterile disposable inner cannula and replaced it inside the outer cannula. Using the same gloves, she opened a packaged trach sponge and placed it under the flange next to the stoma. The LPN left copious amounts of gray tan crusted secretions around the stoma, on and in the crevices of the outer cannula. The LPN was asked what she used the sterile gloves for, to which she responded, "I used them to clean around the trach." LPN #3 kept the same sterile gloves on throughout the entire trach care process. Throughout the procedure she also readjusted the resident's gown and covers using the same gloves.

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**Summary Statement of Deficiencies**

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Contamination to what the nurse was attempting to clean, as well as other surfaces. According to the RN, it was not appropriate to dip back into the reservoir of hydrogen peroxide with soiled gloves and continue cleaning the site. She was able to produce an inservice record with sign in sheet where LPN #3 had attended.

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According to the facility's policy and procedure entitled "Tracheostomy Care" dated 2/28/14 it indicated tracheostomy care involved performing stoma site care and cleaning and replacing the tracheostomy tube inner cannula. Although the procedure is performed primarily to control the build up of secretions that can potentially obstruct
Continued from page 23.

the artificial airway, it is also necessary to maintain the integrity of the skin at the stoma site; which is prone to inflammation (i.e., stomatitis) and healthcare-acquired infection. The policy also supported RN #2's statements regarding the procedure for trach care.

On 3/12/15 at approximately 4:30 p.m., the aforementioned observations were shared with the Administrator, the Corporate Nurse and the DON. No further information was provided to the survey team.

2. The licensed nurse poured liquid Colace medication in and out of its multi-dose bottle using a standard 30 ml medication cup until she obtained the correct dose amount. This practice had the potential for contaminates to go back into the bottle of Colace.

Resident #14 was re-admitted to the nursing facility on 2/14/15 with diagnoses that included constipation.

Resident #14 had physician's orders dated 2/15/15 for Colace 50 milligrams (mg) 5 ml twice a day (BID).

During a medication pass observation on 3/11/15 at 9:00 a.m., RN #3 poured liquid Colace medication in and out of its multi-dose bottle, using a 30 ml medicine cup, until she acquired 5 ml.

An interview was conducted with the Director of Nursing (DON) on 3/11/15 at 11:00 a.m. She stated the overage of a poured medication should be discarded and never poured back into a multi-dose bottle of any type of medication.
The above aforementioned observation was shared with the Administrator, Corporate nurse and revisited with the DON on 3/12/15 at 4:30 p.m. No further information was provided to the survey team.

The facility's policy and procedure entitled "Oral Medication Administration" dated 4/28/09 indicated the following:
"If medication is a multi-dose bottle, removes bottle cap from multi-dose bottle and places cap upside down on work surface. Holds bottle with label against palm of hand while pouring. Pours liquid medication at eye level. Pours the desired volume of liquid so that base of meniscus is level with line on the scale. Discards any excess liquid into a sink. Wipes the lip and neck of the bottle with a paper towel and recaps the bottle."

Potter and Perry 7th Edition Chapter 35 page 721 Administering Oral Medications
To prepare liquids:
2) Hold multi-dose bottle with label against palm of hand while pouring.
3) Hold medication cup at eye level, and fill to desired level on scale. Make sure scale is even with fluid level at its surface or base of meniscus, not edges. Draw up volumes less than 10 mL in syringe without needle. Rationale: (Ensures accuracy of measurement. Use of syringe is more accurate for small doses of medication.)
4) Discard any excess liquid into sink. Wipe lip and neck of bottle with paper towel. Rationale: (Prevents contamination of bottle's contents and prevents bottle cap from sticking.)