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	495087	A. BUILDING _____ B. WING _____	C 06/30/2016

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SALEM HEALTH & REHABILITATION	1945 ROANOKE BLVD SALEM, VA 24153

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 6/28/16 through 6/30/16. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 240 certified bed facility was 208 at the time of the survey. The survey sample consisted of 28 current Resident reviews (Residents 1 through 27 and Resident 31) and 3 closed record reviews (Residents 28 through 30).

F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Regina O'Quinn DON/Acting Administrator		7/15/16

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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This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, facility staff failed to complete the comprehensive care plan to address infection control for 3 of 30 residents in the survey sample (Residents #17, 22, and 23).

1. For Resident #17, facility staff failed to care plan for isolation precautions for a resident with VRE (Vancomycin resistant enterococcus).

Resident #17 was admitted to the facility on 2/16/16. The resident's diagnoses included hypertension, gastroesophageal reflux disease, pneumonia, urinary tract infection (UTI), arthritis, non-Alzheimer's dementia, depression, and history of falls. On the significant change minimum data set (MDS) assessment with assessment reference date 5/31/16, the resident scored 4/15 on the brief interview for mental status and was without signs of delirium, psychosis, or behaviors affecting others. The resident had an indwelling urinary catheter and had been diagnosed with a UTI within 30 days of the assessment reference date.

The surveyor observed the resident dressed, sitting in a wheelchair, with a staff member feeding the resident breakfast on 6/29/16 at 8:52 AM. The staff member did not wear gown or gloves when feeding the resident. There was no sign on the door announcing contact precautions.

The surveyor obtained a copy of the resident's comprehensive care plan on 6/29/16. There was no mention of VRE infection. The comprehensive care plan did not include precautions for the

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prevention of spread of VRE to staff or other residents.

Nurse's notes dated 5/31/16 indicated the lab reported the resident's urine culture was positive for VRE, that the physician did not wish to treat the infection with antibiotics, and that the resident was placed on contact precautions. Nurse's notes did not address the discontinuation of the contact precautions.

Physician's orders included a verbal order dated 5/31/16 for contact isolation for VRE and another dated 6/3/16 to discontinue contact isolation for VRE. No reason was given for discontinuing the contact isolation.

The surveyor discussed the concern with the director of nursing (DON) on 6/29/16. The surveyor asked the DON about the 5/31/16 urine culture positive for VRE. The DON stated the physician did not want to treat the infection without symptoms. The surveyor asked what symptoms had prompted the physician to order a urinalysis with culture and sensitivity. The DON offered to investigate.

During a summary meeting on 6/29/16 at approximately 4:30 the surveyor asked why contact precautions had been discontinued. The DON stated that staff had asked the physician to discontinue contact precautions and he had agreed.

During an interview on 6/30/16 the DON stated that the urinalysis had been obtained because the resident's urine contained blood. The DON acknowledged that blood in urine could have been considered a symptom of UTI. The

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F 279	Continued From page 3	F 279		

surveyor discussed the concern with the DON and the corporate clinical nurse on 6/30 at 12:40 PM. DON stated that the resident had a history of bladder cancer and that could have been the cause of the blood in the urine. The surveyor explained that contact precautions were meant to prevent the spread of the organism and were necessary in presence of infection regardless of the treatment.

The surveyor asked for the policy concerning contact precautions for VRE. The facility policy titled Infection Control Policies and Procedures Vancomycin Resistant Enterococci (VRE) Policy Number 1501 Effective Date 2/1/15 section 4. Cultures a. Cultures are obtained by stool culture or rectal swab. b. Two to three negative cultures taken a week apart are to be used to determine when contact precautions may be discontinued.

During a summary meeting on 6/29/16 at approximately 4:30 the surveyor asked why contact precautions had been discontinued. The DON stated that staff had asked the physician to discontinue contact precautions and he had agreed.

2. For Resident #22, facility staff failed to care plan for contact precautions for Vancomycin resistant enterococcus (VRE).

Resident #22 was admitted to the facility on 5/18/16 with diagnoses including urinary tract infection (UTI) with VRE, clostridium difficile infection, hypertension, back pain, and dehydration. On the admission minimum data set (MDS) assessment, the resident was assessed with short and long term cognitive deficits and inability to make decisions of daily living. The

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resident was assessed without signs of psychosis, delirium, or behaviors affecting others.

During initial tour, surveyors noted the resident was on contact precautions. The appropriate notifications was on the door of the room and a sufficient supply of personal protective equipment was present outside the resident's room.

Clinical record review revealed a physician order dated 5/18/16 for contact precautions for VRE urine on admission to the facility.

The resident's comprehensive care plan did not address the need for contact precautions when caring for the resident. The surveyor discussed the concern with the care plan with the resident's nurse. The nurse stated that the care plan did not address contact precautions.

During a summary conference on 6/30/16 at approximately 4:30 PM, the surveyor notified the administrator and director of nursing of the concern.

3. For Resident #23, facility staff failed to care plan for contact precautions for Vancomycin resistant enterococcus (VRE).

Resident #23 was admitted to the facility on 5/13/16. The resident's diagnoses included end stage renal disease with hemodialysis, urinary tract infection (UTI), hypertension, diabetes mellitus, cardiopulmonary disease, and anxiety. On the minimum data set assessment with assessment reference date 6/24/16, the resident scored 12/15 on the Brief Interview for Mental Status and was assessed without signs of delirium, psychosis, or behavior affecting others.

F279	1. Resident #17's care plan was corrected to include contact precautions for VRE. Resident #22's care plan was corrected to include contact precautions for VRE. Resident 23's care plan was corrected to include contact precautions for VRE. 2. Nursing leadership will review current residents that receive contact precautions. Care plans will be corrected immediately as indicated.	

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F 279	Continued From page 5 During initial tour, surveyors noted the resident was on contact precautions. The appropriate notifications was on the door of the room and a sufficient supply of personal protective equipment was present outside the resident's room. Clinical record review on 6/30/16 revealed the physician order for contact precautions had been discontinued on 5/20/16. The resident's comprehensive care plan did not address the need for contact precautions when caring for the resident. The surveyor discussed the concern with the care plan with the resident's nurse. The nurse stated that the care plan did not address contact precautions. On 6/30/16, the surveyor discussed the concern with the resident's nurse. The nurse stated that the resident's order for contact precautions had not been renewed when the resident was readmitted to the facility on 5/27/16. The nurse added the order for contact precautions to the resident's clinical record and the comprehensive care plan. During a summary conference on 6/30/16 at approximately 1:30 PM, the surveyor notified the administrator and director of nursing of the concern.	F 279	Continued 3. Current licensed nursing staff will be educated regarding developing comprehensive care plans to meet the active care needs of the residents. Licensed nursing staff will make daily updates to care plans as applicable. Staff Development Coordinator or designee will review care plans weekly x 8 weeks to ensure contact precautions are included. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 7-26-16	
F 309 SS=D	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	F 309		

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F 309	Continued From page 6 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, facility staff failed to provide for the highest practicable well-being for 3 of 30 residents in the survey sample (Residents #5, 21, and 23). 1. For Resident #21, facility staff failed to develop an interim care plan to address the need for contact precautions for Vancomycin resistant enterococcus (VRE) infection. Resident #21 was admitted to the facility on 6/23/16 with diagnoses including end stage renal disease with hemodialysis, diabetes mellitus, bilateral above the knee amputation, major depression, and sepsis (VRE and clostridium difficile). On the resident's minimum data set assessment with assessment reference date 6/15/16, the resident scored 11/15 on the brief interview for mental status. The resident was assessed without signs of delirium, psychosis, or behaviors affecting others. During the initial tour on 6/28/16, surveyors observed the resident on contact precautions, with appropriate signage on the room and adequate supply of personal protective equipment outside the door. During clinical record review on 6/30/16, the surveyor was unable to locate a physician order for contact precautions.	F 309		

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The surveyor reviewed the resident's interim care plan on 6/30/16. The surveyor was unable to locate contact precautions for VRE on the resident's care plan.

The surveyor reported the concern to the director of nursing (DON) on 6/30/16 at 12:10 PM. The DON offered the Care plan dated 6/27/16 . Focus: The resident has impaired immunity r/t HEP C (hepatitis C). Goal: The resident will not display any complications related to immune deficiency. Interventions: Provide precautions as indicated. The care plan did not address the need for contact precautions.

2. For Resident #23, facility staff failed to ensure a [physician order for contact precautions and to care plan for a resident with Vancomycin resistant enterococcus (VRE).

Resident #23 was admitted to the facility on 5/13/16. The resident's diagnoses included end stage renal disease with hemodialysis, urinary tract infection (UTI), hypertension, diabetes mellitus, cardiopulmonary disease, and anxiety. On the minimum data set assessment with assessment reference date 6/24/16, the resident scored 12/15 on the Brief Interview for Mental Status and was assessed without signs of delirium, psychosis, or behavior affecting others.

During initial tour, surveyors noted the resident was on contact precautions. The appropriate notifications was on the door of the room and a sufficient supply of personal protective equipment was present outside the resident's room.

Clinical record review on 6/30/16 revealed the

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physician order for contact precautions had been discontinued on 5/20/16.

The resident's comprehensive care plan did not address the need for contact precautions when caring for the resident. The surveyor discussed the concern with the care plan with the resident's nurse. The nurse stated that the care plan did not address contact precautions.

On 6/30/16, the surveyor discussed the concern with the resident's nurse. The nurse stated that the resident's order for contact precautions had not been renewed when the resident was readmitted to the facility on 5/27/16. The nurse added the order for contact precautions to the resident's clinical record and the comprehensive care plan.

During a summary conference on 6/30/16 at approximately 4:30 PM, the surveyor notified the administrator and director of nursing of the concern.
3. The facility staff failed to obtain physician ordered accuchecks for Resident #5.

The clinical record of Resident #5 was reviewed 6/28/16 and 6/29/16. Resident #5 was admitted to the facility 9/24/15 with diagnoses that included but not limited to diabetes mellitus, cancer of the larynx, pneumonitis, cerebrovascular disease, schizophrenia, muscle weakness, atherosclerotic heart disease, dysphagia, hyperlipidemia, insomnia, hypertension, hemiplegia and hemiparesis, and cerebral infarction affecting left non-dominant side.

Resident #5's significant change in assessment minimum data set (MDS) assessment with an

F309	1. Resident #21's care plan was corrected to include contact precautions for VRE. Resident #23's physician was notified and order received for contact precautions. Resident #5 is currently receiving accuchecks as ordered by the physician. 2. Nursing leadership will review current residents that receive contact precautions and that receive accuchecks. Any issues will be addressed immediately at the time of identification.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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assessment reference date (ARD) of 5/25/16 assessed the resident with a cognitive summary score of 12 out of 15 in Section C Summary Score.

An electronic physician order dated 6/6/16 read "Accuchecks one time a day for DM2 (diabetes mellitus type 2) place results on rounds in 2 weeks for MD (medical doctor) to review."

A review of the June 2016 electronic medication administration records (eMAR) failed to reveal the results of the daily accuchecks starting 6/7/16. The entry on the June 2016 eMAR read exactly as the order. In each of the boxes 6/7/16 through 6/19/16, the surveyor observed only nurse's initials. Initials in boxes indicated the care/treatment had been provided. However, there were no accuchecks results.

The surveyor informed the unit manager registered nurse #2 on 6/29/16 at 4:00 p.m. R.N. #2 provided the surveyor with a form titled "Weights and Vitals Summary." The list did not reveal accucheck results for the following 2 week period: 6/7/16, 6/8/16, 6/9/16, 6/14/16, 6/15/16, 6/17/16, 6/18/16 and 6/19/16.

The surveyor reviewed the progress notes for June 2016. There were no accuchecks documented on 6/7/16, 6/8/16, 6/9/16, 6/14/16, 6/15/16, 6/17/16, 6/18/16 or 6/19/16.

The unit manager R.N. #2 informed the surveyor on 6/29/16 at 4:30 p.m. that the eMAR was missing the "prompt to document the results."

The director of nursing informed the surveyor on 6/30/16 at 9:00 a.m. that the accuchecks had not

3. Current licensed nursing staff will be educated regarding developing comprehensive care plans to meet the active care needs of the residents, obtaining physician orders for contact precautions, and accurately documenting accucheck readings on the medication administration record as ordered. Staff Development Coordinator or designee will review care plans weekly X 8 weeks to ensure contact precautions are included and will

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F 309	Continued From page 10 been obtained. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above finding on 6/30/16 at 1:10 p.m. No further information was provided prior to the exit conference on 6/30/16.	F 309	Continued F309 review culture reports daily 5 X weekly x 8 weeks to ensure orders are in place for contact precautions as indicated. Unit managers or designee will review residents receiving accuchecks weekly X 8 weeks to ensure accurate documentation. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 7-26-16	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		

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by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure that 1 of 31 Residents in the sample survey was free of unnecessary medications, Resident #7.
For Resident #7 the facility staff failed to monitor for the administration of a antidepressant medication, Sertraline, to include specific behaviors, side effects, effectiveness and interventions.

The Findings Included:
Resident #7 was an 86 year old male who was originally admitted on 1/8/16 and readmitted on 6/8/16. Admitting diagnoses included, but were not limited to: urinary tract infection, adult failure to thrive, chronic obstructive pulmonary disease, dementia without behaviors, dysphagia and enlarged prostate.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a 14 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 4/26/16. The facility staff coded that Resident #7 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #7 required set up (1/1) to extensive assistance (3/2) with Activities of Daily Living (ADL)'s.
On June 29, 2016 at 8:20 a.m. the surveyor reviewed Resident #7's clinical record. Review of the clinical record produced electronically signed the Physician Order Sheets (POS's). The orders were signed electronically on 6/8/16. Signed POS's included, but were not limited to the following order: "Sertraline HCl Tablet 25 G Give 1 tablet by mouth one time a day for Depression." (sic)
Continued review of the clinical record produced

F329	1. Monitoring for the administration of antidepressant medication has been added for Resident #7 to include specific behaviors, side effects, effectiveness, and interventions 2. Current residents receiving antidepressant medications will be reviewed to ensure monitoring is in place. Any issues will be addressed immediately at the time of identification 3. Licensed nursing staff will be educated on the requirements for monitoring antidepressant	

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F 329	Continued From page 12 the June 2016 Medication Administration Records (MAR's). Review of the June 2016 MAR's documented that the facility staff were administering the Sertraline, a antidepressant, every day as ordered by the physician. Further review of the June 2016 MAR's failed to document specific behaviors/depressive symptoms, side effects, effectiveness and interventions for the use of the Sertraline since 6/6/16. On June 29, 2016 at 9:15 a.m. the surveyor notified the Unit Manager, who was a Registered Nurse (RN #4) that Resident #7 was receiving an antidepressant, Sertraline, and that behavior monitoring was not being done. The surveyor reviewed the clinical record with the UM (RN #4). The surveyor pointed out the specific physician order for the Sertraline. The surveyor then reviewed the June 2016 MAR's with the UM (RN #4). The surveyor pointed out that the facility staff had not documented specific behaviors/depressive symptoms, side effects, effectiveness and interventions for the use of the Sertraline since 6/6/16. On June 29, 2016 at 4:30 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #7 was receiving Sertraline, an antidepressant, and that the facility staff were not monitoring Resident #7 for the medication use. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #7 was free of unnecessary medication, Sertraline, use.	F 329	Continued F329 medications to include specific behaviors, side effects, effectiveness, and interventions. Nursing leadership will review order listing reports daily 5 X weekly X 8 weeks to ensure monitoring is in place for antidepressant orders. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 7-26-16	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=E	Continued From page 13 SPREAD, LINENS	F 441		

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 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.

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, facility staff failed to 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 for 4 of 30 residents in the survey sample (Residents #17, 21, 22, and 23), and for residents receiving portable X-ray examinations.

1. For Resident #17, facility staff failed to care plan for isolation precautions for a resident with VRE (Vancomycin resistant enterococcus).

Resident #17 was admitted to the facility on 2/16/16. The resident's diagnoses included hypertension, gastroesophageal reflux disease, pneumonia, urinary tract infection (UTI), arthritis, non-Alzheimer's dementia, depression, and history of falls. On the significant change minimum data set (MDS) assessment with assessment reference date 5/31/16, the resident scored 4/15 on the brief interview for mental status and was without signs of delirium, psychosis, or behaviors affecting others. The resident had an indwelling urinary catheter and had been diagnosed with a UTI within 30 days of the assessment reference date.

The surveyor observed the resident dressed, sitting in a wheelchair, with a staff member feeding the resident breakfast on 6/29/16 at 8:52 AM. The staff member did not wear gown or gloves when feeding the resident. There was no sign on the door announcing contact precautions.

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The surveyor obtained a copy of the resident's comprehensive care plan on 6/29/16. There was no mention of VRE infection. The comprehensive care plan did not include precautions for the prevention of spread of VRE to staff or other residents.

Nurse's notes dated 5/31/16 indicated the lab reported the resident's urine culture was positive for VRE, that the physician did not wish to treat the infection with antibiotics, and that the resident was placed on contact precautions. Nurse's notes did not address the discontinuation of the contact precautions.

Physician's orders included a verbal order dated 5/31/16 for contact isolation for VRE and another dated 6/3/16 to discontinue contact isolation for VRE. No reason was given for discontinuing the contact isolation.

The surveyor discussed the concern with the director of nursing (DON) on 6/29/16. The surveyor asked the DON about the 5/31/16 urine culture positive for VRE. The DON stated the physician did not want to treat the infection without symptoms. The surveyor asked what symptoms had prompted the physician to order a urinalysis with culture and sensitivity. The DON offered to investigate.

During a summary meeting on 6/29/16 at approximately 4:30 the surveyor asked why contact precautions had been discontinued. The DON stated that staff had asked the physician to discontinue contact precautions and he had agreed.

During an interview on 6/30/16 the DON stated

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that the urinalysis had been obtained because the resident's urine contained blood. The DON acknowledged that blood in urine could have been considered a symptom of UTI. The surveyor discussed the concern with the DON and the corporate clinical nurse on 6/30 at 12:40 PM. DON stated that the resident had a history of bladder cancer and that could have been the cause of the blood in the urine. The surveyor explained that contact precautions were meant to prevent the spread of the organism and were necessary in presence of infection regardless of the treatment.

The surveyor asked for the policy concerning contact precautions for VRE. The facility policy titled Infection Control Policies and Procedures Vancomycin Resistant Enterococci (VRE) Policy Number 1501 Effective Date 2/1/15 section 4. Cultures a. Cultures are obtained by stool culture or rectal swab. b. Two to three negative cultures taken a week apart are to be used to determine when contact precautions may be discontinued.

During a summary meeting on 6/29/16 at approximately 4:30 the surveyor asked why contact precautions had been discontinued. The DON stated that staff had asked the physician to discontinue contact precautions and he had agreed.

2. For Resident #22, facility staff failed to care plan for contact precautions for Vancomycin resistant enterococcus (VRE).

Resident #22 was admitted to the facility on 5/18/16 with diagnoses including urinary tract infection (UTI) with VRE, clostridium difficile infection, hypertension, back pain, and

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dehydration. On the admission minimum data set (MDS) assessment, the resident was assessed with short and long term cognitive deficits and inability to make decisions of daily living. The resident was assessed without signs of psychosis, delirium, or behaviors affecting others.

During initial tour, surveyors noted the resident was on contact precautions. The appropriate notifications was on the door of the room and a sufficient supply of personal protective equipment was present outside the resident's room.

Clinical record review revealed a physician order dated 5/18/16 for contact precautions for VRE urine on admission to the facility.

The resident's comprehensive care plan did not address the need for contact precautions when caring for the resident. The surveyor discussed the concern with the care plan with the resident's nurse. The nurse stated that the care plan did not address contact precautions.

During a summary conference on 6/30/16 at approximately 4:30 PM, the surveyor notified the administrator and director of nursing of the concern.

3. For Resident #23, facility staff failed to care plan for contact precautions for Vancomycin resistant enterococcus (VRE).

Resident #23 was admitted to the facility on 5/13/16. The resident's diagnoses included end stage renal disease with hemodialysis, urinary tract infection (UTI), hypertension, diabetes mellitus, cardiopulmonary disease, and anxiety. On the minimum data set assessment with

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F 441	Continued From page 18	F 441		

assessment reference date 6/24/16, the resident scored 12/15 on the Brief Interview for Mental Status and was assessed without signs of delirium, psychosis, or behavior affecting others.

During initial tour, surveyors noted the resident was on contact precautions. The appropriate notifications was on the door of the room and a sufficient supply of personal protective equipment was present outside the resident's room.

Clinical record review on 6/30/16 revealed the physician order for contact precautions had been discontinued on 5/20/16.

The resident's comprehensive care plan did not address the need for contact precautions when caring for the resident. The surveyor discussed the concern with the care plan with the resident's nurse. The nurse stated that the care plan did not address contact precautions.

On 6/30/16, the surveyor discussed the concern with the resident's nurse. The nurse stated that the resident's order for contact precautions had not been renewed when the resident was readmitted to the facility on 5/27/16. The nurse added the order for contact precautions to the resident's clinical record and the comprehensive care plan.

During a summary conference on 6/30/16 at approximately 1:30 PM, the surveyor notified the administrator and director of nursing of the concern.

4. For Resident #21, facility staff failed to develop an interim care plan to address the need for contact precautions for Vancomycin resistant

F441	1. Resident #17's care plan was corrected to include contact precautions for VRE. Resident #22's care plan was corrected to include contact precautions for VRE. Resident 23's care plan was corrected to include contact precautions for VRE. Resident #21's care plan was corrected to include contact precautions for VRE. The radiology technician was educated regarding policy and procedures for contact precautions. 2. Nursing leadership will review current residents that receive contact precautions.	

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F 441	Continued From page 19 enterococcus (VRE) infection. Resident #21 was admitted to the facility on 6/23/16 with diagnoses including end stage renal disease with hemodialysis, diabetes mellitus, bilateral above the knee amputation, major depression, and sepsis (VRE and clostridium difficile). On the resident's minimum data set assessment with assessment reference date 6/15/16, the resident scored 11/15 on the brief interview for mental status. The resident was assessed without signs of delirium, psychosis, or behaviors affecting others. During the initial tour on 6/28/16, surveyors observed the resident on contact precautions, with appropriate signage on the room and adequate supply of personal protective equipment outside the door. During clinical record review on 6/30/16, the surveyor was unable to locate a physician order for contact precautions. The surveyor reviewed the resident's interim care plan on 6/30/16. The surveyor was unable to locate contact precautions for VRE on the resident's care plan. The surveyor reported the concern to the director of nursing (DON) on 6/30/16 at 12:10 PM. The DON offered the Care plan dated 6/27/16 . Focus: The resident has impaired immunity r/t HEP C (hepatitis C). Goal: The resident will not display any complications related to immune deficiency. Interventions: Provide precautions as indicated. The care plan did not address the need for contact precautions.	F 441	Continued F441 Care plans will be corrected immediately as indicated. Radiology provider will be notified to ensure that current technicians are educated regarding policy and procedures for contact precautions. 3. Current licensed nursing staff will be educated regarding developing comprehensive care plans to meet the active care needs of the residents.	

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F 441	Continued From page 20 5. Facility staff failed to ensure a radiology technician followed contact precautions when providing service to a resident without a diagnosed infection after providing service to a resident on contact precautions. On 6/30/16 at approximately 9 AM, the surveyor observed a radiology staff member gown and glove before entering the room of a resident on contact precautions to perform an X-ray. The surveyor observed the resident exiting the resident's room without gown or gloves and go into the next room. The surveyor asked the radiology technician about the procedure for cleaning between rooms. The technician stated no part of the equipment touches the resident. She said that there are sani-wipes in the van for wiping down the machine between facilities. She stated that she gets sani wipes from the nurse's station and takes them into the room with her to clean the machine between residents if the resident is on contact precautions to avoid cross-contamination. The surveyor did not observe the technician go to the nurse's station for wipes before entering the contact isolation room. The surveyor was unable to locate sani-wipes at the nurse's station. The surveyor asked a nurse if staff kept sani-wipes at the nurse's station. The nurse stated that they could not be left out, for safety of the residents. The nurse showed the surveyor sani-wipes stored in a cabinet in the unit manager's office. The administrator and director of nursing were notified of the concern during a summary meeting on 6/30/16.	F 441	Continued F441 Licensed nursing staff will make daily updates to care plans as applicable to include contact precautions when indicated. Staff Development Coordinator or designee will review care plans weekly x 8 weeks to ensure contact precautions are included. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 7-26-16	
F 502	483.75(j)(1) ADMINISTRATION	F 502		

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The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, it was determined that the facility staff failed to obtain physician ordered laboratory testing on 4 of 31 Residents in the sample survey, Resident #8, Resident #14, Resident #5 and Resident #9.
The Findings Included:
1. For Resident #8 the facility staff failed to obtain a physician ordered CMP on 6/3/16. Resident #8 was an 89 year old female who was originally admitted on 10/18/14 and readmitted on 2/17/15. Admitting diagnoses included, but were not limited to: urinary tract infection, hypertension, pneumonia, history of falls, cataracts, dementia without behaviors, panic disorder, major depression and Schizophrenia.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/24/16. The facility staff coded that Resident #8 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #8 was independent (0/1) to requiring set up assistance with Activities of Daily Living (ADL's).
On June 28, 2916 at 2:25 p.m. the surveyor reviewed Resident #8's clinical record. Review of the clinical record produced a physician ' s order to obtain a CMP on 6/3/16. Further review of the clinical record failed to produce the results of the

1. The physician was notified of missed CMP on 6/3/16 for Resident #8. The physician was notified of missed lipid panel for the month of October 2015 for Resident #14. The physician was notified of a missing TSH and Vitamin D level on 11/6/15 for Resident #5 and for obtaining a CMP instead of a BMP on 11/13/15. The physician was notified of missed CMP on 6/3/16 for Resident #9.
2. Nursing leadership will review current residents with active lab test orders to ensure tests have been completed as indicated per physician order. Any issues will be addressed immediately at the time of identification.

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F 502	Continued From page 22 physician ordered CMP on 6/3/16. On June 28, 2016 at 3:15 p.m. the surveyor notified the Unit Manager, who was a Registered Nurse (RN #4), that Resident #8 had a physician's order to obtain a CMP on 6/3/16. The surveyor notified the UM (RN #4) that reviewed of the clinical record failed to produce the results of the physician ordered CMP for 6/3/16. The surveyor reviewed Resident #8's clinical record with the UM (RN #4). The surveyor pointed out the specific physician order to obtain a CMP on 6/3/16. The UM (RN #4) reviewed the clinical record and was unable to locate the results of the physician ordered CMP for 6/3/16. On June 29, 2016 at 4:30 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #8 had a physician order to obtain a CMP on 6/3/16. The surveyor notified the AT that the surveyor and UM (RN #4) were unable to locate the results of the physician ordered CMP for 6/3/16. No additional information was provided prior to exiting the facility as to why the facility staff failed to obtain a physician ordered CMP on Resident #8 on 6/3/16. For additional information regarding Resident #8 refer to F Tag 514. 2. For Resident # 14 the facility staff failed to obtain a lipid panel for the month of October 2015. A lipid panel is a laboratory test to check for cholesterol. Resident #14 was admitted to the facility on 9/04/12 and again on 12/06/12. Resident #14's diagnoses include but were not limited to: dysphagia, seizures, elevated blood pressure,	F 502	Continued F502 3. Current licensed nursing staff will be educated regarding lab test orders to include order accuracy, tracking, and notification of results. Unit managers or designee will review lab tracking log daily 5 X weekly x 8 weeks to ensure lab tests have been completed as ordered. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 7-26-16	

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asthma, depression and hyperlipidemia.

Resident #14's minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/2/16 assessed him to understand and be understood. He was coded to have a cognitive pattern summary score of 12.

On 6/29/16, Resident #14's clinical record was reviewed. In the physicians summary of orders (POS) the surveyor located an order for a lipid panel with a start date of 3/28/14 to be done every 6 months October and April.

The laboratory section of the clinical record revealed the lipid panel lab test was done in April but one was not located for the month of October 2015.

The director of nurses was asked to assist in finding the missing lab test on 6/29/16.

On 6/29/16, during a summary meeting with the administrator, director of nurses, assistant director of nurse, and regional nurse consultant they were notified of the concern.

On 6/30/16 at 9:25 am, the director of nurses told the surveyor, "I don't have the lab for October."

Prior to exit on 6/30/16, no further information was provided to the surveyor related to the lipid panel.

3. The facility staff failed to obtain physician ordered laboratory tests for Resident #5.

The clinical record of Resident #5 was reviewed 6/28/16 and 6/29/16. Resident #5 was admitted to the facility 9/24/15 with diagnoses that included

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but not limited to diabetes mellitus, cancer of the larynx, pneumonitis, cerebrovascular disease, schizophrenia, muscle weakness, atherosclerotic heart disease, dysphagia, hyperlipidemia, insomnia, hypertension, hemiplegia and hemiparesis, and cerebral infarction affecting left non-dominant side.

Resident #5's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/25/16 assessed the resident with a cognitive summary score of 12 out of 15 in Section C Summary Score.

The clinical record revealed the results of a CBC (complete blood count) and a CMP (comprehensive metabolic panel) obtained 11/6/15. The physician order dated 11/6/15 read "CBC, CMP, TSH (thyroid Stimulating Hormone), and Vitamin D." The surveyor was unable to locate the results in the electronic clinical record for the TSH and the Vitamin D level.

The clinical record also revealed the results of a CBC and CMP (complete metabolic panel) obtained 11/13/15. The physician order dated 11/12/15 read "CBC, BMP (basic metabolic panel) in am (morning) 11/13/15." A CMP (complete metabolic panel) was obtained instead of a BMP (basic metabolic panel) as ordered by the physician.

The surveyor informed the unit manager registered nurse #2 of the above finding on 6/29/16 at 4:00 p.m. After reviewing the clinical record, R.N. #2 stated the laboratory tests were not obtained as ordered.

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F 502	Continued From page 25	F 502		

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above finding on 6/29/16 at 4:35 p.m.

No further information was provided prior to the exit conference on 6/30/16.

4. The facility staff failed to obtain a physician ordered lab on Resident #9.
Resident #9 was originally admitted to the facility on 11/23/15 with a readmission date of 6/16/16. The resident had the following diagnoses of, but not limited to high blood pressure, dementia, pneumonia, sepsis, seizures, diabetes, heart failure and anemia. On the quarterly MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 6/22/16, the resident was coded having short and long term memory problems with being severely impaired in daily decision making. Resident #9 is totally dependent of 2 or more staff for bathing and requires extensive assistance of 2 or more staff members for personal hygiene.
During the clinical record review on 6/29/16, it was noted by the surveyor that a laboratory test was ordered on 6/2/16 which stated to obtain a CMP (Comprehensive Metabolic Panel) on 6/3/16. The surveyor could not locate the results of this test in the electronic or paper clinical record for Resident #9.
Unit manager for Unit 4 was interviewed by the surveyor on 6/29/16 at 1:30 pm. The surveyor asked the unit manager if the results for the CMP that was ordered to be obtained on 6/3/16 could be found. The unit manager stated that she would look and do some investigating and get back to the surveyor regarding this matter. The unit

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F 502	Continued From page 26 manager returned to the surveyor and stated that the CMP was not obtained on 6/3/16. The director of nursing, administrator and corporate nurse were notified of the above findings by the surveyor in the end of the day conference on 6/29/16. No further information was provided to the surveyor concerning the above documented findings.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview facility document review and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for 3 of 31 Residents in the sample survey, Resident #8, Resident #3 and Resident #5. The Findings Included: 1. For Resident #8 the facility staff failed to ensure complete and accurate Physician Order	F 514		

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Sheets (POS ' s) and June 2016 Medication Administration Records (MAR ' s).
Resident #8 was an 89 year old female who was originally admitted on 10/18/14 and readmitted on 2/17/15. Admitting diagnoses included, but were not limited to: urinary tract infection, hypertension, pneumonia, history of falls, cataracts, dementia without behaviors, panic disorder, major depression and Schizophrenia.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/24/16. The facility staff coded that Resident #8 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #8 was independent (0/1) to requiring set up assistance with Activities of Daily Living (ADL's).
On June 28, 2916 at 2:25 p.m. the surveyor reviewed Resident #8's clinical record. Review of the clinical record produced electronically signed Physician Order Sheets (POS's). The electronic POS's included, but were not limited to the following order: "ANTIPSYCHOTIC MEDICATION-Seroquel-MONITOR FOR DRY MOUTH, CONSTIPATION, BLURRED VISION, DISORIENTATION/CONFUSION, DIFFICULITY URINATING, HYPOTENSION, DARK URINE, YELLOW SKIN, N/V (nausea and vomiting), LETHARGY, DROOLING, EPS SYMPTOMS (TREMORS, DISTURBED GAIT, INCREASED AGITATION, RESTLESSNESS, INVOLUNTARY MOVEMENT OF MOUTH OR TONGUE). Document "Y" if monitored and none of the above observed. "N" if monitored and any of the above were observed, select chart code "Other/See Nurses Notes' and progress note findings every shift-Order Date 4/11/15 2117."(sic)
Further review of the clinical record produced the

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June 2016 Medication Administration Records (MAR's). Review of the June 2016 MAR's documented that the facility staff were monitoring Resident #8 for the use of Seroquel, a psychotropic medication, every shift.
Continued review of the clinical record failed to produce a physician order for Seroquel.
On June 28, 2016 at 3:15 p.m. the surveyor notified the Unit Manager, who was a Registered Nurse (RN #4), that the Resident #8's clinical record was inaccurate. The surveyor notified the UM (RN #4) that Resident #8's POS's contained a physician order to monitor for Seroquel, a psychotropic, drug use. The surveyor notified the UM (RN #4) that the June 2016 MAR's documented that the facility staff were monitoring Resident #8 for the Seroquel drug use. The surveyor notified the UM (RN #4) that the surveyor could not locate a physician order for Resident #8 to receive Seroquel. The surveyor and UM (RN #4) reviewed Resident #8's clinical record. The surveyor pointed out the specific physician order to monitor for Seroquel drug use. The surveyor also reviewed the June 2016 MAR's with the UM (RN #4). The surveyor pointed out that the facility staff were documenting the monitoring of the Seroquel drug use on Resident #8 every shift. The UM stated that that the Seroquel had probably been discontinued.
On June 29, 2016 at 4:30 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #8's clinical record was inaccurate. The surveyor notified the AT that Resident #8's POS's and June 2016 were incorrect. The surveyor notified the AT that Resident #8's POS's and June 2016 MAR's

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F 514	Continued From page 29 included a physician order to monitor for Seroquel drug use. The surveyor notified the AT that Resident #8 was not receiving Seroquel. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #8. 2. For Resident #3, the clinical record indicated that a resident with an indwelling catheter had no urinary catheter. Resident #3 was admitted to the facility on 10/23/15 with diagnoses including prostate cancer, obstructive uropathy, hypertension, coronary artery disease, dysphagia, and urinary tract infection. On the quarterly minimum data set assessment with assessment reference date 6/13/16, the resident scored 8/15 on the brief interview for mental status and was assessed as having no signs of delirium, psychosis, or behaviors affecting others. The resident was coded as occasionally incontinent of urine. Indwelling urinary catheter was not coded. Clinical record review on 6/29/16 revealed the indwelling catheter order had been discontinued on 6/16/16. Documentation of catheter care on the treatment administration record continued through 6/29/16. During an interview on 6/29/16, the resident reported that he had a catheter for urine because he could not pass urine without one. The resident showed the surveyor the leg bag for the catheter. The surveyor reported the concern with documentation to the administrator and director of nursing during a summary meeting on 6/29/16.	F 514	F514 1. Resident #8's physician order sheet has been corrected to remove the order for Seroquel medication monitoring. Resident #3 has a current physician order for the use of a Foley catheter. Resident #19's dialysis notes have been removed from Resident #5's record. 2. Nursing leadership will review current residents with Foley catheters and with active behavior monitoring orders to ensure accuracy of records. Medical records coordinator or designee will review residents receiving dialysis to ensure communication records identify correct resident name. Any issues will be addressed immediately at the time of identification.	

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F 514	Continued From page 30 3. The facility staff failed to ensure Resident #5's electronic medical record was accurate. Resident #5's electronic clinical record contained dialysis notes for Resident #19. The clinical record of Resident #5 was reviewed 6/28/16 and 6/29/16. Resident #5 was admitted to the facility 9/24/15 with diagnoses that included but not limited to diabetes mellitus, cancer of the larynx, pneumonitis, cerebrovascular disease, schizophrenia, muscle weakness, atherosclerotic heart disease, dysphagia, hyperlipidemia, insomnia, hypertension, hemiplegia and hemiparesis, and cerebral infarction affecting left non-dominant side. Resident #5's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/25/16 assessed the resident with a cognitive summary score of 12 out of 15 in Section C Summary Score. During clinical record review, the surveyor observed a "Dialysis Communication Form" undated that had been scanned into Resident #5's clinical record. The Dialysis Communication Form was Resident #19's information. The surveyor requested a copy of the dialysis form from registered nurse #4 on 6/29/16 at 1:00 p.m. The surveyor informed the unit manager registered nurse #2 of the above concern on 6/29/16 at 4:00 p.m. R.N. #2 stated the form was scanned incorrectly. The surveyor informed the administrator, the	F 514	Continued F514 3. Current licensed nursing staff will be educated regarding medication monitoring for psychoactive medication use and Foley catheter order processing. Medical records coordinator will be educated regarding process for ensuring that documents are scanned accurately into resident records.	

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F 514	Continued From page 31 director of nursing, and the corporate registered nurse of the above finding on 6/29/16 at 4:35 p.m. and on 6/30/16 at 1:10 p.m. and requested a copy of the facility policy on documentation. The surveyor reviewed the facility policy titled "Documentation Summary" on 6/30/16. The policy read in part "Every page of the medical record will be identifiable to the patient." No further information was provided prior to the exit conference on 6/30/16.	F 514 Continued	F514 Unit managers or designee will review order listing reports daily 5X weekly x 8 weeks to ensure accuracy of medication monitoring for psychoactive medications and will review residents with Foley catheters in use weekly X 8 weeks to ensure accuracy of order. Medical records coordinator will review 10% of resident records per unit per week X 8 weeks to ensure accuracy of scanned documents. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 7-26-16	

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F 000	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 6/28/16 through 6/30/16. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 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 240 certified bed facility was 208 at the time of the survey. The survey sample consisted of 28 current Resident reviews (Residents 1 through 27 and Resident 31) and 3 closed record reviews (Residents 28 through 30).

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:
The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.

12 VAC 5-371-250. Resident assessment and care planning.
12 VAC 5-371-250 (G) Cross Reference to F-279

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (A THRU G) Cross reference to F-309

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (B) Cross reference to F-329.

12 VAC 5-371-180. Infection Control.
12 VAC 5-371-180 (A,B,C) Cross reference to

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F-441.

12 VAC 5-371-310. Administration.
12 VAC 5-371-310 (A) Cross reference to F-502

12 VAC 5-371-360. Clinical Records.
12 VAC 5-371-360 (A, E, f, j) Cross Reference to F-514