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	495086	A. BUILDING _____ B. WING _____	05/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CONCORDIA TRANSITIONAL CARE AND REHAB-BAY POINTE	1148 FIRST COLONIAL RD VIRGINIA BEACH, VA 23454

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F 000	INITIAL COMMENTS An unannounced Federal Comparative Survey was conducted at Kindred Transitional Care Center - Bay Pointe May 8, 2017 through May 12, 2017. Survey activities consisted of a review of 10 resident clinical records during Phase I; review of 8 resident clinical records during Phase II; observations of staff practices; review of the facility's operating procedures; and interviews with residents, families, and facility staff. Immediate Jeopardy (IJ) was identified on May 10, 2017 at 12:30 PM. The facility failed to prevent a burn injury for one Resident. The IJ was abated on May 10, 2017 at 8:05 PM when the survey team accepted the facility's corrective action plan. After analysis of the findings, it was determined that the facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.	F 000		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at	F 164		6/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/31/2017

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F 164	Continued From page 1 §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, facility documentation, and a staff interview, it was determined the facility failed to provide privacy of a resident's body during wound assessment and incontinence care to one (1) of 18 sampled residents (Resident #1). The findings included: Resident #1 admitted to the facility on 1/4/17 with a past medical history that included Alzheimer's	F 164	1. Privacy is being provided to resident #18 during provision of care. 2. Residents residing in the center have the potential to be affected. 3. Staff that provided care were educated on closing the door and pulling the privacy curtain completely during provision of care. SDC, CM, UM, or RM will randomly observe 2 residents a week for 12 weeks during provision of care to validate	

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F 164	Continued From page 2 Disease and Adult Failure to Thrive. The Minimum Data Set (MDS) dated 3/20/17 indicated the resident was a 2+ persons (2 or more person) physical assist for bed mobility. On 5/10/17 at 8:45 AM, Employee #5 asked Employee #4 to assess the wound of Resident #1. Resident #1 was laying on her right side with the lower half of her body exposed during wound assessment. After the wound assessment, the employees performed incontinence care then changed Resident #1's incontinence brief. During the time of the incontinence care and wound assessment, the door was open and privacy curtain was not pulled around the resident. In facility's "Incontinence Management" documentation, Procedure number 2 states to "provide for privacy." On 5/11/17 at 8:50 AM, Employee #4 stated during wound assessment and incontinence care, she "expects to have the curtains pulled."	F 164	provision of privacy. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing.	
F 167 SS=C	RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE CFR(s): 483.10(g)(10)(i)(11) (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents,	F 167		6/19/17

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F 167	Continued From page 3 and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observations and resident group interview, it was determined the facility failed to have results and a notice (sign as to the location) of the most recent survey prominent and readily accessible to residents, family members and the public. This has the potential to affect more than a minimal number of residents and visitors. The census during the survey was 78. The findings included: During the Initial Tour on 5/8/17 at 4:20 PM, there was no notice (sign as to the location) of the most recent survey results posted on the second floor. During facility tour on 5/9/17 at 10:00 AM, the binder containing survey results and the notice of the most recent survey was in the first floor hallway in front of the main entrance sliding doors. Residents were found to be in the	F 167	1. A sign was posted by the 2nd floor Activity board by the Day Room to indicate location of survey results. A Survey results binder and Ancillary charges binder were placed on the 2nd floor. 2. Residents residing in the center have the potential to be affected. 3. DDCO educated ED on survey results being accessible to residence residing in the center. One time a week for 12weeks Ed will validate 2nd floor sign indicating results of survey is in place. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing.	

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F 167	Continued From page 4 following common areas: first floor dining room, second floor activities room, and second floor day room/dining room. During resident group interview on 5/9/17 at 2:10 PM with 7 residents, when asked about the report of the facility's latest survey inspection results, the residents said they did not know the location of the report.	F 167		
F 225 SS=D	INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS CFR(s): 483.12(a)(3)(4)(c)(1)-(4) 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.	F 225		6/19/17

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F 225	Continued From page 5 (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility investigation documentation and clinical records, as well as	F 225	1. DDCO educated ED and DNS on incidents that could be abuse or neglect	

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F 225	Continued From page 6 staff interviews, it was determined that the facility failed to thoroughly investigate a resident burn injury. Additionally, the investigation did not determine that the incident could be abuse or neglect, and the incident was not promptly reported to the State Survey Agency. Deficient practice identified one (1) of 18 residents in the survey sample (Resident #11). The findings include: Resident #11 was re-admitted to the facility on 9/5/16 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Heart Disease, Anxiety, and Hypertension. A review of the resident's Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated 6/1/16, revealed that the resident was alert and oriented with a BIMS (Brief Interview for Mental Status - a tool to assess cognitive function), score of 15 (a score that indicates no cognitive impairment). This MDS assessment also noted that the resident was independent with eating after set up by staff. In an interview with Resident #11 on 5/10/17 at 1:35 PM, she said that last year she was in the dining room being served her lunch when an aide put her coffee cup slightly out of reach. The resident said that she went to move the coffee cup closer to her and it snagged on a fold in the table cloth and the coffee spilled over her legs. She said that it was very hot. She also related that she was treated and still has a scar as a result of the hot coffee.	F 225	and state agency reporting guidelines. DDCO educated ED and DNS conducting interviews when suspected abuse, neglect or unusual occurrences happen. 2. Residents residing in the center have the potential to be affected. 3. Department managers educated that unusual occurrences or incidents that could be abuse or neglect need to be reported to the ED immediately. ED will review unusual occurrences on incidents that could be abuse or neglect to validate appropriate reporting to state agency. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing	

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F 225	Continued From page 7 Nursing documentation on June 16, 2016 indicated that the resident sustained burns over inner thighs with blistering. Review of a corresponding incident/accident investigation report indicated that on 6/17/16, the resident sustained a burn and was reported to the Virginia State Agency on 2/10/17 The report documented that ;"... staff continues to be present in dining room and heard resident holler Staff responded. Resident spilled coffee in her lap. Resident wearing shorts. First aid given." After the incident the facility completed an investigation. This investigation was reviewed on 5/10/17 at 2:00 PM. The review indicated the facts about the incident. However, the investigation did not document any witness statements from the facility staff or any other potential witnesses. In an interview with the Executive Director on 5/10/17 at 6:15 PM, it was acknowledged that the facility did not conduct a thorough investigation with witness statements. She also acknowledged that the incident was not reported to the state agency in a timely manner. She said that the temperature of the coffee was 155 degrees and that the facility put interventions in place to protect Resident #11.	F 225		
F 226 SS=D	DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES CFR(s): 483.12(b)(1)-(3), 483.95(c)(1)-(3) 483.12 (b) The facility must develop and implement written policies and procedures that:	F 226		6/19/17

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F 226	Continued From page 8 (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and review of facility policy Abuse Prevention and Reporting Policy reviewed on 5/11/17, it was determined that the facility failed to follow their policy regarding investigation of resident injuries for one (1) of 18 residents in the survey sample (Resident #11). The findings include:	F 226	1. DDCO educated ED and DNS on incidents that could be abuse or neglect and state agency reporting guidelines. DDCO educated ED and DNS conducting interviews when suspected abuse, neglect or unusual occurrences happen. 2. Residents residing in the center have the potential to be affected. 3. Department managers educated that	

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F 226	Continued From page 9 A review of Resident #11's incident that investigation reports on 5/10/17 at 11:00 AM, revealed Resident was burned on 6/17/16 as the result of hot coffee spilled on the resident's legs. A review of the investigation report provided by the facility revealed that there were no interviews of residents or staff. On 5/10/17 at 3:30 PM a review of the facility's Abuse Policy revealed that; item #10... Interview staff members, visitors and/or patients who may have knowledge of alleged incident being investigated..." In an interview with the Executive Director on 5/10/17 at 5:00 PM, it was acknowledged that there were no staff or resident interviews conducted.	F 226	unusual occurrences or incidents that could be abuse or neglect need to be reported to the ED immediately. ED will review unusual occurrences on incidents that could be abuse or neglect to validate appropriate reporting to state agency. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing	
F 253 SS=C	HOUSEKEEPING & MAINTENANCE SERVICES CFR(s): 483.10(i)(2) (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined the facility failed to provide maintenance service necessary for handrails throughout the facility. This has the ability to affect all residents. The findings included: During initial tour on 5/8/17 at 4:20 PM, the handrails on the north and east wing of the second floor hallways were marred.	F 253	1. Contract to correct marred hand rails obtained. 2. Residents residing in the center have the potential to be affected. 3. M. D. educated that hand rails should be observed for marring on weekly rounds and action taken as needed. M. D. to complete weekly audits in marring to validate marred hand rails have been identified. 4. Results of the observation audits will be	6/19/17

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F 253	Continued From page 10 During the Environment Tour with Maintenance Supervisor on 5/11/17 at 9:55 AM, the handrails on the east wing of the first floor were marred. When asked about the condition of the handrails, the Maintenance Supervisor said he was aware of the condition of the handrails, and have plans to sand and repaint them.	F 253	presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is on going	
F 272 SS=D	COMPREHENSIVE ASSESSMENTS CFR(s): 483.20(b)(1) (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information	F 272		6/19/17

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F 272	Continued From page 11 regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to document the date and location of information regarding the Care Area Assessment (CAA) worksheet for two (2) of 18 sample residents (Residents #9 and #13). The findings included: Resident #9 Resident #9 was readmitted to the facility on 11/26/16 with a past medical history that included Muscle Weakness and Seizures. Review of Section V (CAA Summary) instructions read in part "3. Indicate in the Location and Date of CAA documentation column where information related to the CAA can be found, CAA	F 272	1. Resident #9 and #13 MDS modification to CAA worksheet completed. 2. Residents residing in the center have the potential to be affected. 3. MDSC, SW, and AD were educated on documenting the date and location of information regarding CAA. CM will review 2 CAAs per week for 12 weeks to validate date and location of information is documented. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing	

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F 272	Continued From page 12	F 272		

documentation should include information on the complicating factors, risks, and any referrals for this resident for this care area.

Review of the RAI (resident assessment instruction) manual Chapter 4, section 4.5 reads in part "Written documentation of the CAA findings and decision making process may appear anywhere in a resident's record; for example, in the discipline-specific flow sheets, progress notes, the care plan summary notes, a CAA summary narrative, etc. Nursing homes should use a format that provides the information as outlined in this manual and the State Operations Manual (SOM). If it is not clear that a facility's documentation provides this information, surveyors may ask facility staff to provide such evidence.

Use the "Location and Date of CAA documentation" column of the CAA Summary (Section V of the MDS [minimum data set] 3.0) to note where the CAA information and decision making documentation can be found in the resident's record. Also indicate in the column "Care Planning Decision" whether the triggered care area is addressed in the care plan.

Review of the annual MDS with assessment reference date of 1/30/17 revealed that Section V indicated that the following areas were triggered and care planned: cognitive loss/dementia, ADL (activities of daily living) functional/rehabilitation potential, urinary incontinence and indwelling catheter, behavioral symptoms, falls, nutritional status, pressure ulcer. Each section indicated the date and location was CAA WS (worksheet) 2/1/17 and 2/2/17. Review of the CAA summary worksheet of the aforementioned sections did not

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F 272	Continued From page 13 yield a date and location of the information used to make a decision to care plan. Resident #13 Resident #13 was admitted to the facility on 12/30/13 with a past medical history that included Hypertension and Congested Heart Failure. Review of the annual MDS with assessment reference date of 8/24/16 revealed that Section V indicated that the following areas were triggered and care planned: cognitive loss/dementia, visual function, communication, ADL functional/rehabilitation potential, urinary incontinence and indwelling catheter, falls, nutritional status, dental care, pressure ulcer, psychotropic drug use and pain. Each section indicated the date and location was CAA WS (worksheet) 8/25/16, 8/29/16 and 8/30/16. Review of the CAA summary worksheet of the aforementioned sections did not yield a date and location of the information used to make a decision to care plan. During an interview with the Employee #9 on 5/11/17 at 11:47 AM when asked about the accuracy of the date and location of the information to be care planned, she stated, it "needs to site where they come from." When asked if the information was correct, she stated, "yes, it's not right."	F 272		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development	F 280		6/19/17

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and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

(i) Facilitate the inclusion of the resident and/or resident representative.

(ii) Include an assessment of the resident's strengths and needs.

(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.

483.21
(b) Comprehensive Care Plans

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F 280	Continued From page 15 (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based record review and staff interview the facility failed to update a resident's care plan to	F 280	1. Resident #11 care plan was updated to reflect code status per physician□s order.	

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F 280	Continued From page 16 reflect the current resuscitation status. The deficient practice was identified in one (1) of 18 Residents in the survey sample (Resident #11) Resident #11 was admitted to the facility on 9/5/16 with diagnoses that included Chronic Obstructive Pulmonary Disease, Heart Disease, Anxiety, and Hypertension. On 5/10/17 at 2:30 PM, a review of the clinical record revealed that the resident had a physician's order for "DNR (Do Not Resuscitate)/Comfort measured only" dated 9/12/16. Resident #11 also had a Plan of Care that noted ... is a full code due to ability to make Health Care decisions..." The resident's care plans were last updated on 4/17/17. On 5/11/16 at 3:00 PM it was acknowledged by the first floor Unit Manager that the physician's order would be correct.	F 280	2. Residents residing in the center have the potential to be affected. 3. SW educated on reporting care plan related to residents code status. SW will renew residents MD orders and compare them to care plan to validate care plan & MD orders correspond. CM will randomly audit 3 med records per week for 12 weeks to validate coder orders and care plan correspond. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing	
F 309 SS=E	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care.	F 309		6/19/17

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F 309	Continued From page 17 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, facility documentation, and staff interviews, the facility failed to provide non-pharmacological interventions prior to administering as needed pain medication to 4 of 18 total sampled residents (Residents #6, #7, #9, and #11). Additionally facility failed to provide pressure relieving devices for one (1) of 18 total sampled residents (Resident #1) The findings included: Resident #6	F 309	1. Resident # 6, 7, 9, and 11 are currently being offered non- pharm intervention prior to administering PRN pain medication. Resident #1 is being provided thera-boots per plan of care. 2. Residents residing in the center have the potential to be affected. 3. LN educated to offer non- pharm interventions prior to administering PRN pain medication. Nursing Staff educated on applying as needed per MD order. DNS or UM will randomly review 3 residents per week for 12 weeks to	

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F 309	Continued From page 18 Resident #6 was admitted to the facility on 5/4/16 with diagnoses that included Muscle Weakness, Pain, Hypertension, Falls, and Fracture. Resident #6 had a physician's order for Norco Tablets (Hydrocodone with Acetaminophen) 10-300 mg (milligram) 1 tablet every 6 hours as needed (prn) for pain. On 5/10/17 a review of the clinical record revealed that during the month of April 2017, the resident received 13 doses of the prn Norco that was documented on the Medication Administration Record. The clinical record also documented that non-pharmacological interventions were documented on only 5 of those occasions prior to administration of the medications. Resident #7 Resident #7 was admitted to the facility on 3/15/17 with diagnoses that include Heart Failure, Chronic Obstructive Pulmonary Disease, Pulmonary Hypertension, and Anxiety Disorder. Resident #7 had a physician's order for a Percocet tablets (pain medication) 5-325 mg (milligrams) Give one tablet every four hours as needed (prn) for severe pain. Resident #7 also had an additional physician's order for Tylenol with Codeine 300-30 mg. Give one tablet every 6 hours as needed for pain. A review of the resident's Medication Administration Record, for April 2017 revealed that the resident received 14 doses of the prn	F 309	validate non- pharm intervention are offered prior to PRN pain med administration. DNS or UM will randomly observe 2 residents per week for 12 weeks to validate boots are applied as needed. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing	

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Percocet and prn Tylenol with Codeine (pain medication) on 35 occasions for a total of 49 doses administered. However, non-pharmacological interventions prior to administration were documented for a total of 34 times of the 49 times the prn medications were administered.

Resident #11

Resident #11 was admitted to the facility on 9/5/16 with diagnoses that included Chronic Obstructive Pulmonary Disease, Heart Disease, Anxiety, and Hypertension.

Resident #11 had a physician's order for Norco Tablets (Hydrocodone with Acetaminophen) 5-325 mg (milligram) 1 tablet every 6 hours as needed (prn) for pain.

On 5/10/17 at 2:30 PM, a review of the clinical record revealed that during the month of March 2017, the resident received 5 doses of the prn Norco documented on the Medication Administration Record. Documented non-pharmacological interventions were documented on 1 of those occasions.

A review of the clinical record revealed that during the month of April 2017, the resident received 9 doses of the prn Norco documented on the Medication Administration Record documented. However, non-pharmacological interventions were documented only on 6 of those occasions.

Resident #9

Resident #9 was readmitted to the facility on 11/26/16 with a past medical history that included

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Pain and Osteoarthritis (OA).

Review of the facility policy "Pain Management" dated 3/20/17 reads in part "Provide non-pharmacological interventions for pain management and/or analgesics as ordered by the attending physician for break through pain."

Review of the resident's pain care plan which has as focus that reads Resident #9 "has potential for pain r/t (related to) OA, cervical spondylosis, chronic pain dx (diagnosis)". The goal was listed as Resident #9 "will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date." One of the interventions listed states, "Assess for the appropriateness of non-pharmacological interventions for pain relief distraction, redirection, like put on TV; audio book, call his wife, position change".

Review of the April 2017 physician's order reads Tylenol tablet 325 mg (milligrams). Give 2 tablet by mouth every 4 hours as needed for mild pain-moderate pain not to exceed 3 grams acetaminophen in 24 hours.

Review of the April 2017 medication administration record revealed that Resident #9 was administered Tylenol on April 14, 2017. Further review of the clinical record did not reveal any attempts to perform non-pharmacological interventions prior to administration of as needed pain medication.

Resident #1

Resident #1 had a past medical history that included Adult Failure to Thrive and Alzheimer's

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Disease.

The care plan for "Risk for pressure injury secondary to incontinence and decrease mobility factor" had a goal to "minimize potential for pressure injury by relieving pressure on pressure points" with an intervention/task of "Theraboots (a plastic ankle-foot splint to relieve pressure) to bilateral feet in bed."

Resident #1's record review revealed the quarterly Minimum Data Set (MDS) with Assessment Reference Date of 3/20/17, indicated Resident #1's Range of Motion as "Impairment on both sides," and requires a 2+ persons (2 or more person) physical assist for bed mobility.

During the Initial Tour on 5/8/17 at approximately 5:20 PM, Resident #1 was lying in bed while her Theraboots were on her wheelchair in the corner of her room.

On 5/9/17 at 9:30 AM, Resident #1 was lying in bed while her Theraboots were on her wheelchair in the corner of her room.

On 5/10/17 at 8:45 AM, after incontinence care, Employee #5 left Resident #1's room without placing Theraboots on feet. When asked why Resident #1 did not have her Theraboots on, Employee #5 stated Resident #1 moved her legs enough on bed during the day so the Theraboots are off, and Resident #1 is encouraged to shift sides. When asked where the Theraboots were, Employee #5 pulled the Theraboots out of Resident #1's drawer.

During an interview with Employee #4 on 5/11/17 at 8:50 AM, when asked what was the

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F 309	Continued From page 22 expectation of Theraboots placement, she said Theraboots should be on anytime a resident is in the bed.	F 309		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the	F 315		6/19/17

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F 315	Continued From page 23 facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, record review, and facility documentation, it was determined the facility failed to provide appropriate services to prevent the development of a Urinary Tract Infection (UTI) to one (1) of 18 total sampled residents who was incontinent of bowel and bladder (Resident #1). The findings included: Resident #1 was admitted on 1/4/17 with a past medical history that included UTI, Adult Failure to Thrive, and Drug-Induced Akathesia. Resident #1's record review revealed the quarterly Minimum Data Set (MDS) with Assessment Reference Date of 3/20/17, indicated Resident #1 was "always incontinent" of bladder and bowel function. Review of "Incontinence Management" documentation revealed under Procedure of cleaning the perineal area number 5A to "Remove gloves, wash hands and reapply gloves," and number 8 to "Remove and discard your gloves, and perform hand hygiene." On 5/10/17 at 8:45 AM during incontinence care, Employee #5 cleaned Resident #1 by wiping back and forth- from front of perineum to back of perineum (Perineum is the area between the legs that includes the vagina and anus), then from back of perineum to front of perineum. This	F 315	1. Resident #1 is being provided peri-care per policy. 2. Residents who require assist with peri-care have the potential to be affected. 3. Nursing staff were educated on providing peri- care per policy and procedure. SDC, DNS, and UM, will perform 2 random observations of peri-care per week for 12 weeks to validate peri-care is being performed per policy. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing	

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F 315	Continued From page 24 motion was repeated approximately three times while Resident #1 was lying on her right side. Employee #5 changed gloves after wiping the perineum and before placement of a clean incontinence brief. Employee #5 did not wash hands during incontinence care before reapplying gloves to place clean incontinence brief. Employee #4 assisted Employee #5 during incontinence care by stabilizing resident's position in bed. Employee #4 and Employee #5 did not wash hands after incontinence care. Care plan for "Potential for UTI secondary to h/o (history of) UTI" with a goal to "Minimize occurrence of UTI for this quarter" had intervention of "Ensure correct cleaning technique while providing peri (perineum) care." On 5/11/17 at 8:50 AM, when asked Employee #4, who was assisting Employee #5 during incontinence care on expectations of incontinence care, she stated to "always wipe front to back to prevent stool from getting to vaginal area."	F 315		
F 323 SS=K	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use	F 323		6/19/17

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F 323	Continued From page 25 appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on a review of clinical record, select resident incident/accident report, test tray results and the "American Burn Society Scald (very hot, burning) Injury Prevention Guide," observations and staff interviews, it was determined that the facility failed to maintain the residents' environment free of accident hazards created by increased temperatures of hot liquids served to the residents including one (1) of 18 residents reviewed, who sustained burns from spilled hot liquids (Resident #11). This failure placed the residents in Immediate Jeopardy (IJ) of sustaining injury as the result of scalding burns. Additionally, the facility failed to adequately investigate fall for four (4) of 18 sample residents reviewed (Residents #15, #13, #4 and #1). The findings include: Resident #11 was re-admitted to the facility on 9/5/16 with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Heart Disease, Anxiety, and Hypertension,	F 323	1. There are no witness statements for resident #15, 13, 4, and 1. Residents will be interviewed for preference of hot liquids. Residents that receive hot liquids will be assessed for safety and preference on consuming hot liquids? 2. Residents residing in the center have the potential to be affected. 3. LN in serviced to collect witness statements post fall /event. DNS, UM, and SDC will review witness statements with each fall. LN will review results of hot liquid safety assessment and resident preference and discuss with resident or responsible party, and document the risk and benefits of consuming beverages hotter than recommend by American Burn Association. 4. Witness statements post fall/event and hot liquid safety assessments will be presented to QAPI committee for review and recommendation of change and	

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F 323	Continued From page 26 A review of the resident's Minimum Data Set assessment (MDS - a federally mandated standardized assessment process conducted periodically to plan resident care) dated 6/1/2016, revealed that the resident was alert and oriented with a BIMS (Brief Interview for Mental Status - a tool to assess cognitive function), score of 15 (a score of indicates no cognitive impairment). This MDS assessment also noted that the resident was independent with eating after set up by staff In an interview with Resident #11 on 5/10/17 at 1:35 PM, she said that last year she was in the dining room being served her lunch when an aide put her coffee cup slightly out of reach. The resident said that she went to move the coffee closer to her and it snagged on a fold in the table cloth and spilled over her legs. She said that it was very hot. She also related that she was treated and still has a scar as a result of the hot coffee. Nursing documentation on June 16, 2016 indicated that the resident sustained burns over inner thighs with blistering. Review of a corresponding incident/accident investigation report indicated that on 6/17/16 and reported to the Virginia State agency on 2/10/17 documented that ;"... staff continues to be present in dining room and heard resident hollered Staff responded. Resident spilled coffee in her lap. Resident wearing shorts. First aid given." In an interview with the Executive Director on 5/10/17 at 6:15 PM, it was acknowledged that the facility did not conduct a thorough investigation	F 323	further need for review beyond the 12 weeks to assure compliance is ongoing.	

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and witness statements. She said that the temperature of the coffee was 155 degrees and that the facility put interventions in place to protect Resident #11.

The Executive Director reported that the issue was presented before the Quality Assurance Performance Committee (QAPI). In a review of the Root Cause Analysis provided, "What steps contributed to the event? None temperatures within acceptable range."

Review of the "American Burn Association Scald Injury Prevention Educator's Guide" (undated) revealed that older adults have thinner skin so hot liquids cause deeper burns with even brief exposure. The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed. When the temperature of a hot liquid is increased to 140 degrees Fahrenheit, it takes only five seconds or less for a serious burn to occur. A temperature of 148 degrees Fahrenheit takes 2 seconds for severe burns and at 155 degrees Fahrenheit takes 1 second for a severe burn to occur.

In the facility, a review of test trays done by the facility between 6/24/16 and 4/28/17. The coffee, tea, and other hot beverages are documented at temperatures between usually served at 161 degrees to 188 degrees Fahrenheit resulting in almost instantaneous burns to the residents.

Review of a "Test Tray" form (a facility form noting the temperatures of the food and beverages on the residents' meal trays, used to monitor service temperatures for food safety and palatability) revealed that after the resident had sustained a

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burn as the result of a hot coffee spill, a "Test Tray" was done on 6/24/2016, at the breakfast meal. The hot beverage was documented at 161 degrees. The test tray left the kitchen at 7:40 AM and the last tray served at 8:10 AM. In addition, he said that the facility does a test tray about weekly on different units and records the temperatures of the foods on the test tray

An interview conducted on May 10, 2017, at approximately 1:20 PM with the facility's Dietary Manager, revealed that the Dietary Department does not have a policy for the temperatures at point of delivery by the facility. He did acknowledge that the facility does use the US food Code. He also stated that he calibrates his thermometer on a daily basis.

He further said that he is in charge of the Dietary Department and if there were any changes to be made regarding his department he would have been notified and would have made any changes. He did hear of a resident being burned with a hot liquid but had no further information. He said that to his knowledge no other resident had been burned. He said that he has been working at the facility for three years.

In an interview with the Dietitian at 2:30 PM on 5/9/17, it was acknowledged that cold foods should be served under 41 degrees and hot foods under 145 degrees.

During an interview with the resident's responsible party on 5/10/17, at approximately 3:00 PM she confirmed that Resident #11 had incurred a reddened blistered area in her inner thighs and was treated. She said that the facility had served the coffee in a cup without a lid when

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the spill occurred. She said that the facility has now supplied a cup with a lid and there hasn't been another accident with her mother.

As the result of the facility's failure to identify and consistently monitor the temperatures of hot liquids served to the residents and the risk of scalding to the residents as the result of the elevated temperatures found during the survey Immediate Jeopardy to the health and safety of the residents was identified to the Nursing Home Administrator on May 10, 2017, at 12:30 PM. The facility was requested to develop a corrective action plan

Following verification of the implementation of the corrective action plan and review of the staff education log & subject. The Immediate Jeopardy was lifted at 8:05 PM on May 10, 2017 with a corrective action plan being accepted.

The facility's corrective action plan included:

1. Nursing and Therapy staff who serve or assist residents with dining were inserviced program on Scald Injury Prevention Guidelines per the American Burn Association.

2.Resident Council President educated the center will no longer routinely put hot beverages on each resident tray, but will provide per resident request.

3.Culinary Staff educated to continue to honor current likes for hot beverages for residents who are unable to request.

4 Culinary Staff educated to continue to honor current likes for soups and hot cereals.

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5.Culinary Staff educated on serving temperatures for hot beverages, hot cereals and soup per the American Burn Association.

6.Culinary staff educated coffee will be sent to the units in urns at controlled temperature of no greater than 140 degrees for nursing staff to provide per resident request/preference.

7.Nursing Staff educated coffee will be sent to units in urns for nursing staff to provide per resident
request/preference.

A temperature assessment of the hot liquids and the liquid-like foods (i.e. oatmeal, soup) served to the residents during the breakfast meal at 8:10 AM on 5/11/17, revealed a coffee temperature of 137 degrees. The hot cereal temperature was 121 degrees. The lunch temperature of the soup taken at 5/11/17 at 11:45 AM was 134 degrees and the hot coffee was 130 degrees.

Resident #15

Resident #15 was admitted to the facility on 1/24/17 with a past medical history that included Muscle Weakness.

Review of the resident's 30-day PPS (prospective payment system) of the MDS (minimum data set) dated 2/10/17 revealed in Section G that the resident was unsteady on his feet with transfers and mobility.

Review of the resident's Post Fall Investigation (V.3.01) dated 2/14/17 revealed the resident had an unwitnessed fall onto the floor. The

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investigation also indicated that there were no injuries associated with the fall. Further review of the clinical record revealed there were no witness statements from the person who found Resident #15.

During an interview with First Floor Unit Manager on 5/11/17 at 9:40 AM, when asked about witness statements from Resident #15's fall, she stated they did not have any witness statements association with his fall.

Resident #13

Resident #13 was admitted to the facility on 12/30/13 with a past medical history that included Extrapyramidal Movement and Vascular Dementia.

Review of the resident's Quarterly MDS with an Assessment Reference Date (ARD) of 8/24/16 revealed in Section G that the resident was unsteady when moving from seated to standing position and from surface to surface transfer.

Review of the resident's Post Fall Investigation (V.3.01) dated 4/15/17 revealed the resident had a witnessed fall onto the floor. The investigation also indicated that there were no injuries associated with the fall. Further review of the clinical record revealed there were no witness statements from the named witness indicated on the fall investigation form for Resident #13.

During an interview with First Floor Unit Manager on 5/11/17 at 9:40 AM, when asked about witness statements from Resident #13's fall, she stated they did not have any witness statements association with his fall.

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Resident #4

Resident #4 was readmitted to the facility on 3/26/17 with a past medical history that included Cerebrovascular Accident and Difficulty Walking.

Review of the resident's Quarterly MDS with an ARD of 3/20/17 revealed in Section G that the resident was unsteady when moving from seated to standing position and from surface to surface transfer

Review of the resident's Post Fall Investigation (V.3.01) dated 3/26/17 and 4/18/17 revealed the resident had unwitnessed falls onto the floor. The investigation also indicated that there were no injuries associated with the fall. Further review of the clinical record revealed there were no witness statements from the persons who found Resident #4 on the floor.

During an interview with First Floor Unit Manager on 5/11/17 at 9:40 AM, when asked about witness statements from Resident #4's fall, she stated they did not have any witness statements association with his fall.

Resident #1 was admitted to the facility on 1/4/17 with a past medical history that included Adult Failure to Thrive, Alzheimer's Disease, and Dementia.

Resident #1's record review revealed a quarterly Minimum Data Set (MDS) with Assessment Reference Date of 3/20/17, indicated Resident #1 had fallen since admission or prior assessment, and one fall with no injury.

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F 323	Continued From page 33 The post fall investigation record from 4/4/17 at 6:50 PM revealed the following: Resident #1 fell on 4/2/17 at 4:30 PM. There was no witnesses. Resident #1 was found in her room on the floor. She was "found lying on her right side, on the left side of the bed." When asked to specify if patient slipped, record shows "pt (patient) rolled out of bed." Resident #1 was last toileted 10 minutes before the fall and was alone at time of fall. Resident #1 had no complaints of pain. During an interview with First Floor Unit Manager on 5/11/17 at 9:40 AM, when asked about witness statements from Resident #1's fall, she stated they did not have any witness statements with her fall.	F 323		
F 332 SS=D	FREE OF MEDICATION ERROR RATES OF 5% OR MORE CFR(s): 483.45(f)(1) (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, review of facility documentation, clinical review and staff interviews, the facility failed to ensure the facility had a medication error rate less than 5%. During the medication administration observation 27 opportunities were made. There was 2 medication errors for medication error rate was 7.4%. The findings included:	F 332	1. Residents #17 and 18 are receiving their medication per MD order. 2. Residents residing in the center have the potential to be affected. 3. LN educated on the rights of medication administration pass. SDC will observe med pass of 2 residents a week for 12 weeks to validate compliance with the rights of med pass. 4. Results of the observation audits will be	6/19/17

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F 332	Continued From page 34 Resident #17 Review of Resident #17's May 2017 physician's order read the following: Potassium Chloride Solution 20mEq (miliequivalents)/15 ml (milliliters) (10%). Give 20 mEq via G-tube (gastrostomy tube) two times a day for low potassium. On the Potassium bottle the following words were affixed, "mix with 4-8 oz (ounces) of juice or water. During medication pass observation on 5/9/17 at 8:34 AM, Employee #7 pour 15 ml of Potassium into a medicine cup and administered it to Resident #17. During an interview with Employee #7 on 5/11/17 at approximately 10:45 AM the Potassium bottle was reviewed with this surveyor. Upon reading the affixed label to mix with juice or water, when asked if this was done during medication pass on 5/9/17, she stated, "no, I didn't do that." Resident #18 Review of Resident #18's May 2017 physician's order read the following: Latanoprost Solution (Xalatan) 0.005%. Instill 1 drop in left eye in the morning for open angle glaucoma. During medication pass observation on 5/9/17 at 9:07 AM, Employee #8 administered 1 drop of Xalatan in the right and left eye.	F 332	presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing.	

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F 332	Continued From page 35 During an interview with Employee #8 on 5/11/17 at approximately 10:40 AM she acknowledged that she gave the eye drop to the wrong eye.	F 332		
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on Observation, staff interview and review of facility documentation, it was determined that the facility failed to ensure that food was prepared, dated and stored in a sanitary manner	F 371	1. Tomatoes and buns were discarded. Can opener was cleaned. DM was provided 1:1 education on hand washing. 2. Residents who receive food or	6/19/17

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F 371	Continued From page 36 as evidenced by outdated hot dog buns, soiled can opener, failure of staff to properly wash hands and outdated items in the refrigerator. The findings include: During a kitchen tour on 5/8/17 at 4:10 PM, the following was observed: In the kitchen; In the walk-in refrigerator: A container with three tomatoes had a date of 3/6/17. In the food preparation area; The can opener had an accumulation of a slippery substance. In the dry storage room; One package of 12 hot dog buns dated 3/26/17 One open bag of 6 hot dog buns dated 3/26/17, no opened date. In an interview with Employee #1 who was present during the initial tour of the kitchen, who acknowledged the observations. On 5/9/17 at 11:30 AM, the Dietary Manager was observed washing his hands and then turning off the spigots with his hands. In an interview on 5/9/17 at 2:15 PM, the Dietary Manager acknowledged that he failed to use a towel to dry his hands. On 5/11/17 in a review of Kindred Healthcare	F 371	beverages from the culinary department have the potential to be affected. 3. Culinary staff was educated on dating food, cleaning the can opener after use and proper hand washing. 3 times a week for 12 weeks DM will validate food is dated and equipment is clean. Twice a week for 12 weeks Dm will observe culinary staff performing hand washing to validate hand wasting is performed per policy. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing.	

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F 371	Continued From page 37 Food Storage Guidelines dated 9/2/12 it documented lengthen of time for storage; Breads, fresh - Dry Storage for 5-7 days. Tomatoes- fresh - Raw-Refrigerator for - 1 week.	F 371		
F 372 SS=F	DISPOSE GARBAGE & REFUSE PROPERLY CFR(s): 483.60(i)(4) (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility failed to store refuse in a sanitary manner. The findings include: On 5/8/17 at 4:15 PM, while on a tour of the outside area of the kitchen with Employee #1, the following was observed; outside the kitchen area, a large laundry cart contained numerous trash bags, the ground area around the loading area contained numerous cigarette butts and pieces of paper. In the dumpster area, there was a used adult diaper on the ground stained with a yellow substance. There were numerous pieces of blue plastic on the ground around the dumpsters. Employee #1 who was present at the time of observation acknowledged the observations.	F 372	1. Areas outside kitchen and around dumpster are clean. 2. Residents residing in the center have the potential to be affected. 3. Staff was educated when dumping trash to pick up any remaining debris left on the ground and surrounding areas. DM will observe area outside kitchen dumpsters 3 times a week for 12 weeks to validate no debris is left on the ground and surrounding areas. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing.	6/19/17
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program.	F 441		6/19/17

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 441	Continued From page 39 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, facility documentation and staff interview, it was determined that the facility failed to maintain sanitary practices to prevent the spread of infection. The findings included: On 5/10/17 at 12:45, during an observation of the second floor dining room, Employee #2 was observed washing her hands and turn off the spigot with her hands. Employee #2 was interviewed several minutes later and acknowledged that she should have used a paper towel to close the spigot.	F 441	1. Employees #2, 3, 8 and the Culinary Mgr were provided a 1:1 in service on hand washing. 2. Residents residing in the center have the potential to be affected. 3. Center staff was educated on the hand washing policy. SDC will randomly observe 3 staff members per week for 12 weeks to validate compliance with hand washing procedure. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing	

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F 441	Continued From page 40 On 5/10/17 at 12:46 PM, Employee #3 was observed washing her hands and then turning off the spigot with her hands. In an interview with Employee #3 at the time of observation, Employee #3 said," I must have forgotten." During medication pass observation on 5/9/17 from 9:07 AM and 9:30 AM, Employee #8 administered medications to Resident #18. At approximately 9:17 AM she entered into the resident's bathroom and commenced to washing her hands for less than 10 seconds, the she admistered medications to a resident. Employee #8, again several minutes later (9:20 AM), washed hands for less than 10 seconds then she administed medications to another resident.	F 441		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514		6/19/17

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F 514	Continued From page 41 (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the medical records were maintained accurately for 2 of 18 total sampled residents (Residents #13, and #4). The findings included: Resident #13 Resident #13 was admitted to the facility on 12/30/13 with a past medical history that included Extrapyramidal Movement and Vascular Dementia. Review of the resident's Post Fall Investigation (V.3.01) dated 4/15/17 revealed the resident had a witnessed fall onto the floor. The investigation also indicated that there were no injuries	F 514	1. Employee #6 provided 1:1 education regarding data entering VS in medical record. 2. Residents in center have potential to be affected. 3. LN educated on data entering VS in medical record. DNS and UM will review post fall evaluations to validate VS are entered from the time a fall occurs. 4. Results of the observation audits will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing	

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F 514	Continued From page 42 associated with the fall. Further review of the clinical record revealed that the vital signs that were recorded were from a previous date of 3/21/17. During an interview with Employee #6 on 5/10/17 at 8:50 AM, when asked what vital signs should be recorded at the time of a fall, she replied, "vital signs should be from the time of the fall." She agreed that the wrong date and time was entered on the fall investigation form. Resident #4 Resident #4 was readmitted to the facility on 3/26/17 with a past medical history that included Cerebrovascular Accident and Difficulty Walking. Review of the resident's Post Fall Investigation (V.3.01) dated 4/18/17 revealed the resident had an unwitnessed fall onto the floor. The investigation also indicated that there were no injuries associated with the fall. Further review of the clinical record revealed that the vital signs that were recorded were from a previous date of 4/6/17. During an interview with Employee #6 on 5/10/17 at 8:50 AM, when asked what vital signs should be recorded at the time of a fall, she replied, "they should have selected new vital signs. This is incorrect."	F 514		
F 518 SS=F	TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS CFR(s): 483.75(m)(2) The facility must train all employees in emergency procedures when they begin to work in the facility;	F 518		6/19/17

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F 518	Continued From page 43 periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on facility documentation and staff interviews, it was determined that the facility failed to ensure fire drills were completed as required for all shifts. This has the ability to affect all residents. The findings included: During the Environmental Tour on 5/12/17 with the Maintenance Supervisor at 9:55 AM, when asked about how frequently were fire drill held at the facility, he stated, "one per shift per quarter except third shift." He further went on to say, "we were told not to ring bell on third shift so as to not scar residents." Review of the facility policy entitled, "Emergency Drills/Fire Drill" dated 12/29/16 revealed the following instructions, "1. Conduct a fire drill three times a month at varying times so that all three shifts participate in a drill...18. Conduct silent fire drills during the time frames of 9:30 p.m. to 5:30 a.m. Normal A.R.A.C.E. (a verbal notice, rescue, alarm, contain extinguish/evacuate) procedures are maintained except the person initiating the drill will intercept the sounding of the alarm. The charge nurse will announce appropriate overhead (i.e. "Code red - Zone #, Room 232) but the alarm system will remain silent." Review of the Fire/Disaster Drill Record from May 2016 through April 2017 revealed that fire drills were not conducted on all three shifts for the following months in 2016, February, March, April,	F 518	1. Main. Dir provided 1:1 education on fire drills 2. Residents residing in center have the potential to be affected. 3. Main. Dir will present education material and log to ED how he conducted each fire drill monthly x 3 months. 4. QAPI committee will review to validate compliance ongoing.	

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F 518	Continued From page 44 June, July, August, September, October, November, December. Fire drills were also not conducted on all three shifts for the following months in 2017, February, March and April. During an interview on 5/12/17 at 3:12 PM with District Director of Clinical Operations, when asked about the frequency of the fire drills, she stated, "we didn't follow our policy."	F 518		
F 520 SS=F	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of	F 520		6/19/17

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F 520	Continued From page 45 action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Base on facility record review and staff interview the facility failed to develop corrective actions that prevent identified safety problems. These lack of corrective actions has the potential of exposing residents to injuries. Findings include: Nursing documentation on June 16, 2016 indicated that Resident #11 sustained burns over inner thighs with blistering. Review of a corresponding incident/accident investigation report indicated that on 6/17/16 and reported to the Virginia State agency on 2/10/17 documented that ;"... staff continues to be present in dining room and heard resident hollered Staff responded. Resident spilled coffee in her lap. Resident wearing shorts. First aid given." In an interview with the Executive Director on 5/10/17 at 6:15 PM, it was acknowledged that the facility did not conduct a thorough investigation and witness statements. She said that the	F 520	1. DDCO educated ED and DNS on QAPI conduction a thorough investigation and witness statements. 2. Residents residing in canter have the potential to be affected. 3. DDCO educated ED and DNS on QAPI conduction a thorough investigation and witness statements. Any root cause analysis completed at Hoc QAPI will be presented in monthly QAPI meeting for QA committee review monthly 3x. 4. Results of the root cause analysis will be presented to QAPI committee for review and recommendation of change and further need for auditing beyond the 12 weeks to assure compliance is ongoing	

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temperature of the coffee was 155 degrees and that the facility put interventions in place to protect Resident #11.

The Executive Director reported that the issue was presented before the Quality Assurance Performance Committee (QAPI). In a review of the Root Cause Analysis provided, "What steps contributed to the event? None temperatures within acceptable range." Review of the "American Burn Association Scald Injury Prevention Educator's Guide" (undated) revealed that older adults have thinner skin so hot liquids cause deeper burns with even brief exposure. The severity of a scald injury depends on the temperature to which the skin is exposed and how long it is exposed. When the temperature of a hot liquid is increased to 140 degrees Fahrenheit, it takes only five seconds or less for a serious burn to occur. A temperature of 148 degrees Fahrenheit takes 2 seconds for severe burns and at 155 degrees Fahrenheit takes 1 second for a severe burn to occur.

On 6/17/16 the QAPI committee developed an action plan for the incident. Fourteen Actions/Interventions were developed. Only one of the actions address the temperature of the coffee, "check coffee temperature immediately," coffee was 155 degrees.

However, the plan did not indicate that the high temperature of the coffee was a significant factor in causing the burn injury to Resident #11. Consequently the QAPI committee never established a safe temperature for hot liquids and what is to be done if the safe temperature is exceeded.

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F 520	Continued From page 47 Review of food temperature logs from January to May 2017 revealed temperatures for coffee from 160 to 168 degrees. Cross reference to F323	F 520		