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HOLLY MANOR NURSING HOME	2003 COBB STREET FARMVILLE, VA 23901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the abbreviated survey conducted 5/30/19 through 5/31/19, and 6/3/19 through 6/4/19 was conducted 7/16/19 through 7/17/19. Corrections are required for compliance with the following 42 CFR Part 483 of the Federal Long Term Care requirements. The census in this 120 certified bed facility was 106 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents #101-119) and no closed record reviews.	{F 000}		
{F 695} SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide respiratory care and services consistent with professional standards of practice, and the comprehensive person-centered care plan for one of 19 residents in the survey sample, Residents #113. The facility staff failed to administer Resident #113's oxygen according to the physician's orders.	{F 695}	F000 To remain in compliance with all Federal and State regulations, that facility has or will take the following actions set forth in the following plan of correction. The alleged deficiencies cited have been or will be corrected by the date(s) indicated. F695 1)O2 for resident #113, was placed back	8/12/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/06/2019

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 695} Continued From page 1

The findings include:

Resident #113 was admitted to the facility on 5/14/19. Diagnosis include but are not limited to, acute respiratory failure with hypoxia (1), chronic obstructive pulmonary disease with (acute) exacerbation (2), shortness of breath, obesity, and anemia. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 6/11/19, coded the resident as scoring a 13 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the resident had no cognitive impairment for making daily decision making. The Resident required supervision and setup for eating; extensive assistance for transfers, dressing, toileting, and hygiene, total care for bathing; was frequently incontinent of bladder and bowel.

A review of the clinical record revealed a physician's order dated 5/16/19, that documented in part, "Oxygen via NC (nasal cannula) at 4 L/min (Liter/minute) continuous to keep O2 (oxygen) saturation >90%..."

On 7/16/19 at 2:46 PM, an observation of Resident #113's oxygen concentrator, flow rate was conducted. Resident #113's oxygen concentrator flowrate was observed at 3 1/2 Liter/minute. This observation was conducted at eye level with the oxygen flow meter.

On 7/17/19 at 9:11 AM, an observation of Resident #113's oxygen concentrator, flow rate was conducted. Resident #113's oxygen concentrator flowrate was observed between 3

{F 695}

on 4L. Resident # 113' care plan updated for noncompliance with O2 administration as confirmed with her legal guardian.
2)All other residents with O2 administration were checked and receiving the prescribed amount of O2.
3)Re-education provided to nurses on O2 administration including the checking of flow rates each shift as a resident may bump the concentrator causing the dial to shift.
4)During quarterly audits flow rates will be verified for rooms with O2 in use. Concerns will be reported to QA committee/compliance for review and recommendations.
5)8/12/19

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{F 695}	Continued From page 2 1/2 Liter/minute and 4 Liter/minute. This observation was conducted at eye level with the oxygen flow meter. At this time, Resident #113 was asked who adjusts the oxygen concentrator flowrate, she stated, "The nurses do that. They have to do it." On 7/1/7/19 at 3:52 PM, an observation of Resident #113's oxygen concentrator was made. Upon entering Resident 113's room, LPN (Licensed Practical Nurse) #2 was observed standing in front of Resident #113's oxygen concentrator with her hand on the flowmeter knob. LPN #2 stated, "I need to check her oxygen rate. Yes. It is on 4 Liter/minute." LPN #2 was asked to demonstrate how the staff know if the oxygen concentrator is set at the flowrate ordered physician. LPN #2 stood in front of the oxygen concentrator and knelt down to eye level with the flowmeter. LPN #2 stated, "You get down at eye level to make sure the ball is on the correct line." A review of the clinical record revealed a care plan dated 12/23/16, with a reviewed and revised date of 7/9/19, which, documented in part, "Activity intolerance: Interventions: Administer medications/treatments as ordered..." On 7/17/19 at 2:35 PM, an interview was conducted with LPN #3. LPN #3 was asked about the process staff follows for setting a resident's oxygen flowrate. LPN #3 stated, "You would get down at eye level and turn the knob until it ball is at middle of the line the physician ordered. If you stand up and look at it, it would not be the same. It would not be as accurate." When asked about the concerns for a resident with the oxygen set at the wrong rate, LPN #3	{F 695}		

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{F 695}	Continued From page 3	{F 695}		

stated, "You would need to assess your patient to make sure they are ok and get their pulse ox (3) to make sure their oxygen levels are ok."

On 7/17/19 at 3:10 PM, an interview was conducted with RN (Registered Nurse) #3. RN #3 was asked about the process for setting a resident's oxygen flowrate. RN #3 stated, "You get down at eye level with the gauge and measure where the ball is. The ball is in the center of the line." RN #3 was asked what the concerns would be if the oxygen to be set at the wrong rate. RN #3 stated, "Your immediate concern is the resident and if they are in respiratory distress or hypoxia."

A review of the facility's policy, "Oxygen Administration" documented in part, "...Procedure: 1. check physician's order for liter flow and method of administration...5e. Set the flow meter to the rate ordered by the physician...11. At regular intervals, check liter flow contents of oxygen cylinder, fluid level of humidifier and assess resident's respirations to determine further need for oxygen therapy... "

A review of the facility's operator's manual for "(Name of) Oxygen Concentrators" documented in part, "...DO NOT change the L/min setting on the flowmeter unless a change has been prescribed by your physician or therapist...Flowrate: 1. Turn the flowrate knob to the setting prescribed by your physician or therapist. Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min. line prescribed...."

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{F 695}	Continued From page 4	{F 695}		

According to Fundamentals of Nursing, sixth edition, Potter and Perry, 2005, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity (Thomson, 2002). As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

On 7/17/19 at 4:42 PM, ASM (Administrator Staff Member) #1 the Assistant Administrator, ASM #2, the Director of Nursing, and ASM #3, the Director of Compliance by conference call, were made aware of the findings.

No further information was provided by the end of the survey.

(1) Hypoxia: Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.

(2) Chronic obstructive pulmonary disease with (acute) exacerbation: Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(3) According to Lippincott's Manual of Nursing Practice, 8th edition, (2006). pg. 213, oxygen saturation is measured using a pulse oximetry. A

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{F 695}	Continued From page 5 pulse oximetry functions by passing a light beam through a vascular bed, such as the finger, to determine the amount of blood that is saturated with oxygen.	{F 695}		
{F 880} SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(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; §483.80(a)(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	{F 880}		8/12/19

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{F 880}	Continued From page 6 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 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. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(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, resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement infection control practices for five of 19 residents in the survey	{F 880}	F880 1)(A) LPN#2 cleaned the glucometer after realizing the oversight brought to her attention by the surveyor. (B) Staff serving meals were promptly address when	

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{F 880}	Continued From page 7 sample; Residents #104, #105, #117, #118, #119. 1. The facility staff failed to follow infection control practices for the use of a glucometer for Resident #104. 2. The facility staff failed to serve food to the residents in a sanitary manner during a dining room observation in the main dining room and Lee unit dining room, for Resident #105, Resident # 117, Resident #118, and Resident #119. The findings include: 1. The facility staff failed to follow infection control practices for the use of a glucometer [devices that measure blood glucose levels (1)] for Resident #104. Resident #104 was admitted to the facility on 2/13/12 with the diagnoses that include but are not limited to, gastroparesis, overactive bladder, irritable bowel syndrome, congestive heart failure, colitis, dysphagia, anxiety disorder, dementia, oxygen dependence, diabetes, chronic obstructive pulmonary disease, stroke, and osteoporosis. The annual/30-day readmission MDS (Minimum Data Set) assessment coded the resident as cognitively intact in ability to make daily life decisions. (Resident #109 was admitted to the facility on 3/20/18 with the diagnoses of but not limited to gastrointestinal hemorrhage, dysphagia, heart failure, anxiety disorder, peripheral vascular	{F 880}	concern brought to our attention, observations made thereafter and proper serving was provided with no further issues on 7/17/19. 2)(A) No other nurses were observed obtaining glucose readings without cleaning the glucometer between uses on the evening of 7/16/19 and the morning of 7/17/19 when audited. (B) Staff monitored plate delivery following the 7/16/19 observation and found no staff serving in an unsanitary manner on 7/17/19. 3)(A)Facility nurses were re-education on cleaning the glucometer between each use. (B) Facility food service serving staff were re-educated on sanitary food delivery, including serving plates without touching the top inner rim when serving them. 4)Unannounced quarterly observations will be made of various staff (A) during medication pass and (B) serving meals to ensure hand placement on plates avoid the top rim of the plates. Concerns will be addressed during training observations and reported to QA/Compliance for review and recommendations. 5)8/12/19	

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disease, kidney failure, heart attack, and respiratory failure with hypoxia. The quarterly MDS with an ARD of 6/5/19 coded the resident as being mildly impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing; extensive care for dressing, toileting, hygiene and transfers; and was independent for eating. A review of the clinical record for Resident #109 revealed an order dated 7/12/19 for "Accuchecks - Obtain blood sugar checks before meals (with sliding scale) and at bedtime.")

A review of the clinical record for Resident #104 revealed an order dated 5/31/19 for "Accuchecks - Obtain blood sugar checks before meals (with sliding scale) and at bedtime."

On 7/16/19 at 4:02 PM, LPN #2 (Licensed Practical Nurse) was observed performing blood sugar checks on another resident, Resident #109. After performing the blood sugar finger-stick check for Resident #109, LPN #2 returned to the medication cart. She then obtained a new test strip an lancet and alcohol pad to perform a blood sugar check on Resident #104. LPN #2 then went into Resident #104's room and performed a blood sugar check on Resident #104. LPN #2 did not clean the glucometer device between residents.

On 7/6/19 at 4:52 PM, in an interview with LPN #2, she stated that it (glucometer) should be cleaned between residents and that she thought she had. The observation was reviewed with LPN #2 and she stated that she did not realize that she didn't clean it (glucometer).

On 7/6/19 at 4:52 PM, an interview was

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conducted with LPN #1. LPN #1 was asked about completeing accuchecks on residents. LPN #1 stated that she would clean the device (glucometer) down first, and while in the room would set it down on a clean tissue, and when she is done she would wipe it down with a clean alcohol pad between residents.

A review of the manufacturer's manual for the glucometer did not specify if the device was intended for single individual use or if it could be used with multiple residents/patients. The manual did not document to sanitize between residents/patients for multiple person use. On page 4 under "Intended Use" did document that the device "is intended for both lay use by people with diabetes and in a clinical setting by healthcare professionals...." On page 44, under "Cleaning and Disinfection (name of device)," the following was documented, "Cleaning and disinfecting your meter and lancing device is very important in the prevention of infectious disease...." And on page 47, "If the meter or lancing device is being operated by a second person who is providing assistance to the user, the meter or lancing device should be disinfected prior to use by the second person...."

A review of the facility policy, "Blood Sugar Monitoring" did not document any criteria for the sanitizing of the glucometer between residents. It did document, "3. Follow manufacturer's directions for use and care of the equipment used in your facility."

According to the Centers for Disease Control (CDC): "Blood glucose meters are devices that measure blood glucose levels. Whenever possible, blood glucose meters should be

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assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. (1)

On 7/17/19 at 4:43 PM ASM #1 (Administrative Staff Member, the Assistant Administrator) and ASM #2 the Director of Nursing, and ASM #3 Director of Compliance (via conference call) were made aware of the findings.

(1) Blood glucose meters are devices that measure blood glucose levels. This information was obatined from the website: http://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html

2. The facility staff failed to serve food to the residents in a sanitary manner during a dining room observation in the main dining room and Lee unit dining room, for Resident #105, Resident # 117, Resident #118, and Resident #119.

Resident #119 was admitted to the facility on 6/24/19 with the diagnoses of but not limited to high blood pressure, abdominal aortic aneurysm (1), and pain. The most recent MDS (Minimum Data Set), an admission/5-day assessment, with an ARD (Assessment reference date) of 7/1/19, coded the resident as scoring a 12 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for making daily decision making. The resident was coded as requiring setup assistance for eating.

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Resident #117 was admitted to the facility on 2/8/19 with the diagnoses of but not limited to acute systolic (congestive) heart failure (2), retention of urine, and gastro-esophageal reflux disease. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 4/29/19, coded the resident as scoring a 15 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had no cognitive impairment for making daily decision making. The resident was coded as requiring limited assistance for eating.

Resident #105 was readmitted on 7/1/19 with the diagnoses of but not limited to systemic lupus erythematosus (3), high blood pressure, and unspecified convulsions. The most recent MDS (Minimum Data Set), a significant change assessment, with an ARD (Assessment reference date) of 6/15/19, coded the resident as scoring a 9 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had moderate cognitive impairment for making daily decision making. The resident was coded as requiring supervision and setup for eating.

Resident #118 was admitted to the facility on 12/18/18 with the diagnosis of but not limited to age-related osteoporosis (4), hypothyroidism, and fracture upper end of right humerus. The most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment reference date) of 6/21/19, coded the resident as scoring a 5 out of 15 on the BIMS (Brief Interview for Mental Status) score, indicating the Resident had severe cognitive impairment for making daily decision making. The resident was coded as

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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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requiring setup assistance for eating.

On 7/16/19 between 4:27 PM and 4:36 PM, an observation of the main dining room meal service was conducted. OSM (Other Staff Member) #4, a server, was observed bringing plates to Resident #119. OSM #4 touched the food contact, surface area of the rim of the plates with her bare hand as she retrieved the plates from the dietary aid in the kitchen and placed the plates on the table.

On 7/16/19 at 4:44 PM, an observation of the meal service in the dining room on the Lee Unit was conducted. OSM #1, the Dietary Manger, was observed bringing a plate to Resident #117. OSM #1 touched the food contact, surface area of the rim of the plate with her bare hand as she retrieved the plate from the dietary aid in the kitchen and placed the plate on the table for Resident #117.

On 7/16/19 at 4:46 PM, an observation of the dining room on the Lee Unit was conducted. OSM #1 was observed bringing a plate to Resident #105. OSM #1 touched the food contact, surface area of the rim of the plate with her bare hand as she retrieved the plate from the dietary aid in the kitchen and placed the plate on the table for Resident #105.

On 7/16/19 at 4:50 PM, OSM #6, a server, was observed bringing a plate to Resident #118. OSM #6 touched the food contact, surface area of the rim of the plate with her bare hand as she retrieved the plate from the dietary aid in the kitchen and placed the plate on the table.

On 7/17/19 at 12:13 PM, an interview was conducted with OSM #8, a server. OSM #8 was

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	495339	A. BUILDING ______ B. WING ______	R-C 07/17/2019

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{F 880}	Continued From page 13 asked about the process for serving resident meals in the dining rooms. OSM #8 stated, "In this kitchen we don't go into the kitchen to get the food. A dietary aid in the kitchen hands it (plated food) to us at the door with the resident's ticket under the plate." OSM #8 was asked about the process for carrying plates to the resident's table. OSM #8 stated, "I pick it up from underneath and take it to the table. I slide the plate onto the table and remove the ticket." OSM #8 was asked if staff member's thumbs should be on the food contact, surface area of a resident's plate when serving the resident. OSM #8 stated, "No. Never." OSM #8 stated, "It (plate) would be contaminated." When asked what a server should do if their thumbs were on the food contact, surface area of the plate, OSM #8 stated, "Get another plate." On 7/17/19 at 12:24 PM, an interview with OSM #9, a server, was conducted. OSM #9 was asked about the process for serving resident meals in the dining room. OSM #9 stated, "The food is served on a plate. We put the plate on a tray and take it to the table." OSM #9 was asked the process for removing the plate from the tray and placing the plate on the table. OSM #9 stated, "We have a stand to put the tray on and remove the plate and serve the resident. We pick up the plate on the side of the plate." OSM #9 demonstrated holding a plate and pointed to the palm of her hand and stated, "I normally pick it up with my four fingers underneath and my thumbs on the side." When was asked if thumbs should be on the food contact surface area, OSM #9 stated, "Not at all." OSM #9 was asked what the concern was if a server had their thumbs on the food contact surface area. OSM #9 stated, "Our hand are not supposed to touch the food area, it	{F 880}		

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would be contaminated." OSM #9 was asked what a server should do if their thumbs were on the food contact surface area of a residents plate. OSM #9 stated, "We would need to take it back to the kitchen to be remade."

On 7/17/17 at 2:47 PM, an interview was conducted with OSM #1. OSM #1 was asked about the process for serving resident meals in the dining room. OSM #1 stated, "We have servers in the dining room. A dietary aid will hand the server the plate at the door and they will take it to the resident." OSM #1 was informed of the observations of staff carrying plates with bare hands and their thumbs on the food contact, surface area of resident's plates, during the lunch dining room service in the main dining room and the ancillary dining rooms. OSM #1 stated, "No. Normally, I use gloves when I do. I take them off and throw them in the trash. I normally don't serve plates. OSM #1 was asked if the staff should have their thumbs on the top of the food surface area of the plate. OSM #1 stated, "I get what you are getting at. I know the right thing to do." When asked about the process the staff follows if they touch the top of the food contact, surface area with their bare hand, OSM #1 stated, "Take it back to the kitchen and get another one."

A review of the facility policy "Dining Atmosphere" documented in part, "...3...Serve food carefully to avoid drips and spills..." The policy did not include any criteria for serving food to the residents in a sanitary manner.

A review of the facility policy "Dining Room Service" documented in part, "...3. Staff should check individual name and diet on the meal

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identification (ID) car/ticket to verify that the meal is served to the correct person..." The policy did not include any criteria for serving food to the residents in a sanitary manner.

On 7/17/19 at 4:42 PM, ASM (Administrator Staff Member) #1 the Assistant Administrator, ASM #2, the Director of Nursing, and ASM #3, the Director of Compliance by conference call, were made aware of the findings.

No further information was provided by the end of the survey.

(1) Abdominal aortic aneurysm: The aorta is the main blood vessel that supplies blood to the abdomen, pelvis, and legs. An abdominal aortic aneurysm occurs when an area of the aorta becomes very large or balloons out. The information was obtained from the website: https://medlineplus.gov/ency/article/000162.htm

(2) Acute systolic (congestive) heart failure: A condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html

(3) Systemic lupus erythematosus: Systemic lupus erythematosus (SLE) is an autoimmune disease. In this disease, the immune system of the body mistakenly attacks healthy tissue. It can affect the skin, joints, kidneys, brain, and other organs. This information was obtained from the website:

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{F 880}	Continued From page 16 https://medlineplus.gov/ency/article/000435.htm (4) Age-related osteoporosis: Makes your bones weak and more likely to break. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html.	{F 880}		