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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495256 | A. BUILDING _____ B. WING _____ | C 04/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN CARE OF CHESAPEAKE | 715 ARGYLL ST CHESAPEAKE, VA 23320 |

| (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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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey was conducted 4/11/17 through 4/13/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey.<br><br>The census in this certified 117 bed facility was 110 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through 20) and 4 closed record reviews (Residents #21 through 24). | F 000 | | |
| F 278 SS=D | 483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.<br><br>(h) Coordination<br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>(i) Certification<br>(1) A registered nurse must sign and certify that the assessment is completed.<br><br>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>(j) Penalty for Falsification<br>(1) Under Medicare and Medicaid, an individual who willfully and knowingly- | F 278 | | |



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE Administrator — (X6) DATE 5/3/17

Paul Conradt-Eberlin

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(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, clinical record review, and facility document review the facility staff failed to ensure the MDS (Minimum Data Set) assessments for 2 of 24 residents in the survey sample were accurate, Resident #14 and Resident #10.

1. The facility staff failed to ensure the Quarterly MDS with an assessment reference date (ARD) of 3/16/17 Section O. Special Treatments, Procedures, and Programs O0100 J. was accurate for Resident #14.

2. The facility staff failed to ensure the Significant Change MDS with an assessment reference date (ARD) of 1/24/17 Section J. Heath Conditions J1900 C. was accurate for Resident #10.

The findings included:

1. Resident #14 was a 83 year old originally admitted to the facility on 5/17/12 and readmitted on 6/10/16 with diagnoses to include End Stage Renal Disease (1) and Dependence on Renal Dialysis (2).

1. MDS assessments were corrected and transmitted prior to 4/13/17 for residents # 10 & 14.
2. Any resident has the potential to be affected.
3. In-service by the Regional Reimbursement Specialist or designee on accurate completion with the MDS team.
4. Random audits weekly of MDS assessments for accuracy by the DON or designee x 4 weeks and then random monthly x 3 months.
   B) Audit results will be shared in QAPI meetings.
5. Will be in compliance as of May 26th, 2017.

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The most recent MDS assessment was a Quarterly assessment with an assessment reference date (ARD) of 3/16/17. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated Resident #14 was cognitively intact and capable of daily decision making. Under Section O. Special Treatments, Procedures, and Programs O0100 J. Dialysis (while a resident of this facility within the last 14 days) Resident #14 was not coded.

Resident #14's Comprehensive Care Plan last revised 3/21/17 was reviewed and documented in part, as follows:

Focus: (Name of Resident #14) on schedule days Dialysis. Date initiated: 4/6/16.
Goal: Resident will be free of complications from dialysis pain/infection/bleeding from site thru next review. Date initiated: 4/6/16.
Interventions: Dialysis as ordered on _ Tuesday, Thursday, Saturday_____days. Date initiated: 4/6/16.

Resident #14's April 2017 Physician Orders electronically signed by the Attending Physician on 3/25/17 at 9:03 a.m. were reviewed and documented in part, as follows:

Order Summary:
*May attend dialysis. Order Status: Active. Order Date 6/10/16.
*Admit to LTC (long term care) under the services of (Name of Attending Physician), Diagnosis include; end stage renal disease with dialysis. Order Status: Active. Order Date 8/15/16.

On 4/12/17 at 3:30 p.m. a Resident Interview was

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conducted with Resident #14 and her dialysis was discussed. Resident #14 stated, "I go to dialysis on Tuesday, Thursday, and Saturdays, and they always pack me a lunch. When I get back they check my fistula (dialysis port) and remove the dressing."

On 4/12/17 at 4:30 p.m. an interview was conducted with the MDS Coordinator. The MDS Coordinator was asked if Resident #14 goes to dialysis. The MDS Coordinator stated, "Yes, she does." The surveyor handed the MDS Coordinator the Quarterly MDS assessment with the ARD date of 3/16/17 and asked if the resident was coded for dialysis and should she have been. The MDS Coordinator stated, "No, it is not coded and yes, it should have been coded." The surveyor asked, "Why should the dialysis have been coded for the resident?" The MDS Coordinator stated, "The MDS captures the resident and helps us make sure we are aware and meeting their needs."

On 4/12/17 the MDS Coordinator modified and resubmitted the Quarterly MDS assessment with the ARD date of 3/16/17 coding dialysis for Resident #14 under Section O. Special Treatments, Procedures, and Programs O0100 J. The MDS Coordinator provided the surveyor with a copy of Section Z of the MDS showing the modification date of 4/12/17 and stated, "I don't know how I missed that, it was in my notes, just human error."

The facility has no written policy regarding an accurate MDS; however, the MDS Coordinator stated, "We follow the RAI (Resident Assessment Instrument) Manual."

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The MDS Coordinator provided the document from the CMS's (Center for Medicare Services) RAI Version 3.0 Manual and is documented in part, as follows:

Page Z-6:

Z0400: Signatures of Persons Completing the Assessment or Entry/Death Reporting:
Attestation Statement: I certify that the accompanying information accurately reflects resident assessment information for this resident and that I collected or coordinated collection of this information on the dated specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Item Rationale:
*To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation

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*The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for:
-the development of an individualized care plan;
-the Medicare Prospective Payment System;
-Medicaid reimbursement programs;
-quality monitoring activities, such as the quality measure reports;
-the data-driven survey and certification process;
-the quality measures used for public reporting;
-research and policy development.

Coding Instructions:
*All staff who completed any part of the MDS must enter their signatures, titles, sections or portion(s) of section(s) they completed, and the date completed.
*Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status.

On 4/13/17 at approximately 3:15 p.m. a pre-exit debriefing was held with the Administrator and the Director of Nursing where the above information was shared. Prior to exit no further information was provided.

(1) End Stage Renal Disease: a disease condition that is essentially terminal because of irreversible damage to vital tissue or organs. Kidney or end stage renal disease is defined as a point at which the kidney is so badly damaged or scarred that dialysis or transplantation is required for patient survival.

(2) Hemodialysis: a procedure in which

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impurities or wastes are removed from the blood, used in treating patients in renal failure and various toxic conditions. The patient's blood is shunted from the body through a machine for diffusion and ultrafiltration and then returned to the patient's circulation. Hemodialysis requires access to the patient's bloodstream, a mechanism for the transport of the blood to and from the dialyzer.

The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

2. The facility staff failed to ensure the significant change MDS (Minimum Data Set) with an assessment reference date (ARD) of 1/24/17 section J. Health Conditions J 1900 C. was accurate for Resident #10.

Resident #10 was originally admitted to the facility on 2/2/16 with a readmission on 1/16/17. The resident's diagnoses included a left tibia/fibula (bones in the lower leg located below the knee and above the ankle) fracture.

The significant change MDS with an assessment reference date of 1/24/17 coded the resident as scoring a 13 out of a possible 15 on the brief interview for mental status (BIMS), indicating the resident had intact cognition. The resident's prominent language was Spanish. The resident was wheelchair bound and was dependent on two staff for transfers. Section J. Health Conditions J 1900 Number of Falls Since Admission/entry or Reentry or Prior Assessment coded the resident as having had one fall with a major injury.

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| F 278 | Continued From page 7<br>A review of the clinical records and the facility's internal investigation report failed to evidenced the resident sustained the fracture due to a fall.<br><br>On 4/11/17 at approximately 6:30 pm, the MDS Coordinator was questioned about the accuracy of this MDS. She stated she would look into it.<br><br>On 4/12/17 at 10:25 am, the MDS Coordinator stated the MDS was inaccurate and a corrected MDS was submitted yesterday.<br><br>The above findings was shared with the Administrator and the DON (Director of Nursing) during the pre-exit interview conducted on 4/13/17. | F 278 | | |
| F 309 SS=E | 483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>483.24 Quality of life<br>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.<br><br>483.25 Quality of care<br>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 | F 309 | | |

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| F 309 | Continued From page 8 but not limited to the following:<br><br>(k) Pain Management.<br>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.<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview staff interview, facility documentation and clinical recorded review, the facility staff failed to follow physician orders for 2 out 24 Residents in the survey sample, Resident #15 and #20.<br><br>1. The facility staff failed to follow physician orders for the prescribed administration times for the following medications: Spiriva Handi-Haler capsule 18 mcg, Symbicort Aerosol 80-4.5 MCG/ACT, DuoNeb solution 0.5-2.5 (3) mg/3 ml, Tussionex Pennkinetic ER Suspension Extended Release 10-8 mg/5 ml and Ventaolin HFA Solution 108 (90 base).<br><br>2. During the course of a complaint investigation the facility staff failed to follow the physician's orders for the administration of a Fentanyl pain patch for Resident #20.<br><br>The findings included: | F 309 | 1. No correction to be made for residents # 15 & 20.<br><br>2. Residents receiving a Fentanyl patch are at a potential risk. Any residents that receive medications are at risk.<br><br>3. In-service by ADON or designee for licensed nursing staff on medication pass to include:<br>a. times of administration<br>b. documentation<br>c. following MD orders<br>- Notification of MD when medications are not administered<br>d. follow up on medications ordered on admission, especially pain medications<br><br>4. Med pass audits will be done on all units randomly on a weekly basis x 4 weeks and then random monthly x 3 months.<br>b) Audit results will be shared in QAPI meetings.<br><br>5. Will be in compliance as of May 26th, 2017. | |

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1. Resident #15 was admitted to the facility on 09/03/16. Diagnoses for Resident #15 included but are not limited to Respiratory Failure (1), Chronic Obstructive Pulmonary Disease (COPD (2)) and Lung Cancer (3). Resident #15's Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/19/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident was cognitively intact with no problems in decision making.

The care plan for Resident #15 identified Terminal care/Hospice and focuses on death with comfort and dignity. The intervention to include but not limited to: comfort measures and administering medication as ordered.

Review of Resident #15's Physician orders and Medication Administration Record for April 2017 indicated the following medication orders:

1). Spiriva Handi-Haler (4) capsule 18 mcg (micrograms) take 1 puff inhale orally one time a day for cough at 9:00 a.m.

2). Symbicort Aerosol (5) 80-4.5 MCG/ACT , take 2 puffs orally every morning and at bedtime for chronic obstructive pulmonary disease (COPD) - rinse mouth after use - scheduled to be administered at 8:00 a.m. and 8:00 p.m.

3). DuoNeb solution 0.5-2.5 (6) mg (milligram)/3 ml (milliliter) - 1 via inhale orally three times a day for congestion; scheduled to be given at 9:00 a.m., 1:00 p.m., and 5:00 p.m.

4). Tussionex Pennkinetic ER (extended release)

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Suspension Extended Release (7) 10-8 mg/5 ml - Give 5 ml by mouth every 12 hours for cough hold for sedation - scheduled to be given every 12 hours at 9:00 a.m. and 9:00 p.m.

Review of Resident #15 Medication Administration Audit Record for April 2017 revealed the following medication administration times:

1). Spiriva inhaler was documented as administered at the following times for the 9 a.m. dose: on 4/12 at 11:11 am, 4/09 at 11:30 am, 4/5 at 1:53 p.m. and 4/3 at 12 p.m.

2). Symbicort inhaler was documented as administered at the following times for the 9 a.m. dose: on 4/12 at 11:11 am, 4/11 at 9:50 a.m., 4/10 at 10:12 a.m., 4/5 at 1:53 p.m. and 4/3 at 11:59 a.m.

3). DuoNeb was documented as administered at the following times for the 9 a.m. dose: on 4/12 at 11:09 a.m., 4/9 at 12:47 p.m., and 4/3/ at 11:59 a.m.

4). Tussionex was documented as administered at the following times for the 9 a.m. dose: on 4/12 at 11:05 a.m., 4/9 at 11:32 a.m., 4/5 at 1:53 p.m. and 4/3 at 12:00 p.m.

On 04/13/17 an interview was conducted with the Nurse Practitioner (NP) at approximately 3:00 p.m. who stated all medication is to be given at the time as ordered, anything other than that is unacceptable. Resident #15's lungs are not in good shape with his chronic lung problems. His respiratory medication helps to assist the airflow within his lungs.

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An interview was conducted with LPN #1 on 4/12/17 at approximately 4:00 p.m., who stated, "I've been having difficulty trying to administer Resident #15's medications on time ever since night shift stopped doing the morning blood sugars and insulins." Resident #15 is on the opposite side of the hall and by time I get to him, Resident #15's medications are already late. The surveyor asked when can a scheduled medication be administered, LPN #1 replied, "May give 1 hour before the mediation is due and 1 hours after the scheduled time for medication". I usually start on hall 1 first but Resident #15 is on hall 2, so by time I get to hall 2, Resident #15's medications are already late and not giving him his respiratory medication on time can definitely increase his problems with his breathing.

An interview was conducted with the Administrator and DON on 04/13/17 at approximately 3:15 p.m., the DON stated, "We have a unit manager that can help LPN #1 if she needs help, I just can't believe she never asked for help". The DON stated that giving medication late is not acceptable, I expect for everyone's medication to be administered on time.

The facility's policy on Medication Administration Times (Revision Date: 05/01/10)

Procedure:
1). Facility should ensure that authorized personnel, as determined by Applicable Law, administer medications according to times of administration as determined by Facility's pharmacy committee and/or Physician/Prescriber.

2). Facility should commence medication

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administration within sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration.

The facility's policy "General Dose Preparation and Medication Administration" (Last Revision Date: 01/01/13)

*Procedure:
4. Prior to administration of medication, Facility staff should take all measures required by Facility policy and Applicable Law, including but not limited to the following:
4.1 The facility staff should: 4.1.1 - Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time and for the correct resident.

5. During medication administration, Facility staff should take all measures required by Facility policy and Applicable Law, including, but not limited to the following:
5.4 - Administer medications within timeframe's specified by Facility policy.

6. After medication administration, facility staff should take all measures by facility policy and Applicable Law, including, but not limited to the following:
6.1 Document necessary medication administration/treatment information (e.g., when medications are given) on appropriate forms.

(1) Respiratory Failure is the inability of the cardiovascular and pulmonary systems to maintain adequate exchange of oxygen and carbon dioxide in the lungs (Mosby's Dictionary of

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Medicine, Nursing & Health Professions, 7th Edition).

(2) COPD makes it hard for you to breathe. The two main types are chronic bronchitis and emphysema. The main cause of COPD is long-term exposure to substances that irritate and damage the lungs. (https://medlineplus.gov/ency/article/007365.htm).

(3) Lung Cancer is a pulmonary malignancy attributable - it is one of the most common cancers in the world. It is a leading cause of cancer death in men and women in the United States (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition).

(4) Sprivia Handi-Haler is used to control symptoms of COPD - it helps make your lungs work better for 24 hours and help reduce the likelihood of flair-ups and worsening of COPD symptoms. Instructions: Exactly as prescribed (Manufacture's package insert and label information).

(5) Symbicort is used to treat asthma, maintenance treatment of airflow obstruction in patients with chronic obstructive pulmonary disease (COPD) including bronchitis and emphysema. Instructions: Exactly as prescribed (Manufacture's package insert and label information).

(6) DuoNeb is a combination of two medication called bronchodilators; Ipratropium Bromide and Albuterol Sulfate. These two medicines work together to help open the airways in your lungs and is used to help treat airway narrowing (bronchospasm) that happens with COPD.

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Instructions: exactly as ordered by prescriber (Manufacture's package insert and label information).

(7) Tussionex Pennkinetic ER contains two medicines, hydrocodone and chlorpheniramine Hydrocodone is a narcotic cough suppressant. Chlorpheniramine is an antihistamine. Tussionnex is used to treat cough and upper respiratory symptoms you have with allergies or a cold. Instructions: exactly as ordered by prescriber (Manufacture's package insert and label information).
2. The facility staff failed to follow the physicians orders for the administration of a Fentanyl pain patch for Resident #20.

The complainant alleged the facility staff failed to administer a Fentanyl patch for 8 days.

Resident #20 was admitted to the facility from home on 7/1/16 for long term care. The resident's diagnosis included chronic pain syndrome.

The admission MDS (Minimum Data Set) with an assessment reference date of 7/14/16 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact. Under Section J. Health Conditions J 0110 Section Paint Management A. Received scheduled pain medication regimen was checked "yes".

The resident's Comprehensive Person-Centered Care Plan dated 7/1/16 included pain. The goal was that the resident will maintain comfort to highest degrees possible. One of the

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interventions to achieve/maintain the goal was to administer pain medication as ordered.

The physician orders dated 7/2/16 included Fentanyl patch 25 mcg (micrograms)/24 hours apply 1 patch transdermally one time a day every 3 days for pain, and remove per schedule.

The admission Nursing Note dated 7/1/16 read, in part: ...Resident noted with a Fentanyl patch 25 mg to her right chest. Resident's daughter stated that she applied to he {sic}Fentanyl patch today. Medications were bought in by resident's daughter."

The Nursing Note dated 7/2/16 read, in part: "When I attempted to place Fentanyl on resident, resident refuses to allow patch to be placed on chest wall. Resident stated she had patch changed yesterday. Patch placed back into narc. (narcotic) box."

A review of the Medication Administration Record for July 2016 evidenced the Fentanyl 25 mcg entry. The nursing staff initialed that the patch was removed on 7/5/16 and a new patch was applied. The entry dated 7/8/16 was coded as a 19=Other/See Nurse Note.

The Medication Administration Nursing Note dated 7/8/16 entered at 10:00 am, Note Text: Fentanyl Patch 72 hour 25 mcg/hr read- no patch available to apply. NP (Nurse Practitioner) notified.

The Medication Administration Nursing Note dated 7/8/16 entered at 12:25 pm, Note Text: Fentanyl Patch 72 hour 25 mcg/hr read-not removed r/t (related to) awaiting new patch.

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The Nursing Note dated 7/8/16 entered at 1:59 pm, Note Text: NP office made aware that resident needed script for Fentanyl patch.

The Nursing Note dated 7/9/16 Note Text: On call phoned this AM pertaining to resident Hard Script for Fentanyl patch 0.25 mcg. Spoke with pharmacy this am regarding if hard script had been faxed from MD office for refill. Spoke with (name) from pharmacy for information on how to receive Fentanyl patch for resident this weekend. Pharmacy gave this fax # to (name of pharmacy and fax number) for quicker delivery this weekend. Awaiting call back from on call (physician). Spoke with daughter who is in DC at this time, voiced concerns of resident going without a new patch.

The resident's drug regimen included additional pain medication that was scheduled every night for chronic pain-Amitryptyline 25 milligrams 3 tablets and Hydrocodone-Acetaminophen 7.5 mg-3000 mg one tablet to be given every six hours as needed for pain.

The MAR evidenced the resident did not request additional as needed pain medication from 7/1/16 through discharge on 7/14/16.

The Nursing Note dated 7/11/16 Note Text: Updated daughter on Fentanyl patch RX (prescription). (Name of NP) NP in facility.

The Medication Administration Record (MAR) for July 2016 evidenced a Fentanyl 25 mcg patch was applied on Monday 7/11/16.

The facility failed to apply the pain patch as

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| F 309 | Continued From page 17<br>scheduled on 7/8/16. The resident was without the pain patch for 3 days, from 7/8/16 through 7/10/16.<br><br>The above findings was shared with the Administrator and the Director of Nursing during an end of day meeting on 4/12/16.<br><br>On 4/13/17 the Administrator and the Director of Nursing provided a copy of the hard script for the Fentanyl 25 mcg patch dated 7/11/16. | F 309 | | |
| F 314 SS=D | COMPLAINT DEFICIENCY<br>483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>(b) Skin Integrity -<br><br>(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-<br><br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br><br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint | F 314 | | |

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investigation, the facility staff failed to ensure infection prevention measures to prevent the transmission of infection for 1 of 24 residents in the survey sample (Resident #1) on contact isolation (1) was followed during wound care.

The findings included:

Resident #1 was admitted to the facility on 9/7/16 with a readmission on 2/22/17. Diagnoses for Resident #1 included but are not limited to Paraplegia (2), Renal Insufficiency (3), Diabetes (4), Clostridium Difficile (5) and Stage III Pressure Ulcer (6) of the Left heel (previously treated for MRSA (Methicillin-resistant Staphylococcus aureus (7)).

Resident #1's Significant Change Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/1/17, coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 15 of 15 indicating no cognitive impairment.

In addition, the Significant Change Minimum Data Set coded Resident #1 requiring Extensive Assistance with 2 staff person assistance for Bed Mobility. In addition, Resident #1 was coded as having a suprapubic (8) catheter for a diagnosis of Urinary Retention (9) and was coded as frequently incontinent of Bowel functioning.

Resident #1 was observed on 4/12/17 at approximately 1:00 p.m. for his Left Heel wound care. The Licensed Practical Nurse (LPN) #5 was observed to wash hands, don a mask, gown, and gloves to begin Resident #1's heel wound care per physician's 3/22/17 order: Cleanse left and right heels with normal saline, apply silvasorb

1. No correction to be made for resident # 1.

2. Any resident with a wound is at risk for this issue.

3. In-service by the ADON or designee for licensed nursing staff on providing a wound treatment to include establishing a clean field. Return demonstration will be performed.

4. A) DON/designee will perform random audits of nurses providing wound care 3x a week for 12 weeks.

   b) Audit results will be shared in QAPI meetings.

5 Will be in compliance as of May 26th, 2017.

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and cover with mepilex daily.

LPN #5 was observed to place a clean red plastic trash bag over the corner of an unsanitized bed side table. LPN #5 was observed to place her supplies on top of the clean red plastic trash bag. LPN #5 was observed to complete the wound care per the Physician's orders without incident.

On 4/12/17 at approximately 2:30 p.m., Corporate Registered Nurse (RN) was asked what her expectations were regarding sanitizing the table prior to wound care. She stated that a clean plastic bag would create a clean field, and she stated that if the table was dirty, she would expect it to be cleaned prior to wound care.

On 4/13/17 at approximately 9:30 a.m., the Director of Nursing (DON) was asked what her expectations were regarding sanitizing table prior to wound care. She stated that it would be her expectation to sanitize the table prior to beginning of wound care.

The Facility's Policy and Procedure titled, "Skin and Wound Care Guideline" with an effective date of July 2012 documented the following:

"Clean technique involves strategies used in patient care to reduce the overall number of microorganisms or to prevent or reduce the risk of transmission of microorganisms from one person to another or from one place to another. Clean technique involves meticulous hand-washing, maintaining a clean environment by preparing a clean field, using clean gloves, sterile instruments, and prevention of direct contamination of materials and supplies..."

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Prior to observing the wound care observation, Resident #1 was sitting in his wheel chair, with his arm resting on the bedside table. The table had multiple items on it which LPN #5 moved to the side.

The facility administration was informed of the findings during a briefing on 4/13/17 at approximately 3:10 p.m. The facility did not present any further information about the findings.

Definitions:

(1) Contact isolation: Medline Plus documents: May be needed for germs that are spread by touching. Contact precautions help keep staff and visitors from spreading the germs after touching a person or an object the person has touched.

(2) Paraplegia: Medline Plus documents: the loss of muscle function in part of the body

(3) Renal Insufficiency: Mosby's Medical, Nursing, and Allied Health Dictionary documents: Partial kidney function failure characterized by less than normal urine excretion.

(4) Diabetes: Medline Plus documents: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high

(5) Clostridium Difficile: Medline Plus documents: a bacterium that causes diarrhea and more serious intestinal conditions such as colitis.

(6) Stage III Pressure Ulcer Left Heel: : National Pressure Ulcer Advisory Panel documents:

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| F 314 | Continued From page 21<br>Full-thickness skin loss<br>Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.<br><br>(7) Methicillin-resistant Staphylococcus aureus: Mayo Clinic documents: MRSA infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections.<br><br>(8) Suprapubic catheter: Medline Plus documents: a tube inserted through an incision through the abdomen to the bladder to drain urine.<br><br>(9) Urinary Retention: Medline Plus documents: problem emptying urine from the bladder. | F 314 | | |
| F 315 SS=D | 483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>(e) Incontinence.<br>(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. | F 315 | | |

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| F 315 | Continued From page 22<br>(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(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;<br><br>(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<br><br>(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.<br><br>(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the 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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed to ensure a suprapubic catheter was anchored to prevent potential complications related to positioning of the catheter for one of 24 residents in the survey sample (Resident #1)..<br><br>The findings included: | F 315 | 1. The facility applied an anchoring device for the catheter immediately after being informed of the missing anchor by 4/13/17.<br><br>2. Any resident with a catheter is at risk.<br><br>3. In-service by the ADON or designee for nursing department employees on caring for indwelling catheters to include catheter care and anchoring the catheter tubing.<br><br>4. DON or designee will conduct 100% audit of residents who have a catheter for correct anchorage of device 5x a week for 12 weeks.<br><br>b) Results of audit will be brought to QAPI<br><br>5 Will be in compliance as of May 26th, 2017. | |

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Resident #1 was admitted to the facility on 9/7/16 with a readmission on 2/22/17. Diagnoses for Resident #1 included but are not limited to Paraplegia (2), Renal Insufficiency (3), Diabetes (4), Clostridium Difficile (5) and Stage III Pressure Ulcer (6) of the Left heel (previously treated for MRSA (Methicillin-resistant Staphylococcus aureus (7))

Resident #1's Significant Change Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 3/1/17, coded Resident #1 with a BIMS (Brief Interview for Mental Status) of 15 of 15 indicating no cognitive impairment.

In addition, the Significant Change Minimum Data Set coded Resident #1 requiring Extensive Assistance with 2 staff person assistance for Bed Mobility. In addition, Resident #1 was coded as having a suprapubic (8) catheter for a diagnosis of Urinary Retention (9) and was coded as frequently incontinent of Bowel functioning.

Resident #1 was observed on 4/12/17 at approximately 1:30 p.m. after his Left Heel wound care. The Licensed Practical Nurse (LPN) #5 was asked if Resident #1 had his Suprapubic tube anchored. LPN #5 stated, "Yes." Immediately Resident #1 stated, "No, it's not." LPN #5 then began to feel for the anchor clip and was not able to locate the anchor.

Resident #1's Physician order of 2/22/17 documented: Anchor catheter tubing and check placement every shift. Every shift for protocol.

The Facility's Policy and Procedure titled, "Catheter Care Urinary Male-Female" with an

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| AUTUMN CARE OF CHESAPEAKE | 715 ARGYLL ST CHESAPEAKE, VA 23320 |

| (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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| F 315 | Continued From page 24 | F 315 | | |

revision date of July 2015 documented the following:

"Secure catheter with a leg band."

On 4/12/17 at approximately 1:30 pm Resident #1 was observed sitting in his wheel chair with his arm resting on the bedside table. When asked if his catheter tubing was anchored, Resident #1 stated, "I sometimes get an anchor and sometimes I don't."

The facility administration was informed of the findings during a briefing on 4/13/17 at approximately 3:10 p.m. The facility did not present any further information about the findings.

Definitions:

(1) Contact isolation: Medline Plus documents: May be needed for germs that are spread by touching. Contact precautions help keep staff and visitors from spreading the germs after touching a person or an object the person has touched.

(2) Paraplegia: Medline Plus documents: the loss of muscle function in part of the body

(3) Renal Insufficiency: Mosby's Medical, Nursing, and Allied Health Dictionary documents: Partial kidney function failure characterized by less than normal urine excretion.

(4) Diabetes: Medline Plus documents: Diabetes is a disease in which your blood glucose, or blood sugar, levels are too high

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| F 315 | Continued From page 25<br>(5) Clostridium Difficile: Medline Plus documents: a bacterium that causes diarrhea and more serious intestinal conditions such as colitis.<br><br>(6) Stage III Pressure Ulcer Left Heel:: National Pressure Ulcer Advisory Panel documents: Full-thickness skin loss<br>Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury.<br><br>(7) Methicillin-resistant Staphylococcus aureus: Mayo Clinic documents: MRSA infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections.<br><br>(8) Suprapubic catheter: Medline Plus documents: a tube inserted through an incision through the abdomen to the bladder to drain urine.<br><br>(9) Urinary Retention: Medline Plus documents: problem emptying urine from the bladder. | F 315 | | |
| F 360 SS=D | 483.60 PROVIDED DIET MEETS NEEDS OF EACH RESIDENT<br><br>The facility must provide each resident with a nourishing, palatable, well-balanced diet that | F 360 | | |

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| F 360 | Continued From page 26 | F 360 | | |

meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview and clinical record review the facility staff failed to take into consideration the dietary needs and preferences for 1 of 24 residents in the survey sample, Resident #12.

Resident #12 stated she has a diagnosis of diverticulosis (1) and could not eat certain foods such as rice and corn. She stated the facility continues to serve her these items.

The findings included:

Resident #12 was admitted to the facility on 9/15/15 with diagnosis to include GERD (gastric reflux).

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 3/21/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact.

On 4/12/17 at 11:50 am, the resident was observed in bed. The resident's husband was at the bedside. The resident was alert and orientated to person, place and time. She was asked about the care and services provided by the facility. She stated one concern was that the dietary department continues to serve her food that she can't eat, such as corn and rice. She stated she has diverticulosis and had a sigmoid colon resection in 2006 due to this. She

1. Dietary card clearly notes resident # 14's needs and preferences.

2. All residents are at risk for the issue.

3. In-service of dietary staff by the Food Service Director concerning the need to follow information on dietary tray cards regarding preferences and needs.

4. Meal tray for resident # 12 will be monitored for accuracy by Food Service Director or designee M-F x 3 weeks.
b. Food Service director/designee will randomly audit meal trays on all four units, 5x a week for 12 weeks, for adherence to residents needs and preferences.
4c. Results of audits will be shared in QAPI meetings.

5 Will be in compliance as of May 26th, 2017

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| F 360 | Continued From page 27 | F 360 | | |

continued to state that these food items could get lodged in her intestine and cause an infection. During the interview the resident's lunch tray was brought into the room and placed on the bedside table. The resident was served fish, tater tots, corn bread and corn. The residents preferences and dislikes were on the printed meal ticket sent with the tray. The list included among other preferences "No corn, No Rice".

The clinical record was reviewed. The current active diagnosis list did not include diverticulosis. The dietary orders dated 2/16/16 read, "reduced sodium diet, mechanical soft, thin consistency. Pt (patient) able to have a regular hot dog texture as tolerated. Resident prefers more vegetables than meat for GE reflux (gastric reflux)..."

On 4/12/17 at approximately 1:00 pm, one of the nurse practitioners (NP) for the attending physician was interviewed. She stated she was not the NP for Resident #12, that particular NP was on leave. The NP stated she would look further into the resident's alleged diagnosis of diverticulosis and return with an update.

On 4/12/17 at 1:40 pm, the NP returned to the conference room and provided this inspector with additional information. She provided a copy of a Cardiology Specialists consult dated 3/16/16. This consult included under Past Medical History: Patient Active Problem List
Diagnosis-Diverticulosis of colon without bleed. The NP stated the resident's diagnosis list will be updated to include diverticulosis. When asked if the resident should be on a restricted diet, she stated "Yes".

The NP wrote the following dietary orders dated

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| F 360 | Continued From page 28<br>4/12/17- Reduced sodium, mechanical soft, thin consistency and no nuts, corn, popcorn or seeds every shift for diet.<br><br>On 4/13/17 at 2:15 pm, the Food Service Manager was interviewed. The resident's concern with food items being served that were not to be served, and the observation of the resident being served corn when the food preference list clearly read that the resident was not to get corn was shared. She stated, "It was because they (dietary staff) didn't read her meal ticket".<br><br>The above findings was shared with the Administrator and the DON (Director of Nursing) during the pre-exit interview conducted on 4/13/17.<br><br>(1) Diverticulosis-Diverticula in the colon without inflammation or symptoms. Only a small percentage of persons with diverticulosis develop diverticulitis. Diverticulitis is an inflammation of a diverticulum or Diverticula in the intestinal tract, especially in the colon, causing pain, anorexia, fevers and occasional peritonitis (inflammation of the serous membrane that lines the abdominal cavity). Taber's Cyclopedic Medical Dictionary Edition 20. | F 360 | | |
| F 364 SS=D | 483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>(d) Food and drink<br><br>Each resident receives and the facility provides-<br><br>(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; | F 364 | | |

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| F 364 | Continued From page 29 | F 364 | | |

(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature;
This REQUIREMENT is not met as evidenced by:
Based on observations, group and staff interviews, the facility staff failed to serve food that was palatable, and at a safe and appetizing temperature for one of four Units of the facility.

The findings included:

Observations made at 12:18 P.M. on 4/13/17 during the Lunch meal indicated food was not served which was palatable and at a safe and appetizing temperature.
During the Group Interview on 4/12/17 at 11:00 A.M. one resident stated food is not always served hot on the One Hundred Unit. At 12:18 P.M. on 4/13/17 a test tray was conducted on the One Hundred Unit. The facility food services were set up with a kitchen area on four units. Food was prepared in the main kitchen and carted to the unit's steam tables for serving.

The lunch menu consisted of Chicken Alfredo, Fettuccini Pasta, green beans, and brownies for desert. The alternate menu was Beef Stew.
At 11:18 A.M. the initial temperatures were started for the tray line. The initial temperatures were as follows: Chicken Alfredo 127 degrees, Noodles 138 degrees, Broccoli 122 degrees, ground chicken 160 degrees, puree chicken 163 degrees, puree green beans 155 degrees, Alfredo sauce 152 degrees, and beef stew at 149 degrees.

The Chicken Alfredo was re-tempted at 191

1. No resident cited for this deficiency.

2. All residents are at risk for this issue.

3. In-service by Food Service Director for dietary staff on food temps and proper procedure for taking food temps.
3b. In-service by ADON or designee for nursing department staff on the timely serving of meals on the units to ensure meals are served at proper and palliative temps.

4. Food temps will be checked daily on the tray line prior to serving by the Food Service Director or designee and then random weekly.

b) A test tray will be checked weekly at each meal 5x a week x 3 months by Food Service Director or designee.

C)Audit results will be shared in QAPI meetings.

5 Will be in compliance as of May 26th, 2017.

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degrees. The noodles were re-tempted at 207 degrees. The green beans were re-tempted at 167 degrees. The ground chicken were re-tempted at 177 degrees. The puree chicken were re-tempted at 188 degrees. The puree green beans were re-tempted at 186 degrees, The Alfredo sauce were re- tempted at 169 degrees. The beef stew were re-tempted at 166 degrees.

Kitchen Aide #1 prepared a test tray at 12:24 P.M. The Kitchen Aide placed a serving plate of ground Chicken Alfredo, and green beans on the food plate with a top. The plate was not heated nor did it have heat pellets. The cart had doors which closed. The cart was attended to by two Certified Nurse Assistants (CNA) who served residents who ate in their rooms. At 12:51 P.M. the CNAs delivered the last resident meal. The green beans were tempted at 109.9 degrees. The ground chicken was delivered at 114.0 degrees. A taste of the food found it cold, hard to chew and unpalatable.

During an interview at 12:59 P.M. on 4/13/17 with Kitchen Aide #1 when told of the temperatures she stated, "The food is to cold."

During an interview on 4/13/17 at 2:15 P.M., with the Dietary Manager she was asked what the expectations were for serving hot meals? The Dietary Manager stated she would expect the food to be served timely and hot. The Dietary Manager stated the food would hold temperatures better if the covered plate had warmers and heat pellets.

A Dietary Policy for serving hot food was requested. No policy was presented during the

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| F 364 | Continued From page 31<br>survey.<br><br>The facility staff failed to served food that was palpable and at a safe and appetizing temperature. | F 364 | | |
| F 371 SS=E | 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(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.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>(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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, resident interview, staff interviews, facility documentation review, clinical record review, and in the course of a complaint investigation: | F 371 | | |

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

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1. The facility staff failed to maintain the Quaternary (QAC) chemical sanitizing solution according to the manufacturer's recommendations and per the facility's policy of 150 to 400 PPM (parts per million).

2. The facility staff failed to ensure that foods were served in a sanitary manner.

The findings included:

1. On 4/11/17 during the initial observation of the kitchen at approximately 11:35 a.m., the QAC bucket was tested by a dietary staff member and was found to be at 50 PPM (parts per million).

The dietary staff member was asked what the test strip should read. The dietary staff member stated, "It should be 150. We are short staffed today. I will change it."

The Dietary Manager was asked on 4/12/17 at approximately 2:00 p.m., what range the QAC bucket test strip should be and she stated, "It should be between 150 and 200."

The Facility's Policy and Procedure titled, "Sanitizer Bucket Policy" with an effective date of February 2016 documented the following:

"Temperature and sanitizer strength of the sanitizing bucket shall be monitored and recorded following each meal. Surfaces are sanitized by ensuring temperature and sanitizer strength in the sanitizing buckets is appropriate."

1. No resident cited for this deficiency.

QAC solution was discarded and re-mixed to meet manufacturer's recommendation by 4/13/17.

2. All residents are at risk for this issue.

3. In-service by Food Service Director for dietary staff on safe storage, handling, preparing and serving food to include
   - QAC solution
   - washing of hands
   - discarding of soiled, wet paper towels
   - proper procedure for taking food temps.

4. a)Audit daily of QAC solution readings per policy by the Food Service Director or designee.

   b)Audit by Food Service Director or designee of dietary staff for proper handwashing three times a week for 12 weeks.

   c) Results of audits will be brought to QAPI

5 Will be in compliance as of May 26th, 2017.

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The Facility's Kitchen log titled, "Sanitizing solution Strength QUAT sanitizer", documents the range of sanitizing solution strength to be 150 to 400 PPM (parts per million).

The facility administration was informed of the findings during a briefing on 3/13/17 at approximately 3:15 p.m. The facility did not present any further information about the findings.

2. Observations made at 12:18 P.M. on 4/13/17 during the Lunch meal on Unit One Hundred indicated food was not being served under sanitary conditions.

During the Group Interview on 4/12/17 at 11:00 A.M. one resident stated food is not always served hot on the One Hundred Unit. At 12:18 P.M. on 4/13/17 a test tray was conducted on the One Hundred Unit. The facility food services were set up with a kitchen area on four units. Food was prepared in the main kitchen and carted to the unit's steam tables for serving.

At 11:13 A.M. on 4/13/17 the food from the kitchen area arrived on Unit One Kitchen area. Dietary Aide #1 was observed to wash her hands. At the time there were no paper towels to wipe her hands. This employee was observed to reach up into the cabinet doors above the sink and take a pair of plastic gloves out and place them on her hands while hands were still wet. At 11:16 A.M. on 4/13/17 a second Dietary Aide arrived and was asked to go and get some paper towels. Dietary Aide #1 is observed placing food from the main kitchen area onto the Unit One Hundred Kitchen area steam tables.

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Once completing the task of placing the food on the steam tables, Dietary Aide #1 is observed to take her gloves off re-wash her hands for about 5 seconds with clear water and no soap. Dietary Aide #1 was observed to wipe her hands with several paper towels. After wiping her hands, the soiled wet paper towels are observed sitting on the sink counter.

Dietary Aide #1 began to take temperatures of the food on the steam table. The Dietary Aide is observed taking the temperature of the Fettuccini Pasta noodles first. After taking the temperature, Dietary Aide #1 is observed to wipe the thermometer with the soiled wet paper towel used to wipe her hands. Next the Dietary Aide #1 is observed to take the temperature of the green beans. Dietary Aide #1 is observed to wipe the thermometer with the soiled wet paper towel. Dietary Aide #1 is observed to temp the Alfredo Sauce. After taking the temperature, Dietary Aide #1 wiped the thermometer with the soiled wet paper towel and set the thermometer on the counter.

After finding several foods below temperature, Dietary Aide #1 is observed taking the tong used for the Fettuccini Pasta noodles and the spoon used for the green beans and place them on top of a tray of clean unused utensils. At 11:20 A.M. Dietary Aide #1 is observed to wash her hands without soap for five seconds. Dietary Aide #1 is observed to temp the ground chicken, rinse the thermometer, wipe the thermometer with the same soiled paper towels used to wipe her hands.

Dietary Aide #1 is observed to use a plate to

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| F 371 | Continued From page 35<br>scoop noodles on to it. The noodles were re-heated. Dietary Aide #1 is observed to use the same plate used to place the noodles, to re-heat broccoli.<br><br>At 12:01 P.M. the Dietary Manager sends to Unit One Hundred Kitchen area different food sources because the original food temperatures were not meeting holding temperatures. Dietary Aide #1 sent all of the food back and kept the same food originally tempted except for the Fettuccini Sauce.<br><br>During an interview at 1:03 P.M. with Dietary Aide #1, she was asked about serving food and wiping the thermometer with the soiled paper towel and re-tempting the food. Dietary Aide #1 stated, "I was not aware that I was using the same paper towel that I washed my hands with."<br><br>The Dietary Manager stated during an interview at 2:35 P.M. on 4/13/17 , that she would have expected the Dietary Aide to use alcohol swabs to clean the thermometer prior to taking food temperatures.<br><br>There were no policy presented during the survey for serving food under safe and sanitary conditions. | F 371 | | |
| F 431 SS=E | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general | F 431 | | |

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| F 431 | Continued From page 36<br>supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>(g) Labeling of Drugs and Biologicals.<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>(h) Storage of Drugs and Biologicals.<br>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the | F 431 | 1. Expired medications and open vials not dated were discarded by 4/13/17.<br><br>2. All residents are at risk for this issue.<br><br>3. In-service by ADON for licensed linen, equipment and trash. Nursing staff for proper storage of medications / biologicals to include:<br>a. dating of vials when opened<br>b. monitoring and disposal of expired drugs<br>c. proper storage<br><br>4. A)Unit Manager or designee will audit medication rooms, to ensure multi-dose vials are dated when opened and expired medications are disposed of per policy 5x a week for 3 months.<br><br>b) Unit Manager or designee will audit cart and to ensure multi-dose vials are dated when opened and expired medications are disposed of per policy 5x a week for 3 months. | |

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Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews and facility document review the facility staff failed to ensure biologicals were stored under proper temperature controls and labeled properly on 3 of 4 nursing units.

The findings included:

An inspection of the medication rooms was conducted on 4/11/17. The following biologicals were found expired, undated and or stored improperly:

1. Unit 100 - One opened multi-dose vial of Novolin R. 100 units/milliliters insulin was not dated when opened and stored inside the medication refrigerator. One multi-dose vial of Tuberculin PPD-Aplisol test dose 1 ml (0.1 ml=10 tests) dated opened on 2/21/17.
The nurse (licensed practical nurse/LPN#1) who accompanied this inspector was asked once the vial of PPD was opened, when should it be discarded? She stated, "Not sure, I'll have to find out."

2. Unit 300 - One multi-dose vial of Tuberculin PPD-Aplisol test dose 1 ml (0.1 ml=10 tests) dated opened on 1/27/17. One opened multi-dose vial of Flulaval Quadrivalent (Flu vaccine) 5 ml (0.5 ml=10 doses), not dated when opened.
The nurse (licensed practical nurse/LPN#3) who

c) Unit Manager or designee will audit refrigerator weekly to ensure multi-dose vials are dated when opened and expired medications are disposed of per policy 5x a week for 3 months.

d) This will be an ongoing audit and results will be shared in monthly QAPI meetings x3.

5 Will be in compliance as of May 26th, 2017.

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accompanied this inspector was asked when should a multi-dose vial be dated? She stated, "It should have a date when opened."

3. Unit 400 - One multi-dose vial of Flulaval Quadrivalent (Flu vaccine) 5 ml (0.5 ml=10 doses), dated opened on 2/23/17. One multi-dose vial of Novolin 70/30 insulin dated opened on 2/18/17 and stored refrigerated, one multi-dose vial of Humalog 100 units dated opened on 3/6/17.
The nurse (licensed practical nurse/LPN#4) who accompanied this inspector was asked once the Flu vaccine multi-dose vial is opened, how long is it good for? She stated, "Let me find the answer." Upon returning the nurse stated, "six weeks to forty two days."

The manufacturers guidelines for the Flulaval Quadrivalent read, in part: Once entered, the multi-dose vial should be discarded after 28 days.

The manufacturers guidelines for the multi-dose vial of Tuberculin PPD-Aplisol read, in part: Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.

The facility's pharmacy Insulin Storage Recommendations revised March 31, 2017 read, in part:
Novolin (R, N, 70/30) opened - Do Not Refrigerate After Opening, opened room temperature-42 days.
Humalog-opened refrigerated-28 days.

The facility's policy titled "5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles", revised 10/31/16 read, in

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| F 431 | Continued From page 39<br>part:<br>This policy 5.3 sets for the procedures relating to the storage and expiration dates of medications, biological, syringes and needles.<br>Procedure:<br>5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record date opened on the medication container when the medication has a shortened expiration date once opened.<br>11. Facility should ensure that medications and biologicals are stored at their appropriate temperatures according to the United States Pharmacopoeia guidelines for temperature ranges.<br><br>The above findings was shared with the Administrator and the DON (Director of Nursing) during the pre-exit interview conducted on 4/13/17. The DON stated the staff was recently inserviced that the night shift nurses were responsible for checking the medication refrigerators temperatures and checking medications for expiration dates. | F 431 | | |
| F 441 SS=D | 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, | F 441 | | |

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| F 441 | Continued From page 40<br>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);<br><br>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv) When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(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 | F 441 | 1. No resident cited for this deficiency.<br><br>2. All residents are at risk for this issue.<br><br>3. a)In-service by ADON for dietary staff and nursing department on proper handwashing procedure.<br><br>3b. In-service by ADON or designee for nursing department staff on proper disposal of soiled linen, equipment and trash.<br><br>4. a)Audit of soiled utility rooms by direct observation by DON or designee to ensure proper disposal of soiled items and trash daily x 1 week then random weekly x 3 months.<br><br>b) Audit results will be shared in QAPI meetings x3.<br><br>5 Will be in compliance as of May 26th, 2017. | |

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(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 observations, and staff interviews, the facility staff failed to wash hands consistent with accepted standards of practice, to reduce the spread of infections and prevent cross-contamination and the facility failed to provide a safe, sanitary environment to prevent the development and transmission of disease and infection.

The findings included:

1. Observations made at 12:18 P.M. on 4/13/17 during the Lunch meal on Unit One Hundred indicated: Dietary Staff on Unit One Hundred were not implementing hand washing practices consistent with accepted standards of practice to reduce the spread of infections and prevent cross-contamination.

At 11:13 A.M. on 4/13/17 the food from the kitchen area arrived on Unit One Hundred Kitchen area. Dietary Aide #1 was observed to

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wash her hands. At the time there were no paper towels to wipe hands. This employee was observed to reach up into the cabinet doors above the sink and take a pair of plastic gloves out and place them on her hands while hands were still wet. At 11:16 A.M. on 4/13/17 a second Dietary Aide arrived and is asked to go and get some paper towels. Dietary Aide #1 is observed placing food from the main kitchen area onto the Unit One Kitchen area steam tables.

Once completing the task of placing the food on the steam tables, Dietary Aide #1 is observed to take her gloves off, re-wash her hands for about 5 seconds with clear water and no soap. Dietary Aide #1 was observed to wipe her hands with several paper towels. After wiping her hands, the soiled wet paper towels are observed sitting on the sink counter.

A facility policy for Hand Washing in the Kitchen indicated: Policy: ' Staff will wash hands frequently as needed throughout the day following proper hand washing procedures. Hand washing facilities should be readily accessible and equipped with paper towels and soap. Encourage hand washing instead of the use of chemical sanitizing gels or lotions in the dietary department. If chemical sanitizing gels are used, dietary staff must first wash hands as stated below.

Procedure: Wash hands and exposed portions of arms immediately before beginning any food preparation, clean equipment, clean utensils and unwrapped single service, single use articles.

Wash Hands as follows:

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1. Turn on faucet. Wet hands and forearms with warm water. Vigorously lather hands and forearms with soap and rub them together, creating friction to all surfaces for ten (10 to fifteen (15) seconds under a moderate stream of running warm water (105) . Pay close attention to cuticles and fingernails, using a brush as needed.

2. Rinse hands thoroughly with clean, running, warm, water.

3. Dry Hands thoroughly with paper towel (s) and then turn off faucets with towel(s), being careful not to touch the faucet(s) with hands.

4. Discard paper towel(s) in a foot-release trash container.

5. Staff shall not wash "gloved" hands. Staff will change gloves as necessary. Disposable gloves shall not be substituted for proper hand washing.

8. Staff is educated on the importance of hand washing and routinely retrained as necessary on the above philosophy/guidelines.

The facility staff failed to wash their hands in a manner to prevent cross contamination and the spread of infections.

2. The facility staff failed to put soiled gloves, a bag of trash, a bag of dirty clothes and two pillows in the trash and dirty clothes bin.

On 04/12/17 at approximately 10:10 a.m., on unit 4 in the soiled utility room were 4 soiled gloves and a bag of trash observed on the floor next to a trash can; the trash can was observed without a cover lid. The maintenance director stated, "This

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is unacceptable, the gloves should be in the trash and covered with a lid; I'm going to inform the Director of Nursing (DON); this doesn't make any sense". Observation in the janitor's closet was a dirty glove inside the mop sink station.

On 04/12/17 at approximately 2:15 p.m., an interview was conducted with the Director of Nursing (DON) who stated "This is unacceptable, I expect for my staff to put all soiled gloves in the trash not on the floor."

On 04/13/17 at approximately 9:40 a.m., the Maintenance Director and surveyor returned to Unit 4 and inspected the service suite area. Inside the soiled linen room were two pillows, a bag of trash and a bag of soiled linens were observed on the floor. There were 3 two compartment bins inside the service suite room located against the wall by the soiled line room labeled trash and linen. The Maintenance stated, "This is a problem, I don't understand." The lead CNA entered the service suite during that time, the Maintenance Director asked her to clean up the soiled linen room; she immediately removed all items off the floor, put the trash in the trash bin outside the door, put a trash can inside the soiled linen room and stated, "This yellow bag is from someone being on contact precautions."

The facility Administrator and DON was informed of the findings during a briefing on 04/13/17 at approximately 3:15 p.m. The facility did not present any further information about the findings.

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| F 465 SS=D | 483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON | F 465 | |

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| F 465 | Continued From page 45<br>(i) Other Environmental Conditions<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility staff failed to maintain a safe, clean, comfortable and sanitary environment.<br><br>The findings included:<br><br>During general observation of the facility on 04/13/17 at 9:30 a.m., with the Maintenance Director, the facility staff failed to maintain a safe, clean, comfortable and sanitary environment.<br><br>On unit 4 in the soiled linen room was a large hole in the sheet rock on the left side as you enter the room. The maintenance director stated he know it was there but just haven't had time to do the repairs. On unit 1 in the spa room, the spa room was cluttered with mechanical lifts (4) and there was a hole on the corner of the spa tub measuring 3 inches x 1 inch. Inside the spa was dead insects; on the seat and floor of the spa. The maintenance director stated, "I'm not sure who is responsible for cleaning out the spa tub but we will clean it up right now".<br><br>The Administrator and DON were informed of the findings during a briefing on 04/13/17 at | F 465 | Hole in the soiled linen room is repaired as of 5/3/17.<br><br>Spa tub on unit 1 was cleaned as of 4/15/17. Clutter was removed from the spa room on unit as of 4/15/17.<br><br>2. All residents are at risk for this issue.<br><br>3. In-service by Maintenance Director for maintenance staff and housekeeping staff on maintaining cleanliness of spa rooms and making repairs.<br><br>4. Maintenance Director or designee will audit spa rooms for clutter and cleanliness 5x weekly for 12 weeks.<br><br>b) Administrator will audit maintenance work books for follow up once a week for three months.<br><br>c) Audit results will be shared in QAPI meetings x 3 months<br><br>5 Will be in compliance as of May 26th, 2017. | |

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| F 465 | Continued From page 46<br>approximately 3:15 p.m. The facility did not present any further information about the findings. | F 465 | | |
| F 514 SS=D | 483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>(i) Medical records.<br>(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. | F 514 | | |

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This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview and clinical record review the facility staff failed to ensure the clinical record was accurate for 1 of 24 residents in the survey sample, Resident #12.

Resident #12 stated she has a diagnosis of diverticulosis (1). The clinical record did not include this diagnosis.

The findings included:

Resident #12 was admitted to the facility on 9/15/15 with diagnosis to include GERD (gastric reflux).

The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 3/21/17 coded the resident as scoring a 15 out of a possible 15 on the Brief Interview for Mental Status, indicating the resident's cognition was intact.

On 4/12/17 at 11:50 am, the resident was observed in bed. The resident's husband was at the bedside. The resident was alert and orientated to person, place and time. She was asked about the care and services provided by the facility. She stated one concern was that the dietary department continues to serve her food that she can't eat, such as corn and rice. She stated she has diverticulosis and had a sigmoid colon resection in 2006 due to this. She continued to state that these food items could get lodged in her intestine and cause an infection. During the interview the resident's lunch tray was brought into the room and placed on the bedside table. The resident was served fish, tater tots,

1. Resident # 12's medical record was updated to include the diagnosis of Diverticulosis.

2. All residents are at risk for this issue.

3. In-service by the ADON or designee for licensed nursing staff and MDS staff on maintaining accurate medical records to include updating diagnosis.

4. Within 72 hours of admission/readmission, the DON/designee for accuracy and ensure diagnosis are updated x 3 months.
   b) Audits will be shared in QAPI meetings x 3months
5 Will be in compliance as of May 26th, 2017.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495256 | A. BUILDING _____ B. WING _____ | C 04/13/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| AUTUMN CARE OF CHESAPEAKE | 715 ARGYLL ST CHESAPEAKE, VA 23320 |

| (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 514 | Continued From page 48 | F 514 | | |

corn bread and corn. The resident's preferences and dislikes were on the printed meal ticket sent with the tray. The list included among other preferences "No corn, No Rice".

The clinical record was reviewed. The current active diagnosis list did not include diverticulosis. The dietary orders dated 2/16/16 read, "reduced sodium diet, mechanical soft, thin consistency. Pt (patient) able to have a regular hot dog texture as tolerated. Resident prefers more vegetables than meat for GE reflux (gastric reflux)..."

On 4/12/17 at approximately 1:00 pm, one of the nurse practitioners (NP) for the attending physician was interviewed. She stated she was not the NP for Resident #12, that particular NP was on leave. The NP stated she would look further into the resident's alleged diagnosis of diverticulosis and return with an update.

On 4/12/17 at 1:40 pm, the NP returned to the conference room and provided this inspector with additional information. She provided a copy of a Cardiology Specialists consult dated 3/16/16. This consult included under Past Medical History: Patient Active Problem List
Diagnosis-Diverticulosis of colon without bleed. The NP stated the resident's diagnosis list will be updated to include diverticulosis. When asked if the resident should be on a restricted diet, she stated "Yes".

The NP wrote the following dietary orders dated 4/12/17- Reduced sodium, mechanical soft, thin consistency and no nuts, corn, popcorn or seeds every shift for diet.

The above findings was shared with the

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|---|---|---|---|---|
| F 514 | Continued From page 49<br>Administrator and the DON (Director of Nursing) during the pre-exit interview conducted on 4/13/17.<br><br>(1) Diverticulosis-Diverticula in the colon without inflammation or symptoms. Only a small percentage of persons with diverticulosis develop diverticulitis. Diverticulitis is an inflammation of a diverticulum or Diverticula in the intestinal tract, especially in the colon, causing pain, anorexia, fevers and occasional peritonitis (inflammation of the serous membrane that lines the abdominal cavity). Taber's Cyclopedic Medical Dictionary Edition 20. | F 514 | | |