

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

PRINTED: 04/02/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495218</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/05/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>188 OLD FINCASTLE ROAD</b> <b>FINCASTLE, VA 24090</b>	
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E 000	Initial Comments  An unannounced Emergency Preparedness survey was conducted 1/3/18 through 1/5/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS  An unannounced Medicare/Medicaid standard survey was conducted 1/3/18 through 1/5/18. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.	F 000		
F 607 SS=D	The census in this 60 certified bed facility was 50 at the time of the survey. The final survey sample consisted of 14 current Resident reviews (Residents 1 through 14) and 3 closed record reviews (Residents 15 through 17). Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)  §483.12(b) The facility must develop and implement written policies and procedures that:  §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,  §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and  §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		2/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/01/2018

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 607	<p>Continued From page 1</p> <p>by: Based on staff interview and facility document review, the facility staff failed to obtain professional and/or personal references prior to hire for 1 of 5 new hires (employee #1).</p> <p>The findings included:</p> <p>The facility staff failed to obtain professional and/or personal references prior to hire for 1 of 5 new hires (employee #1).</p> <p>The surveyor reviewed five newly hired employees on 1/3/18. Employee #1 was hired on 11/16/17. Upon review of employee #1's personnel file, the surveyor was unable to locate references. The form titled "Employment Verification Release" was completed by the applicant in the designated area on 1 of the 2 releases provided. However, the lower part to be completed by the previous employer was not completed. Both releases were blank.</p> <p>The surveyor requested the assistance of the corporate human resources on 1/3/18 at 4:42 p.m. The corporate HR staff member reviewed the employee record and stated "I don't see anything filled out. We require 2 references." The surveyor requested the facility policy on screening new employees.</p> <p>The surveyor reviewed the facility policy titled "Abuse" on 1/3/18. "SPECIFIC PROCEDURE/REQUIREMENTS 1) Screening a). The organization will screen potential employees for a history of abuse, neglect or mistreating residents i) If employment references cannot be obtained, personal references will be checked."</p>	F 607	<p>Kissito Healthcare shares the state's focus on the health, safety and well being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, we have implemented a plan of correction to demonstrate our continuing effort to provide quality care to our residents.</p> <p>F 607</p> <p>Employee #1 is no longer employed by the facility.</p> <p>A review of new hires for the last 3 months was completed to ensure professional and/or personal references have been obtained prior to hire.</p> <p>The Payroll/Human Resources Coordinator was educated by the Corporate Director of Human Resources/designee on the requirements for new hires including obtaining professional and/or personal references prior to employment.</p> <p>The Chief Administrative Officer(CAO)/designee will review new hire personnel files at the time of hire to ensure new hire paperwork has been</p>		

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F 607	Continued From page 2  The surveyor informed the administrative staff of the above issue with reference checks not done on employee #1 prior to hire in the end of the day meeting on 1/5/18 at 4:36 p.m.  No further information was provided prior to the exit conference on 1/5/18.	F 607	completed including reference checks.  The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.  CAO/DON responsible for implementation of the plan of correction.		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.  §483.12(c)(4) Report the results of all	F 609		2/14/18	

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F 609	<p>Continued From page 3</p> <p>investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow the facility policy for reporting resident abuse for 2 of 17 residents (Resident #45 and Resident #22).</p> <p>The findings included:</p> <p>1. The facility staff failed to report the results of a facility reported incident (FRI) final investigation to the State Survey Agency within 5 working days of the incident that affected Resident #45.</p> <p>The clinical record of Resident #45 was reviewed 1/3/18 through 1/5/18. Resident #45 was admitted to the facility 12/15/16 and readmitted 9/24/17 with diagnoses that included but not limited to chronic respiratory failure with hypercapnia, tracheostomy, type 2 diabetes mellitus, convulsions, iron deficiency anemia, dysphagia, constipation, chronic atrial fibrillation, altered mental status, and pain in left shoulder.</p> <p>Resident #45's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/19/17 assessed the resident with a BIMS (brief interview for mental status) as 11 out of 15 in Section C.</p> <p>The Office of Licensure and Certification received a facility reported incident (FRI) dated 9/27/17</p>	F 609	<p>F609</p> <p>No action was taken for Resident #45 or Resident #22 due to the time frame had already passed.</p> <p>An audit was conducted for Facility Reported Incidents (FRI) for the last 6 months to ensure the five day follow up(s) was completed and faxed to the required outside agencies in the required time frame.</p> <p>The CAO and Director of Nursing will be educated by the Chief Nursing Officer/designee on the requirements for reporting FRI(s) and five day follow up(s).</p> <p>The CAO/designee will monitor to ensure the five day follow up(s) are completed and faxed to the required outside agencies after the submission of a Facility Reported Incident (FRI).</p> <p>The results will be reported to the monthly to the Quality Assurance Committee for</p>		

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F 609	<p>Continued From page 4</p> <p>that read "It was reported that C. N.A was rough while providing care to residents and spoke to them inappropriately. C.N.A. suspended pending investigation."</p> <p>The surveyor discussed the issue with the director of nursing on 1/5/18 at 11:01 a.m. The DON stated she was unable to locate the 5-day follow-up to the state agency. The DON stated the C.N.A. was suspended for three days then changed to prn (whenever needed to work) and then terminated.</p> <p>The facility policy titled "Abuse" was reviewed 1/5/18. The policy read in part "5) Investigation Designated staff will immediately review and investigate all allegations or observations of abuse. a) The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State Law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified corrective action must be taken."</p> <p>The surveyor informed the administrative staff in the end of the day meeting on 1/4/18 at 3:31 p.m. and 1/5/18 at 4:36 p.m.</p> <p>The facility staff failed to provide evidence that the final investigation of physical/verbal abuse to Resident #45 was reported to the state agency within 5 working days of the incident.</p> <p>2. The facility staff failed to report the results of a facility reported incident (FRI) final investigation to the State Survey Agency within 5 working days of the incident that affected Resident #22.</p>	F 609	<p>review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.</p> <p>CAO/DON responsible for implementation of the plan of correction.</p>		

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F 609	<p>Continued From page 5</p> <p>The clinical record of Resident #22 was reviewed 1/5/18. Resident #22 was admitted to the facility 11/28/16 with diagnoses that included but not limited to acute and chronic respiratory failure with hypoxia, anoxic brain damage, traumatic brain injury, persistent vegetative state, neuromuscular dysfunction of the bladder, quadriplegia, joint contractures, convulsions, hypertension, and gastroesophageal reflux disease.</p> <p>Resident #22's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/17/17 assessed the resident in Section B as in a persistent vegetative state.</p> <p>The Office of Licensure and Certification received a facility reported incident (FRI) dated 9/27/17 that read "It was reported that C. N.A was rough while providing care to residents and spoke to them inappropriately. C.N.A. suspended pending investigation."</p> <p>The surveyor discussed the issue with the director of nursing on 1/5/18 at 11:01 a.m. The DON stated she was unable to locate the 5-day follow-up to the state agency. The DON stated the C.N.A. was suspended for three days then changed to prn (whenever needed to work) and then terminated.</p> <p>The facility policy titled "Abuse" was reviewed 1/5/18. The policy read in part "5) Investigation Designated staff will immediately review and investigate all allegations or observations of abuse. a) The results of all investigations are to be communicated to the administrator or his or her designated representative and to other officials in accordance with State Law, including</p>	F 609			

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F 609	Continued From page 6 to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified corrective action must be taken."  The surveyor informed the administrative staff in the end of the day meeting on 1/4/18 at 3:31 p.m. and 1/5/18 at 4:36 p.m.	F 609			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)  §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F 657		2/14/18	

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F 657	<p>Continued From page 7</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to review and revise 1 of 17 residents comprehensive care plan (Resident #47).</p> <p>The findings included:</p> <p>The facility staff failed to review and revise Resident #47's comprehensive care plan. Resident #47 was care planned to have diabetes mellitus and a PICC line (peripherally inserted central catheter). Resident #47 did not have a diagnosis of diabetes or a PICC line.</p> <p>The surveyor reviewed Resident #47's clinical record 1/3/18 through 1/5/18. Resident #47 was admitted to the facility 7/2/16 with the last readmission on 12/20/17. Resident #47's diagnoses included but not limited to quadriplegia, chronic multifocal osteomyelitis, resistance to multiple antibiotics, urinary tract infection, neuromuscular dysfunction of the bladder with suprapubic catheter, pressure ulcers right and left hip and right and left buttock, sepsis, anxiety, insomnia, depressive disorder, iron deficiency anemia, constipation, ileus, pain, hypertension, and acute respiratory failure with hypoxia.</p> <p>Resident #47's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/20/17 identified the resident with a BIMS</p>	F 657	<p>F657</p> <p>Resident's #47 care plan has been updated to exclude the diagnosis of Diabetes Mellitus and to include the presence of a Hickman catheter instead of a PICC.</p> <p>Care plans for current residents in the facility were reviewed to ensure the appropriate diagnosis and correct types of catheters are identified on the plan of care.</p> <p>The Interdisciplinary team (IDT) will be educated by the Director of Nursing/designee on updating and revising care plans to reflect the residents current functional and physical status, to include accuracy of diagnosis and type of catheters.</p> <p>Ten care plans will be reviewed weekly by the Director of Nursing/designee to ensure the accuracy of the care plan for diagnosis and types of catheters.</p>		



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F 657	<p>Continued From page 8</p> <p>(brief interview for mental status) score as 15 out of 15. Resident #47 was interviewable.</p> <p>Resident #47's current comprehensive care plan was reviewed. One area of focus read "The resident has a patent PICC line left chest and is receiving IV antibiotics for MDRO (multi-drug resistant organism) in urine and MRSA (methicillin resistant staphylococcus aureus) in left hip wound Date initiated: 1/02/2018. Revision on: 1/04/2018. Interventions: Monitor PICC line site for s/s (signs and symptoms) of infection."</p> <p>The surveyor observed Resident #47 during a wound care observation on 1/4/18 at 10:08 a.m. Resident #47 has a Hickman Catheter in the left shoulder/upper chest area with 2 ports per the wound care registered nurse #1. Current physician orders dated 12/26/17 read "Change left Hickman Dressing every 7 days and prn (as needed) and Flush left chest Hickman with 10cc (cubic centimeters) NS (normal saline) flush q (every) shift."</p> <p>The current comprehensive care plan also had the focus area of Diabetes with insulin use with risk for hyper or hypoglycemia Date initiated: 09/18/2017. Interventions: Administer medications as ordered, blood glucose checks as ordered, lab work as ordered, observe for signs and symptoms of hyper/hypoglycemia, and podiatry referral as needed.</p> <p>The surveyor reviewed the diagnoses list and current signed physician orders and did not find any current orders for diabetic care for Resident #47.</p>	F 657	<p>The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.</p> <p>CAO/DON will be responsible for implementation of the plan of correction.</p>		

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F 657	Continued From page 9 The survey team met with the administrative staff on 1/4/18 at 3:31 p.m. and again on 1/5/18 at 4:36 p.m. and informed them of the issues on Resident #47's current comprehensive care plan. The corporate MDS nurse stated she had completed the care plan for diabetes and may have put another resident's needs on Resident #47's care plan.	F 657			
F 686 SS=D	No further information was provided prior to the exit conference on 1/5/18. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (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 (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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide wound care as prescribed to a pressure ulcer for 3 of 17 residents in the survey sample (Resident's #29, #47 and #40)).  The findings included:	F 686	F686  Resident #29 and Resident #47 are currently receiving wound care by following manufacturer's guidelines for adding moisture to the pressure ulcer dressing.	2/14/18	

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F 686	<p>Continued From page 10</p> <p>1. During the wound care observation, the facility staff did not follow manufacturer's guidelines in adding moisture to the pressure ulcer dressing for Resident #29.</p> <p>Resident #29 was readmitted to the facility on 9/29/17 with the following diagnoses of, but not limited to anemia, high blood pressure, manic depression, Multi-drug Resistant Organism, pressure ulcer, aphasia, respiratory failure and seizure disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/4/17, the resident was coded as having short term and long term memory problem in which the resident is severely impaired in decision making. Resident #29 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.</p> <p>On 1/4/18 at 11:35 am, the surveyor accompanied the wound care nurse into Resident #29's room to observe wound care being performed to the resident's left hip and sacral area. During this observation, the surveyor noted that the wound care nurse moistened the Hydrofera dressing with the wound care cleanser prior to applying it to the wound bed in the sacral area.</p> <p>The administrative team was notified at 3:30 pm of the above documented observations made by the surveyor. The surveyor asked the administrative team if the Hydrofera dressing could be moistened with the wound care cleanser prior to it being placed in the wound bed of a pressure ulcer. The director of nursing stated that she did not know the answer but would find out.</p>	F 686	<p>No action was taken for Resident #40 due the time frame had already passed. The RN</p> <p>RN #1 was educated on cleaning of scissors when performing wound care.</p> <p>Current residents in the center with wounds have the potential to be affected.</p> <p>Licensed nurses was educated by the Director of Nursing/designee on the facilities' policy for wound care including adding moisture to dressings per manufacturers' guidelines and cleaning of scissors.</p> <p>The Director of Nursing/designee will via direct observation, observe wound care two times weekly to ensure wound care protocol is followed including following manufacturer's guidelines and cleaning of the scissors.</p> <p>The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.</p> <p>CAO/DON will be responsible for implementation of the plan of correction.</p>		

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F 686	<p>Continued From page 11</p> <p>The surveyor was provided a copy of the package insert of the Hydrofera dressing at approximately 5 pm. The manufacturer's recommendations stated to moistened the dressing with sterile normal saline or sterile water prior to applying it to a wound bed.</p> <p>On 1/5/18 at approximately 10:30 am, the wound care nurse came into the conference room and stated that new orders had been written to reflect the usage of sterile water or sterile normal saline is to be used to moistened the Hydrofera dressing before applying it to a wound bed.</p> <p>No further information was provided to the surveyor prior to the exit conference on 1/5/18.</p> <p>2. The facility staff failed to follow package instructions for the use of Hydrofera Blue used for the treatment of the pressure area on Resident #47's left buttock.</p> <p>The surveyor reviewed Resident #47's clinical record 1/3/18 through 1/5/18. Resident #47 was admitted to the facility 7/2/16 with the last readmission on 12/20/17. Resident #47's diagnoses included but not limited to quadriplegia, chronic multifocal osteomyelitis, resistance to multiple antibiotics, urinary tract infection, neuromuscular dysfunction of the bladder with suprapubic catheter, pressure ulcers right and left hip and right and left buttock, sepsis, anxiety, insomnia, depressive disorder, iron deficiency anemia, constipation, ileus, pain, hypertension, and acute respiratory failure with hypoxia.</p> <p>Resident #47's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/20/17 identified the resident with a BIMS</p>	F 686			

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F 686	<p>Continued From page 12</p> <p>(brief interview for mental status) score as 15 out of 15. Resident #47 was interviewable. Section M Skin Conditions identified two (2) stage 3 pressure ulcers and two (2) stage 4 pressure ulcers.</p> <p>Current comprehensive care plan identified skin as a focus area with multiple interventions that included air mattress and wedge used for pressure relieving, education, floating extremities, turning and repositioning as resident will permit, mechanical lift for transfers, nutritional support by dietician, wound clinic visits, treatments per order of physician, and continent care.</p> <p>The current physician order for Resident #47's left buttock pressure area read to clean over left buttock with wound cleanser, pat dry, then apply Hydrofera Blue dressing and cover with dry dressing q (every) day and as prn (whenever needed) soiling. Order date 11/24/17 Start date 11/25/17.</p> <p>The surveyor observed Resident #47 during a wound care observation on 1/4/18 at 10:08 a.m. with the wound care nurse registered nurse #1. R.N. #1 gowned and gloved prior to entering Resident #47's room. Resident #47 was currently on isolation precautions. R.N. #1 washed hands and donned gloves. Old dressing removed and discarded. Gloves off and hands washed. Donned gloves. Area on left buttock cleaned with dermal wound cleaner. Dried. R.N. #1 sprayed the Hydrofera blue with dermal wound cleanser to moisten the dressing and then applied Hydrofera Blue to the area and covered with island dressing. R.N. #1 removed gloves and washed hands and returned dermal wound cleanser to cart.</p>	F 686			

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F 686	<p>Continued From page 13</p> <p>The surveyor requested the package insert from the Hydrofera blue dressing box from R.N. #1. The surveyor reviewed the package insert for Hydrofera blue on 1/4/18 at 5:00 p.m. The package insert read "Application of Hydrofera blue dressings d. Moisten the dressing with sterile saline or sterile water, and squeeze out the excess." Indications for use read "Hydrofera blue bacteriostatic dressings are intended as an external dressing for use in local wound management, such as pressure ulcers, venous stasis ulcers, arterial ulcers, donor sites, abrasions, lacerations, superficial burns, post-surgical incisions, diabetic ulcers, and other wounds caused by trauma."</p> <p>The surveyor interviewed the wound care nurse on 1/5/18 at 10:00 a.m. regarding the use of dermal wound cleanser on the Hydrofera blue. The wound care nurse stated that the wound doctor told him he could use anything to dampen the dressing-normal saline, dermal wound cleanser. He didn't say it had to be sterile. The wound care nurse stated he would notify the wound doctor and change the current order.</p> <p>The survey team met with the administrative staff on 1/4/18 at 3:31 p.m. and again on 1/5/18 at 4:36 p.m. and informed them of the issues about Resident #47's wound care observation.</p> <p>No further information was provided prior to the exit conference on 1/5/18.</p> <p>3. The facility staff failed to clean scissors prior to cutting silver alginate used during wound care on Resident #40's right leg amputated site.</p> <p>The clinical record of Resident #40 was reviewed</p>	F 686			

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F 686	<p>Continued From page 14</p> <p>1/3/18 through 1/5/18. Resident #40 was admitted to the facility 12/12/2014 and readmitted 5/30/17 with diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, acquired absence of right leg below knee, acute embolism and thrombosis of unspecified deep vein of lower extremity, epilepsy, peripheral vascular disease, left ankle contracture, leg pain, stage 2 pressure ulcer, right leg amputated stump, insomnia, urine retention, benign prostatic hyperplasia without lower urinary tract symptoms, and hypertension.</p> <p>Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/14/17 assessed the resident with short term memory loss, long term memory loss, and severely impaired cognitive skills for daily decision making. Section M Skin Conditions identified Resident #40 to be at risk for the development of pressure areas.</p> <p>Resident #40's current comprehensive care plan identified a focus area that read the resident is at risk for developing pressure ulcers related to incontinence, the inability to reposition himself, hemiplegia, limited sensation, impaired cognition, and chronic disease; dx (diagnosed) with osteomyelitis with loss of limb Date initiated: 2/9/17 Revision date: 8/31/17. Interventions: Examine skin before and after use of splinting/brace device, pressure reduction mattress and cushion to wc (wheelchair), skin assessment weekly.</p> <p>The most recent weekly skin assessment was dated 12/27/17 and identified a stage 2 pressure area on right below knee amputation stump.</p>	F 686			

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F 686	<p>Continued From page 15</p> <p>Current physician orders dated 12/18/17 read "Clean pressure ulcer (PU) over right BKA (below the knee amputation) with wound cleanser, pat/dry, then apply Silver Alginate dressing and cover with dry dressing every day and as needed (prn) soiling."</p> <p>The surveyor observed wound care with the wound care registered nurse #1 on 1/4/18. R.N. #1 removed supplies from the treatment cart and placed them on a paper towel on treatment cart (dermal wound cleanser, gauze, skin prep, silver alginate). R.N. #1 removed scissors from the uniform pocket and cut the piece of silver alginate to the size heeded for the pressure area and returned the scissors to the uniform pocket. The scissors were not observed to be cleaned prior to cutting the silver alginate or after cutting the silver alginate and returning the scissors to the uniform pocket. Resident #40 grimaced when soiled dressing removed. The wound care R.N. #1 stated he had pain meds earlier. R.N. #1 removed gloves, washed hands and gloves were re-applied. R.N. #1 cleaned area with wound cleanser. Dried the area. Applied skin prep to outer area of wound. Removed gloves and placed silver alginate that had been cut to size in the pressure ulcer area and covered with an island dressing. R.N. #1 dated dressing prior to applying dressing. Resident pulled up in bed. R.N. #1 removed gloves and washed hands.</p> <p>The surveyor interviewed R.N. #1 on 1/5/18 at 10:00 a.m. concerning the use of scissors used to cut the silver alginate. R.N. #1 stated there was no need to clean the scissors. R.N. #1 stated that was his normal. The scissors are never used in any residents' room. R.N. #1 stated he cuts the dressings at the treatment cart.</p>	F 686			



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F 686	Continued From page 16  The surveyor informed the administrative staff of the above concern with not cleaning scissors used to cut dressings for Resident #40's wound care during the end of the day meeting on 1/4/18 at 3:31 p.m. and again on 1/5/18 at 4:36 p.m. The surveyor requested the facility policy on wound care.  The surveyor reviewed the facility policy titled "Wound Care/Treatments Guidelines" on 1/5/18. The policy read in part "3. Set up the supplies on a clean surface at the bedside. 4. Provide privacy for the resident. 5. Wash hands. 6. Explain the procedure to the resident. 7. Cut the tape with your clean scissors. 8. Put gloves on. 9. Remove the soiled dressing and place in a bag at the bedside. Place the soiled scissors on one corner of your setup not touching supplies. 10. Remove gloves and discard the bag. 11. Clean the scissors with 60 seconds of contact with alcohol and place on a CLEAN corner of your setup."  No further information was provided prior to the exit conference on 1/5/18.	F 686			
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3)  §483.25(e) Incontinence. §483.25(e)(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.  §483.25(e)(2) For a resident with urinary incontinence, based on the resident's	F 690		2/14/18	

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F 690	<p>Continued From page 17</p> <p>comprehensive assessment, the facility must ensure that-</p> <p>(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;</p> <p>(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</p> <p>(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.</p> <p>§483.25(e)(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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to anchor an indwelling Foley catheter for 1 of 17 residents (Resident #40).</p> <p>The findings included:</p> <p>The facility staff failed to anchor Resident #40's indwelling Foley catheter.</p> <p>Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/14/17 assessed the</p>	F 690	<p>F690</p> <p>Resident #40's indwelling Foley catheter tubing is anchored to his leg.</p> <p>Current residents in the facility with an indwelling Foley catheter have the potential to be affected.</p> <p>Clinical staff will be educated by the</p>		

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F 690	<p>Continued From page 18</p> <p>resident with short term memory loss, long term memory loss, and severely impaired cognitive skills for daily decision making. Section H coded Resident #40 with an indwelling catheter and "9" urinary continence-not rated, resident had a catheter, urinary ostomy, or no urine output for the entire 7 days.</p> <p>Resident #40's current comprehensive care plan identified the focus are that read "The resident requires a foley catheter related to neurogenic bladder and is incontinent of bowel and wears a brief for comfort and dignity; he is checked ad (sic) changed as needed; hx (history of) frequent UIS (urinary tract infections) risk for infection and complications; the resident is not a candidate for a toileting program secondary to severe cognition and physical impairment. Interventions: Secure catheter with anchor strap as indicated."</p> <p>The surveyor observed Resident #40 on 1/3/18 at 3:55 p.m. The surveyor observed a leg bag attached to the right side of the bed and asked the licensed practical nurse #1 if Resident #40's catheter was anchored. L.P.N. #1 stated the tubing was not anchored. L.P.N. #1 stated she would get a strap and anchor the tubing.</p> <p>The surveyor informed the administrative staff of the above issue on 1/4/18 at 3:31 p.m. and requested the facility policy on Foley catheters. The DON stated some residents are care planned for the catheter straps. Resident #40's care planned stated to secure catheter with anchor strap as indicated.</p> <p>The surveyor reviewed the facility policy titled "Catheter Care" on 1/4/18 at 11:05 a.m. The policy read in part "18. Report unsecured</p>	F 690	<p>Director of Nursing/designee on the anchoring of indwelling Foley catheter tubing as specified on the plan of care.</p> <p>The Director of Nursing/designee will monitor via direct observation of indwelling Foley catheters three times weekly to ensure the tubing is anchored.</p> <p>The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.</p> <p>CAO/DON will be responsible for implementation of the plan of correction.</p>		

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F 690	Continued From page 19 catheters to the staff/charge nurse. Be observant of skin irritation. Check to see that there is no disconnection or leaking of urine from the system."	F 690			
F 761 SS=D	No further information was provided prior to the exit conference on 1/5/18. Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)  §483.45(g) Labeling of Drugs and Biologicals 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.  §483.45(h) Storage of Drugs and Biologicals  §483.45(h)(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.  §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the 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 interview, facility	F 761		2/14/18	
			F761		

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F 761	<p>Continued From page 20</p> <p>document review and in the course of a complaint investigation the facility staff failed to properly label/date opened insulin pens.</p> <p>The findings included:</p> <p>For medication cart #1, the facility staff failed to place an "opened on" date on a Novolog insulin pen and a Levimir insulin pen, and failed to discard a Novolog insulin pen and a Humalog insulin pen 28 after opening per manufacturers recommendation.</p> <p>Surveyor checked medication cart #1 on 01/03/18 at approximately 1250. Surveyor observed a Novolog insulin pen with a date opened of 12/03/17, a Humalog insulin pen with a date opened of 12/05/17, a Novolog insulin pen with no opened on date, and a Levimir insulin pen with no opened on date. Surveyor asked DON if the insulin pens should have an "opened on" date listed on them and she stated that they should.</p> <p>Surveyor requested and was supplied with information on how long after opening should insulin be discarded. Novolog pen was listed as discard after 28 days. The Novolog pen in medication cart with an opened date of 12/03/17 was 3 days past discard date. Humalog pen was listed as discard after 28 days. The Humalog pen in the medication cart with an opened date of 12/05/17 was 1 day past discard date.</p> <p>Surveyor was also supplied with a copy of policy entitled "Storage and Expiration of Medications, Biologicals Syringes and Needles" which read in part "4. Facility should ensure that medications and biologicals: 4.2 Have not been retained longer than recommended by manufacturer or</p>	F 761	<p>Insulin pens found on Med Cart #1 not dated and/or expired were immediately discarded.</p> <p>An audit of medication carts was conducted to ensure insulin pens were dated and un-expired.</p> <p>Licensed nurses were educated by the Director of Nursing/designee on labeling and dating open insulin pens, and discarding expired medications.</p> <p>The Director of Nursing/designee will monitor medication carts via direct observation three times weekly to ensure the labeling and dating open insulin pens and ensuring medications re not expired.</p> <p>The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.</p> <p>CAO/DON will be responsible for implementation of the plan of correction.</p>		

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F 761	Continued From page 21 supplier guidelines".  The concern of the undated insulin pens and the pens past use by date were discussed with the administrative team during a meeting on 01/05/18 at approximately 1645.	F 761			
F 880 SS=E	No further information was provided prior to exit. 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	F 880		2/14/18	

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F 880	<p>Continued From page 22</p> <p>possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§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 observations, staff interview, facility</p>	F 880			
			F880		

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F 880	<p>Continued From page 23</p> <p>document review and clinical record review, the facility staff failed to ensure an effective infection control program in the facility as well as failed to follow infection control guidelines for 4 of 17 residents in the survey sample (Resident #29, #47, #40 and #39).</p> <p>The findings included:</p> <p>1. The facility staff failed provide a date of the infection being resolved on the infection line tracking forms for the months of January 2017 through December, 2017.</p> <p>The surveyor requested the infection control line list (tracking form for facility infections) from December,2017 from the director of nursing services on 1/5/18 at approximately 2:30 pm. When the infection control line listing was provided to the surveyor by the director of nursing services, the form was found to be incomplete. The infection control line listing form did not provide dates that the infection had been resolved or continued to be ongoing problem.</p> <p>The corporate nurse and director of nursing were notified of the above documented findings by the surveyor at 3:30 pm. The corporate nurse stated "We have had a change in staff and the staff member responsible for this data collection is out on leave at present. We noted that we had problems in the past but going forward we have begun a new system in which these dates will be included."</p> <p>No further information was provided to the surveyor prior to the exit conference on 1/5/18.</p> <p>2. The facility staff failed to follow infection control guidelines for Resident #29.</p>	F 880	<p>The infection log for resident #29, #47, #40, and #39 is completed with the resolution date of the infection/antibiotic.</p> <p>Isolation signage for resident #29 is located on the resident's room door.</p> <p>RN#1 was immediately educated on infection control practices/facility policy/wound care including cleaning of scissors during wound care, leaving equipment and supplies in resident's rooms who have isolation needs.</p> <p>Resident #29 and Resident #47 are receiving wound care according to the facility's policy on infection control, isolation requirements and wound protocol.</p> <p>Suction canister for resident #39 was replaced along with the suction catheter.</p> <p>Current residents in the facility with isolation needs, residents with wounds and residents requiring suctioning have the potential to be affected. Including resolution dates on the infection control log for tracking of infections.</p> <p>The Director of Nursing/Infection Control</p>		



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F 880	<p>Continued From page 24</p> <p>Resident #29 was readmitted to the facility on 9/29/17 with the following diagnoses of, but not limited to anemia, high blood pressure, manic depression, Multi-drug Resistant Organism, pressure ulcer, aphasia, respiratory failure and seizure disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/4/17, the resident was coded as having short term and long term memory problem in which the resident is severely impaired in decision making. Resident #29 was also coded as being totally dependent on 2 or more staff members for dressing, personal hygiene and bathing.</p> <p>During the initial tour on 1/3/18 at approximately 12:30 pm, a surveyor on the survey team noted that Resident #29 had an infection control cart located beside of the resident's door but there was no signage on the door.</p> <p>This surveyor made another observation on 1/3/18 at approximately 4:30 pm and the resident's door continued to have no signage but the infection control cart continued to be located beside the resident's door in the hallway.</p> <p>On 1/4/18 at 9:30 am, this surveyor noted that an infection control sign was taped to the resident's door which alerted anyone entering that the resident was in contact isolation. The isolation cart was beside the resident's door as it had been previously observed on 1/3/18 during the initial tour. The surveyor observed registered nurse (RN) #1 go into the resident's room with yellow gown, gloves and mask on. This nurse provided care to the resident, went into resident's bathroom, took yellow gown and gloves and mask off. RN #1 then was observed to wash her hands with soap and water. When RN #1</p>	F 880	<p>Nurse was educated by the Chief Nursing Officer/designee on the use of the infection control log to include the resolution dates of the infection/antibiotic usage.</p> <p>Licensed nurses/Wound care nurse have will be educated by the Director of Nursing/designee on infection control, wound and isolation protocol per the facility's policy. In addition, licensed nurses, respiratory therapist have been educated on emptying and changing suction canisters daily/prn and ensuring suction catheters are covered when not in use.</p> <p>The Director of Nursing/designee will review the infection control log three times weekly to ensure the completion of the log including resolution dates of the infection/antibiotic usage.</p> <p>The Director of Nursing/designee will monitor wound care two times weekly to ensure isolation, infection control and wound care protocol are being adhered too. In addition, the Director of Nursing/designee will monitor suction catheters and suction tubing 5 times weekly during routine rounds to ensure suction canisters are emptied and suction catheters are stored appropriately and isolation signage is appropriately displayed on the residents door.</p>		

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F 880	<p>Continued From page 25</p> <p>returned to hallway, the surveyor asked, when a resident is put into isolation what is to occur or be put in place. RN #1 stated "An infection control sign is put on the door, the cart with supplies is to be placed bedside the resident's door and any equipment needed to be used on that resident is brought into the room and kept in the room until the resident is removed from isolation." The surveyor asked RN #1 when this resident was placed in isolation. RN #1 stated "He has been on a 7 to 10 - day treatment with IV antibiotics, he was re-cultured and then he is on day 2 of 7 now of IV antibiotics." The surveyor asked RN #1 when the isolation signage was placed on the resident's door. RN #1 stated "I cannot remember the exact time but it was done yesterday in the evening." The surveyor asked RN #1 when should the isolation signage on the door be placed. RN #1 stated "When the resident is first placed in isolation and not taken down until the infection has been cleared by a repeat culture."</p> <p>At 11:35 am, the surveyor observed the wound care nurse providing care to a pressure ulcer of Resident #29. The wound care nurse took a bottle of wound cleanser into the resident's room, used it during wound care and then returned the same bottle of wound cleanser to the wound care cart located in the hallway outside of Resident #29's room.</p> <p>The administrative team was notified of the above documented findings by the surveyor on 1/4/18 at approximately 3:30 pm. The corporate nurse and director of nursing stated to the surveyor "the bottle of wound cleanser did not need to be brought back and forth from the hallway into the isolation room and back into the hallway. It should</p>	F 880	<p>The results will be reported to the monthly to the Quality Assurance Committee for review and discussion. Once the Quality Assurance Committee determines the problem no longer exists, audits will be conducted on a random basis.</p> <p>CAO/DON will be responsible for implementation of the plan of correction.</p>		

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F 880	<p>Continued From page 26 have stayed in the resident's room."</p> <p>No further information was provided to the surveyor prior to the exit conference on 1/5/18.</p> <p>3. The facility staff failed to follow infection control guidelines for a resident on contact isolation (Resident #47). R.N. #1 exited Resident #47's room with dermal wound cleanser used to clean a pressure area then returned to the room to complete a second wound care with the same dermal wound care cleanser that had been used previously.</p> <p>The surveyor reviewed Resident #47's clinical record 1/3/18 through 1/5/18. Resident #47 was admitted to the facility 7/2/16 with the last readmission on 12/20/17. Resident #47's diagnoses included but not limited to quadriplegia, chronic multifocal osteomyelitis, resistance to multiple antibiotics, urinary tract infection, neuromuscular dysfunction of the bladder with suprapubic catheter, pressure ulcers right and left hip and right and left buttock, sepsis, anxiety, insomnia, depressive disorder, iron deficiency anemia, constipation, ileus, pain, hypertension, and acute respiratory failure with hypoxia.</p> <p>Resident #47's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/20/17 identified the resident with a BIMS (brief interview for mental status) score as 15 out of 15. Resident #47 was interviewable. Section M Skin Conditions identified two (2) stage 3 pressure ulcers and two (2) stage 4 pressure ulcers.</p> <p>Current comprehensive care plan identified skin as a focus area with multiple interventions that</p>	F 880			

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F 880	<p>Continued From page 27</p> <p>included air mattress and wedge used for pressure relieving, education, floating extremities, turning and repositioning as resident will permit, mechanical lift for transfers, nutritional support by dietician, wound clinic visits, treatments per order of physician, and continent care.</p> <p>The surveyor observed Resident #47 during a wound care observation on 1/4/18 at 10:08 a.m. with the wound care nurse registered nurse #1. R.N. #1 gowned and gloved prior to entering Resident #47's room. Resident #47 was currently on isolation precautions. R.N. #1 washed hands and donned gloves. Old dressing removed and discarded. Gloves off and hands washed. Donned gloves. Area on left buttock cleaned with dermal wound cleanser. Dried. R.N. #1 sprayed the Hydrofera blue with dermal wound cleanser to moisten the dressing and then applied Hydrofera Blue to the area and covered with island dressing. R.N. #1 removed gloves and washed hands and returned dermal wound cleanser to cart.</p> <p>R.N. #1 returned to the treatment cart to prepare the dressings for the next pressure area dressing change. The surveyor observed the wound care nurse place the bottle of dermal wound cleanser on top of the treatment cart to be used with the next pressure area to be dressed.</p> <p>R.N. #1 returned to Resident #47's room with the dermal wound cleanser and other supplies to be used for the pressure ulcer care.</p> <p>The surveyor interviewed the wound care nurse on 1/5/18 at 10:00 a.m. regarding the use of dermal wound cleanser and removing the bottle from Resident #47's room who was currently on isolation. R.N. #1 stated the bottle couldn't be left</p>	F 880			

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F 880	<p>Continued From page 28</p> <p>in the room. "What if someone drank it or used it to spray on someone? Where would I put it?"</p> <p>The survey team met with the administrative staff on 1/4/18 at 3:31 p.m. and again on 1/5/18 at 4:36 p.m. and informed them of the issues about Resident #47's wound care observation. The regional registered nurse stated once the bottle of dermal wound care cleanser went into the resident room, it should not come back out.</p> <p>The surveyor requested the facility policy on infection control for wound care on 1/4/18.</p> <p>No further information was provided prior to the exit conference on 1/5/18.</p> <p>4. The facility staff failed to clean scissors prior to cutting silver alginate used during wound care on Resident #40's right leg amputated site.</p> <p>The clinical record of Resident #40 was reviewed 1/3/18 through 1/5/18. Resident #40 was admitted to the facility 12/12/2014 and readmitted 5/30/17 with diagnoses that included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, acquired absence of right leg below knee, acute embolism and thrombosis of unspecified deep vein of lower extremity, epilepsy, peripheral vascular disease, left ankle contracture, leg pain, stage 2 pressure ulcer, right leg amputated stump, insomnia, urine retention, benign prostatic hyperplasia without lower urinary tract symptoms, and hypertension.</p> <p>Resident #40's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/14/17 assessed the</p>	F 880			

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F 880	<p>Continued From page 29</p> <p>resident with short term memory loss, long term memory loss, and severely impaired cognitive skills for daily decision making. Section M Skin Conditions identified Resident #40 to be at risk for the development of pressure areas.</p> <p>Resident #40's current comprehensive care plan identified a focus area that read the resident is at risk for developing pressure ulcers related to incontinence, the inability to reposition himself, hemiplegia, limited sensation, impaired cognition, and chronic disease; dx (diagnosed) with osteomyelitis with loss of limb Date initiated: 2/9/17 Revision date: 8/31/17. Interventions: Examine skin before and after use of splinting/brace device, pressure reduction mattress and cushion to wc (wheelchair), skin assessment weekly.</p> <p>The most recent weekly skin assessment was dated 12/27/17 and identified a stage 2 pressure area on right below knee amputation stump. Current physician orders dated 12/18/17 read "Clean pressure ulcer (PU) over right BKA (below the knee amputation) with wound cleanser, pat/dry, then apply Silver Alginate dressing and cover with dry dressing every day and as needed (prn) soiling."</p> <p>The surveyor observed wound care with the wound care registered nurse #1 on 1/4/18. R.N. #1 removed supplies from the treatment cart and placed them on a paper towel on treatment cart (dermal wound cleanser, gauze, skin prep, silver alginate). R.N. #1 removed scissors from the uniform pocket and cut the piece of silver alginate to the size heeded for the pressure area and returned the scissors to the uniform pocket. The scissors were not observed to be cleaned prior to</p>	F 880			

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F 880	<p>Continued From page 30</p> <p>cutting the silver alginate or after cutting the silver alginate and returning the scissors to the uniform pocket. Resident #40 grimaced when soiled dressing removed. The wound care R.N. #1 stated he had pain meds earlier. R.N. #1 removed gloves, washed hands and gloves were re-applied. R.N. #1 cleaned area with wound cleanser. Dried the area. Applied skin prep to outer area of wound. Removed gloves and placed silver alginate that had been cut to size in the pressure ulcer area and covered with an island dressing. R.N. #1 dated dressing prior to applying dressing. Resident pulled up in bed. R.N. #1 removed gloves and washed hands.</p> <p>The surveyor interviewed R.N. #1 on 1/5/18 at 10:00 a.m. concerning the use of scissors used to cut the silver alginate. R.N. #1 stated there was no need to clean the scissors. R.N. #1 stated that was his normal. The scissors are never used in any residents' room. R.N. #1 stated he cuts the dressings at the treatment cart.</p> <p>The surveyor informed the administrative staff of the above concern with not cleaning scissors used to cut dressings for Resident #40's wound care during the end of the day meeting on 1/4/18 at 3:31 p.m. and again on 1/5/18 at 4:36 p.m. The surveyor requested the facility policy on wound care.</p> <p>The surveyor reviewed the facility policy titled "Wound Care/Treatments Guidelines" on 1/5/18. The policy read in part "3. Set up the supplies on a clean surface at the bedside. 4. Provide privacy for the resident. 5. Wash hands. 6. Explain the procedure to the resident. 7. Cut the tape with your clean scissors. 8. Put gloves on. 9. Remove the soiled dressing and place in a bag at the</p>	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495218</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/05/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>BRIAN CENTER HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>188 OLD FINCASTLE ROAD</b> <b>FINCASTLE, VA 24090</b>		
(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 880	<p>Continued From page 31</p> <p>bedside. Place the soiled scissors on one corner of your setup not touching supplies. 10. Remove gloves and discard the bag. 11. Clean the scissors with 60 seconds of contact with alcohol and place on a CLEAN corner of your setup."</p> <p>No further information was provided prior to the exit conference on 1/5/18.</p> <p>5. For Resident #39, the facility staff failed to maintain suction equipment to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>Resident #39 was originally admitted to the facility on 5/06/13 and was readmitted on 12/15/16. His diagnoses included, but were not limited to: acute respiratory failure, anoxic brain damage, high blood pressure, anemia, tachycardia, gastro-esophageal reflux disease, persistent vegetative state, contractures, pressure ulcer stage 3, aphasia, and quadriplegia.</p> <p>The current minimum data set assessment (MDS) with an assessment reference date (ARD) completed on 12/13/17 for Resident #39 was a quarterly MDS assessment. Resident #39 in section C, had a cognitive status was persistent vegetative state.</p> <p>Multiple observations were made of Resident #39 throughout the survey process. The Resident was observed to have a suction machine on his table beside the bed on initial tour 1/3/18. The suction machine had attached tubing hanging down beside the bedside table. The suction canister with tubing were observed to be uncovered. The suction canister was half full of red tinged water and secretions.</p>	F 880			



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

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F 880	Continued From page 32  On 1/4/18 at 11:05 am, the surveyor asked LPN #1, to come into the resident's room. She was then asked if the suction machine should be covered. She looked at the machine and the canister and said, "It does need to be changed; I will take care of it."  On 1/5/18 at 4:30pm, the administrator and director of nurses were informed of the suction equipment.  No further information regarding the above issue was provided to the survey team prior to the exit conference.	F 880		