STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495375	A. BUILDING _____ B. WING _____	R 03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA MANOR LLC	200 WEAVER AVENUE EMPORIA, VA 23847

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{E 000}	Initial Comments .	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 1/24/18 through 1/29/18 was conducted 3/20/18 through 3/22/18. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. The census in this 120 bed facility was 88 at the time of the survey. The survey sample consisted of 6 current Resident reviews (Residents #101 through #106). No complaints were investigated during the survey.	{F 000}		
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, and clinical record review, the facility staff failed to follow the professional standards of quality for skin assessment and treatment administration for one Resident (Resident #105) in the survey sample of 6 Residents. For Resident #105, the facility staff failed to identify, assess, and obtain treatment orders for a facial wound.	{F 658}	Comprehensive Care Plan CFR(s): 483.21 (b)(3) F 658 With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice.	4/10/18

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

Electronically Signed | 04/06/2018

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{F 658}	Continued From page 1 The findings included; Resident #105 was re-admitted to the facility on 6-29-15. Diagnoses included; heart attack, insomnia, shortness of breath, weight loss, dementia, osteo-arthritis, and bullous pemphigoid. Resident #105's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12-28-17 was coded as a quarterly assessment. Resident #105 was coded as having a BIMS (brief interview of mental status) score of "unable to complete", indicating severe cognitive impairment. Resident #105 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting. On 3-20-18 at 2:00 p.m. during initial tour observations of the facility surveyors noted a perfectly circular coin shaped wound in the right corner of Resident #105's mouth. The wound was red, inflamed, open, crusted, and approximately the size of a dime. Resident #105 was rubbing it and complaining "it hurts, it hurts." On 3-21-18 the Resident was again observed throughout the day, and continued to complain of pain to the facial wound, and no treatment was applied to the wound. Resident #105's care plan and physician's orders were reviewed and revealed no treatment orders for the mouth wound. Resident #105's nursing notes were reviewed and	{F 658}	Resident #105 facial lesion was assessed on 3/21/18 by the Wound care RN Orders were obtained for treatment from MD on 3/21/18 A full skin assessment was completed for resident #105 on 3/21/18. No new skin issues were found. Resident #105 Care plan was updated to add the new facial wound on 3/21/18. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. The facility has identified all residents as having the potential to be affected by this deficient practice. DON/Designee will review all skin assessments for the past week to ensure skin issues identified have appropriate orders in place and are care planned. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Staff has been in-serviced by the DON/Designee on observation and reporting of new skin issues, and the facility wound care protocol. DON/Designee will audit skin	

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{F 658}	Continued From page 2 indicated no assessment had been completed of a wound on Resident #105's mouth. On 3-21-18 at 1:30 p.m. the Licensed Practical nurse manager (LPN A), for the unit that Resident #105 resided on, was asked why no treatment was applied to the painful wound on the corner of Resident #105's mouth. She responded she was not aware of a wound, and proceeded into the Resident's room to assess the wound. She stated she would call the wound nurse to assess it. The wound nurse, RN (A) (Registered nurse A), came immediately to the Resident's room, assessed the wound and called the doctor for treatment orders. Orders were received to treat the wound, and nursing notes and the Resident's care plan were updated to include this new information. The nursing staff indicated that the standard of care at the facility included that Certified nursing assistants (CNA's) were to report any skin changes that were noted during the provision of giving daily care, and that no one had reported a wound to nursing. The facility policy indicated that any new skin changes would be reported, assessed, and treated. When interviewed on 3-21-18 at 4:00 p.m., the DON (director of nursing) stated that she had been notified by staff of the staff failure to report and assess a facial wound for Resident #105. She further stated that the Resident had a history of bullous pemphigoid, and felt this was most likely a result of that. She stated a full assessment had been completed, and no other	{F 658}	assessments daily x 4 weeks and weekly ongoing to ensure any new skin issues have appropriate treatments and interventions in place and are care planned. DON/Designee will place newly identified skin issues on the resident care plan and 24-hour report for 72 hours. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Reports of the findings from the audits will be reported by the Director of Nursing to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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{F 658}	Continued From page 3 lesions were found intra-orally. The DON stated her expectation was for staff to report skin changes immediately, so they could be treated. The administrator and DON were informed of the failure of the staff to identify, assess, and obtain treatment orders for a facial wound, on 3-21-18 at 4:00 p.m. No further information was provided by the facility.	{F 658}		
{F 842} SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	{F 842}		4/10/18

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{F 842}	Continued From page 4 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	{F 842}		

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{F 842}	Continued From page 5 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for one (Resident #103) of 6 residents in the survey sample, to maintain a complete clinical record. Resident #103's blood glucose level and insulin administration amount was documented on a flow sheet that was not part of the clinical record rather than on the Medication Administration Record (MAR). The findings included: Resident #103 admitted to the facility on 10/10/17 with the diagnoses of, but not limited to, diabetes mellitus type 2, vascular dementia with behavioral disturbance, and congestive heart failure. On 3/21/18 at 10:55 a.m. Resident #103's clinical record was reviewed. The review revealed a physician's order dated 2/17/18 which read: "FSBS (finger stick blood sugar) before meals and at bedtime with Novolog Insuling (sic) Sliding scale coverage..CALL MD IF BS <60 (less than 60 mg/dL-milligrams per deciliter) or >500. " And a physician's order dated 2/6/18 which read: "NOVOLOG 100 UNIT/ML (Novolog insulin 100 units per milliliter) VIAL If BS is 61-200 No units If BS is 201-350 Give 10 units subcutaneous If BS 351-500 Give 20 units subcutaneous Call MD if BS is <60 or >500." Review of the March 2018 MAR revealed on 3/20/18 at 6:30 a.m. Resident #103's blood sugar was recorded as 319 however there was no insulin documented as given; that area on the MAR was blank and per physician's orders she	{F 842}	Resident Records-Identifiable Information CFR(s): 483.20 (f)(5), 483.70 (i)(1) -(5) F 842 With regard to the alleged deficient practice, the facility has taken the following action: 1. Corrective actions(s) accomplished for those residents found to have been affected by the alleged deficient practice. MAR for resident #103 was updated on 3/21/18 as a late entry by the medication nurse based on her documentation on the Diabetic Flow Record from 3/20/18. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action was taken. The facility has identified all residents as having the potential to be affected by this deficient practice. DON/Designee will review the current months Medication Administration Records of residents with fingerstick blood sugars and Sliding scale insulin administration for omissions. 3. Measures/systemic changes put in place to ensure this deficient practice does not reoccur: Staff has been in-serviced by the	

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{F 842}	Continued From page 6 should have received 10 units of insulin. And on 3/20/18 at 9:00 p.m., there was no blood sugar result or insulin administration documented on the MAR. There was no information documented in the nursing notes for the omissions. On 3/21/18 at 3:15 p.m. the Administrator and Director of Nursing were informed of the findings. Review of facility policy titled "Insulin Administration" with a revised date of "September 2014" included: "...Documentation 1. The resident's blood glucose result, as ordered; 2. The dose and concentration of the insulin injection..." And, Policy titled "Obtaining a Fingerstick Glucose Level" with a revised date of "October 2011" included: "Documentation The person performing this procedure should record the following information in the resident's medical record: ...6. The blood sugar results. Follow facility policies and procedures for appropriate nursing interventions regarding blood sugar results (if resident is on sliding scale coverage, and/or physician intervention is needed to adjust insulin or oral medication dosage, etc..." On 3/22/18 at 10:25 a.m. an interview was conducted with the Director of Nursing (Admin-B). Admin-B presented a "DAILY DIABETIC FLOW SHEET" dated 3/20/18 with the additional wording "Attach to daily Report Sheets." The flow sheet had Resident #103's first name only on it and "0600 Blood Sugar 319..." and "Treatment 10	{F 842}	DON/Designee on appropriate documentation of fingerstick blood sugars and documentation in the Medication Administration Record. DON/Designee will audit the Medication Administration Records daily to ensure proper documentation for fingerstick blood sugars and insulin administration. 4. Monitoring of corrective action to ensure the deficient practice does not reoccur: Reports of the findings from the audits will be reported by the Director of Nursing to the QAPI meeting for review until thresholds are met. Any trends or patterns identified will be addressed and corrective action plan revised if applicable.	

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{F 842}	Continued From page 7 units." It also included "9 P (p.m.) Blood Sugar 173..." Another form without a title dated 3/20/18 with Resident #103's full name and "9 P 173." The bottom of the form included the wording "...QA (quality assurance) purposes only, this is not part of the medical record." When asked where she expected the nurses to documented blood sugar results and insulin, Admin-B stated she "Would expect nurse to document on MAR." She explained that part of the plan of correction was to come in the next morning and check (documentation) but hadn't checked before the inspector found the hole (missing documentation). Admin-B was informed of the concern that the clinical record was not complete due to the blood sugar and insulin being documented on a form that was not part of the clinical record. No further information was provided.	{F 842}		