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

PRINTED: 07/28/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495243	A. BUILDING _____ B. WING _____	C 07/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENVOY OF STAUNTON, LLC	512 HOUSTON STREET STAUNTON, VA 24402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 0718/17 through 07/20/17. Significant corrections are required for compliance with the following Federal Long Term Care requirements. Three complaints were investigated. The Life Safety Code survey/report will follow. The census in this 170 bed facility was 152 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents # 1 through 21), and three closed record reviews (Residents # 22 through 24).	F 000	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center's allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.	
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to ensure one of 24 residents, Resident #16, needs were accommodated related to an improperly fitting wheel chair. Resident #16 was observed during the course of the survey sitting in a small, improperly fitting wheel chair.	F 246	RECEIVED AUG 07 2017 VDH/OLC **F 246** 1. Resident #16, was reevaluated by therapy and received by the therapy director the proper fitting wheelchair. 2. A quality review has been conducted by the director of clinical services (DCS)/Designee to ensure that residents with wheelchairs have a proper fitting wheelchair. Follow up based on findings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mitzy Mauck | TITLE: ED | (X6) DATE: 8-4-17

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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The findings include:

Resident #16 was originally admitted to the facility on 12/11/14 and readmitted on 5/24/16, with but not limited to, the following diagnoses: shortness of breath, hypertension, diabetes mellitus, obesity, and congestive heart failure. The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 7/7/17 was a quarterly assessment. The resident was assessed as being a fifteen (15) for cognitive skills, independent in decision-making skills and able to make his needs known.

On 7/19/17 at approximately 2:30 p.m., Resident #16 was observed during the group meeting, sitting in a wheel chair. Resident #16 was turned, sitting to the side, in the wheel chair due to the size of the chair. Resident #16 stated, during the meeting, "I had a bigger wheel chair but it got missing. I only sat in it for a couple of days." When asked if the wheel chair was comfortable, Resident #16 stated, "No, it is rubbing up against my legs and I cannot get situated like I want to."

On 7/20/17 at approximately 7:30 a.m., Resident #16 was observed in bed with her eyes closed. The small wheel chair was observed sitting at the side of the bed.

On 7/20/17 at approximately 7:41 a.m., The unit manager, a licensed practical nurse, who will be identified as LPN #2 was interviewed regarding the resident's wheel chair. LPN #2 stated. "I thought it was in the shower room; they brought two to the floor, one old and one new. The girl, who did not work with the resident, was not familiar with her [Resident #16] so she put her in the old wheel chair." LPN #2 further stated when

3. Nursing staff re-education provided by the staff development nurse/designee to current nursing employees on ensuring residents who have wheelchairs have a proper fitting wheelchair.
A quality review to be conducted by the DCS/designee of five residents per week for three months then monthly to ensure they have a proper fitting wheelchair.
4. Results of the reviews to be reviewed at monthly QAPI meeting. Quality monitoring scheduled to be modified based on findings.. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.
5. September 3, 2017

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asked how long the resident had been in the old wheel chair, LPN #2 stated, "I put her to bed the other night [Monday] and she had it then, the new wheel chair."

On 7/20/17 at approximately 7:50 a.m., the certified nursing assistant, who will be identified as CNA #3, was caring for the resident was interviewed regarding the wheel chair. CNA #3 stated, "I was off on Monday but I know she, the resident, has not had the new wheel chair since I have been back." CNA #3 further stated, "I went to look for it in the shower room and downstairs in the row of wheel chairs that were lined up against the wall. I did not see it there because those chairs were too small." CNA #3 stated, "[Resident named] sit in her wheel chair for long periods of time because she likes to feed the birds and go to all the activities, if she had a bigger wheel chair she could do more and she would be more comfortable."

On 7/20/17 at 7:55 a.m. LPN #2 stated, "I found the wheel chair it was in the therapy room." When interviewed and asked how the wheel chair got in the therapy room, LPN #2 stated, "They [therapy] did not mark it so we did not know it was hers [Resident #16]. When interviewed and asked how long the resident was without the new wheel chair, LPN #2 stated, since Tuesday. I know she had it on Monday because I put her to bed." LPN #2 was interviewed and asked the reason no one saw that the resident was not in the proper fitting wheel chair since Monday, LPN #2 stated, "I don't know it only took me ten minutes to go down to the therapy room and see that the chair was down there."

On 7/20/17 at approximately 8:00 a.m., the new

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F 246	Continued From page 3 wheel chair was observed in the resident's room and at the bedside. Resident #16 was observed in bed during this time with a CNA in the room performing her a.m. care. On 7/20/17 at approximately 12:00 p.m., the administrator and the director of nursing were made aware of the above findings. On 7/20/17 at approximately 12:45 p.m., Resident #16 was observed sitting in the new wheel chair. Resident #16 stated to this Surveyor, "Thank you for getting me a bigger chair."	F 246		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 252	RECEIVED AUG 07 2017 VDH/OLC **F 252** 1. For resident #12, Maintenance repaired the three areas of wall damage along the right side of the closet. Maintenance removed the wheelchairs, mechanical lifts, straight chair and glider/rocker that were stored in the open alcove area on second floor. Maintenance replaced the identified broken floor tiles. Maintenance removed the foam along the control boxes and place plastic covers over the boxes.	

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(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review, the facility staff failed to ensure a safe, homelike environment for one of 24 residents in the survey sample (Resident #12) and failed to ensure a safe, homelike environment on the second floor living unit, third floor living unit and in the therapy department.

Resident #12's room had three areas of wall damage along the right side of the closet. The door was broken from the closet leaving three damaged areas where the hinges had been attached.

The second floor living unit had wheelchairs, a mechanical lift, a straight chair and glider/rocker stored in an open alcove area across from the residents' dining/day area. The third floor living unit had damaged floor tiles, a control box rimmed with glued foam along edges, worn finish along counters at nursing stations, paint worn from the swinging door to nursing area, a hole in the top of the wooden rail adjacent to the dining area, missing end caps on a section of wall mounted rail and a table in use in the therapy department with a broken, rough corner.

The findings include:

1. Resident #12's room had three areas of wall damage along the right side of the closet. The door was broken from the closet leaving three damaged areas where the hinges had been attached.

Maintenance repaired the nurses' station that has worn finish along counters and worn paint from the swinging door to nursing area.
Maintenance repaired the hole in the top of the wooden rail adjacent to the dining area.
Maintenance replaced the end caps on the identified section of the wall mounted rail.
Maintenance repaired the identified table that had a broken corner and was in use in the therapy department.
2. The Maintenance Director/ designee performed a quality review of closets in the facility for damaged areas.
The Maintenance Director/ designee performed a quality review of the alcoves for proper storage of equipment. The Maintenance Director/ designee performed a quality review of the building for broken floor tiles and for foam

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Resident #12 was admitted to the facility on 11/25/13 with diagnoses that included dementia with behaviors, high blood pressure, vitamin deficiency and anxiety. The minimum data set (MDS) dated 5/1/17 assessed Resident #12 with severely impaired cognitive skills.

On 7/18/17 at 2:10 p.m. Resident #12's room was inspected. The door to the right side of the resident's closet was missing. Three broken, damaged areas were noted along the right side of the closet area where the hinges had been attached.

On 7/19/17 at 10:45 a.m. the licensed practical nurse (LPN #7) caring for Resident #12 was interviewed about the damaged wall. LPN #7 stated the resident had broken the door and the hinges about a year ago. LPN #7 stated they had replaced the door several times and the resident continued to break the door from the wall. LPN #7 stated the last time the resident broke the door they decided it was safer to leave the door off. LPN #7 stated she did not know if the damaged areas had been reported to maintenance for repair.

2. The second floor living unit had wheelchairs, a mechanical lift, a straight chair and glider/rocker stored in an open alcove area across from the residents' dining/day area. The third floor living unit had damaged floor tiles, a control box rimmed with glued foam along edges, worn finish along counters at nursing stations, paint worn from the swinging door to nursing area, a hole in the top of the wooden rail adjacent to the dining area, missing end caps on a section of wall

F 252 padding covering control boxes.
Additionally, The Maintenance Director/designee performed a quality review of the nurses' stations for worn finish and worn paint and performed a quality review of the wooden rails for holes.
The Maintenance Director/designee performed a quality review of the rails for end caps and tables for broken, rough corners. Follow up based on findings of quality review.
3. Staff re-education provided by the staff development nurse/designee to current employees on notification to maintenance when there is damage to a closet, improper storage of equipment in alcoves, damaged floor tiles, control boxes rimmed with foam, worn finish on counters at nurses stations, worn paint on swinging doors at nurses station, holes in wooden rails,

missing end caps on rails and tables with broken rough corners.
A quality review to be performed by the Maintenance Director/ designee of five closets per week then

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mounted rail and a table in use in the therapy department with a broken, rough corner.

On 7/20/17 at 7:30 a.m. the second floor living unit identified as 2 N/S unit was inspected. An open alcove area with a fire place across from the dining/day area had nine wheelchairs, a mechanical lift, a chair and a glider/rocking chair stored in the area.

On 7/20/17 at 7:35 a.m. the licensed practical nurse (LPN) #6 unit manager was interviewed about the equipment stored in the resident accessible area. LPN #6 stated she did not have a storage room for the wheelchairs and lifts. LPN #6 stated the alcove once had a table and chairs but residents rarely used the area. LPN #6 stated, "I didn't want it (alcove area) to go to waste." LPN #6 stated since residents did not use the area she used it for storage. LPN #6 stated there had been discussions about closing off the area for storage but she did not know the status of that project.

On 7/20/17 at 8:10 a.m. the third floor unit (3 N/S) was inspected. There were damaged/cracked floor tiles below the fire pull station near room 305. The finish was worn off the counter edge around the nursing station. The swinging door to the nursing area had paint worn away along the top edge. A wall mounted metal control box between room 305 and 307 had two pieces of black foam glued along two edges of the box. A wall mounted control box between rooms 315 and 317 had black glued foam particles attached along the edges. There were multiple other wall mounted control boxes without foam padding or protective covers on the unit.

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monthly ensuring there are no damaged areas.
A quality review to be performed by the Maintenance Director/ designee for proper storage of equipment five times a week for three months then monthly..
A quality review to be performed by the Maintenance Director/ designee of the building for broken floor tiles and for foam padding covering control boxes, nurses' stations for worn finish, worn paint from swinging doors, holes in the wooden railing, missing end caps on wall mounted rails, and broken rough corners on tables weekly x three months then monthly.
4. Results of the reviews to be brought to QAPI meeting. Quality review schedule modified based on finding. QAPI committee to recommend revisions to the plan as indicated to sustain substantial compliance.
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On 7/20/17 at 8:15 a.m. the certified nurses' aide (CNA) #1 was interviewed about the foam padding on the control boxes. CNA #1 states a resident "a long time ago" bumped into one of the boxes. CNA #1 stated the foam was put on the box to protect the residents from bumping them. CNA #1 stated some of the other boxes had newer looking covers and were without the foam.

On 7/20/17 at 8:20 a.m. the third floor unit identified as 3 N/W was inspected. The finish was worn from the wooden top rail covering the low wall around the dining/day area. Across from room 338 there was a broken 1 inch square hole in the wooden top rail at the entrance to the dining area. The section of wall mounted rail near the floor between rooms 330 and 332 was missing end caps.

On 7/20/17 at 9:00 a.m. the unit manager (LPN #5) was interviewed about the wooden rail condition and missing end caps on the wall rail. LPN #5 stated she did not know how the damage occurred on the top wooden rail. LPN #5 stated she reported to maintenance yesterday (7/19/17) the missing end caps on the wall rail.

On 7/20/17 at 9:15 a.m. the therapy department was inspected. The table holding the arm exercise machine was damaged. The corner was broken from the table exposing a rough edge with missing veneer.

On 7/20/17 at 9:30 a.m. the maintenance director was interviewed about the items observed in disrepair. The maintenance director stated they had an old building and were continuously working on items to keep them in good condition. The maintenance director stated they repaired

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items when work orders were issued. The maintenance director stated there had been discussions about modifying the alcove on unit two to make it a storage area.

These findings were reviewed with the administrator and director of nursing during a meeting on 7/19/17 at 5:00 p.m. and on 7/20/17 at 11:45 a.m.

F 279 SS=D 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS

483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

F 252

F 279

F 279

1. For resident #9, the care plan has been updated to include her participation in hospice. There is a provision for the coordination of care between the facility and the hospice provider.
For resident #12, the care plan has been updated to include incontinence and decline in her bowel/bladder function.
Resident #24 no longer resides in the facility.
2. A quality review performed by the MDS Coordinator/designee ensuring residents on hospice, residents that are incontinent, and residents who "porch sit" have appropriate care plan(s) in place. Follow up based on quality review findings.
3. Re-education provided by the staff education nurse/designee to

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(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv)In consultation with the resident and the resident's representative (s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed for three of 24 residents in the survey sample (Residents # 9, 12, and 24), to develop a complete and accurate care plan. The care plan for Resident # 9 failed to include her participation in Hospice, and failed

the interdisciplinary team and licensed nurses on care planning hospice care, incontinence, and "porch sitting".
A quality review to be conducted by the MDS Coordinator/ designee to ensure care planning of hospice, incontinence, and "porch sitting" of five residents per week x3 months then monthly..
4. Results of the reviews to be brought to the Quality Assurance Performance Improvement meeting monthly. Quality Review schedule modified based on review findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.
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to coordinate the provision of care between the facility and the hospice provider. The care plan for Resident # 12 failed to address incontinence, and a decline in bowel and bladder function. The care plan for Resident # 24 failed to address how staff would ensure the resident's safety for her desired activity of going outside to "porch sit".

The findings include:

1. The care plan for Resident # 9 failed to included her participation in Hospice, and failed to coordinate the provision of care between the facility and the hospice provider.

Resident # 9 in the survey sample, a 68 year-old female, was admitted to the facility on 9/13/16 with diagnoses that included lung cancer, hypertension, depression, generalized muscle weakness, dysphagia, cognitive communication deficit, and difficulty walking. According to the most recent Quarterly Minimum Data Set, with an Assessment Reference Date of 5/11/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with moderately impaired daily decision making skills.

According to Resident # 9's clinical record, she entered a Hospice program on 2/7/17.

Review of Resident # 9's care plan, most recently updated on 5/12/17, failed to reveal any problem, goals, or interventions to address her participation in a Hospice program. In addition, there were no provision for the coordination of care between the facility and the hospice provider.

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The findings were brought to the attention of the Director of Nursing and the Administrator during a meeting with the survey team at 4:30 p.m. on 7/19/17.

2. Resident #12 had no care plan developed regarding incontinence and a decline in bowel/bladder function.

Resident #12 was admitted to the facility on 11/25/13 with diagnoses that included dementia with behaviors, high blood pressure, vitamin deficiency and anxiety. The minimum data set (MDS) dated 5/1/17 assessed Resident #12 with severely impaired cognitive skills.

Resident #12's clinical record documented a quarterly MDS dated 5/1/17 assessing the resident as always incontinent of bowel and bladder function (no episodes of continence). Previous assessments dated 2/1/17, 11/13/16 and 8/6/16 assessed the resident as occasionally incontinent (less than 7 episodes of incontinence during the 7 day look back period). The annual MDS dated 11/13/16 included incontinence as a triggered care area requiring the development of care plan.

Resident #12's current plan of care (print date 7/19/17) included no problems, goals and/or interventions regarding the resident's incontinence and made no mention of the resident's decline in bowel/bladder function assessed on 5/1/17.

On 7/19/17 at 10:45 a.m. the licensed practical

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nurse (LPN #7) responsible for MDS and care plan development was interviewed about Resident #12. LPN #7 reviewed Resident #12's care plan and stated she did not see anything listed about incontinence or a decline in bowel and bladder function. On 7/19/17 at 11:20 a.m. LPN #7 stated the look back period for Resident #12's quarterly 5/1/17 MDS was 4/24/17 through 5/1/17. LPN #7 stated the coding of the resident as always incontinent was accurate as the tracking indicated the resident had no episodes of continence during this time. LPN #7 stated there had been no care plan developed addressing the decline in bowel and/or bladder function.

On 7/19/17 at 2:35 p.m. the director of nursing (DON) was interviewed about Resident #12's bowel/bladder decline. The DON stated a bowel and bladder training assessment was conducted with Resident #12 for three days starting on 4/23/17 in response to the resident's decline in continence. The DON stated the resident refused to participate and many times was combative with staff when attempts were made for scheduled toileting. The DON stated the resident was not considered a candidate for scheduled toileting. The DON stated that incontinence and the decline in bowel/bladder function should have been addressed on the resident's care plan.

These findings were reviewed with the administrator and director of nursing during a meeting on 7/19/17 at 5:00 p.m.

3. Resident # 24 did not have a comprehensive care plan developed to address her activity of going outside to "porch sit" as related to

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supervision as she was identified as having poor safety awareness, limited vision, and impaired physical mobility.

Resident # 24 was admitted to the facility 6/11/03 with a readmission date of 3/4/14. Diagnoses for Resident # 24 included, but were not limited to: dementia, high blood pressure, left-side weakness due to history of stroke, and schizoaffective disorder (a mental health disorder including schizophrenia and mood disorder symptoms).

The most recent MDS (minimum data set) was a quarterly review dated 10/7/16 and had Resident # 24 assessed as having moderate impairment in cognition with a total summary score of 09 out of 15.

The care plan for Resident # 24 was then reviewed. The care plan for safety included: "Focus: The resident has the potential for injury related to poor safety awareness, history of stroke with left sided weakness, impaired vision, dementia with behaviors, communication deficit where she usually understands,.....history of falls as evidenced by decreased mobility." Under "Goals" documented "The resident will not injure themselves in a fall through next review. The resident will not sustain serious injury through next review." (It should be noted here that due to the clinical record reviewed as a closed record, the electronic portion for the care plan did not indicate a date as a discharged resident).

Interventions for the safety care plan included "Assess resident ability with hot liquids; Be sure call light within reach; Encourage resident to report any safety concerns to nurse; Maintain

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F 279	Continued From page 14 clear pathway, free of obstacles...." However, there was not a care plan to address the resident going outside nor interventions how staff were going to address keeping the resident safe for that activity. On 7/19/17 at 10:45 a.m. the DON (director of nursing) was interviewed about the incident. The DON stated "[name of resident # 24] usually went outside to 'porch sit' she did that all through the day; she had not been assessed to be an elopement risk." These findings were reviewed with the administrator and director of nursing on 7/19/17 during an end of the day meeting beginning at 4:50 p.m.	F 279		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure proper positioning to prevent loss in range of motion for one of 24 residents in the survey	F 318	**F 318** 1. Resident #18, was re-evaluated by therapy and physical therapist adjusted the Broda chair to provide lower leg support.. 2. A quality review performed by the DCS/designee to ensure residents with Broda chairs have lower leg support when sitting in Broda chairs as indicated. Follow up based on review findings. 3. Nursing staff and therapy staff re-education provided by the staff development nurse/designee on	

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sample. Resident #10 was positioned in a Broda type wheelchair without any support for her lower legs/feet.

The findings include:

Resident #10 was admitted to the facility on 10/14/16 with a re-admission on 1/19/17. Diagnoses for Resident #10 included failure to thrive, diabetes, stroke with right side weakness and history of deep vein thrombosis. The minimum data set (MDS) dated 6/12/17 assessed Resident #10 with severely impaired cognitive skills and with functional limitation in range of motion on one side of her upper and lower extremities (hip, knee, ankle, foot).

On 7/18/17 at 2:20 p.m. Resident #10 was observed seated in a Broda type wheelchair in the dining area. The wheelchair had no foot rests and the resident's feet were hanging unsupported with her toes pointing downward. The resident's feet were approximately 10 to 12 inches from the floor. The chair had a support section behind the resident's lower legs. This section of the chair was in the down position and provided little if any support under the resident's lower legs. Resident #10 was observed seated in this same position on 7/18/17 at 3:00 p.m.

On 7/18/17 at 3:20 p.m. the licensed practical nurse (LPN #3) caring for Resident #10 was interviewed about the resident's feet hanging without support. LPN #3 stated the Broda chair did not have foot rests. LPN #3 stated the lower leg section on the Broda chair could not be raised.

On 7/19/17 at 7:30 a.m. Resident #10 was

how to adjust lower leg support on Broda chairs.

A quality review to be conducted by the DCS/designee to ensure proper leg support for residents sitting in Broda chair. Review to include five residents who have Broda chairs weekly then monthly.

4. Results of the reviews to be brought to QAPI meeting monthly. Quality Review schedule to be modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance.

5. September 3, 2017

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observed again in the Broda chair with her feet and lower legs unsupported.

On 7/19/17 at 9:50 a.m. the rehabilitation (rehab) director was interviewed about Resident #10's positioning in the Broda chair. The rehab director stated the resident was placed in the Broda chair because she "wiggled" and did not maintain a safe position in a standard wheelchair. The rehab director stated the lower portion of the Broda chair was adjustable for lower leg support. The rehab director stated she would get the physical therapist (PT) to review the resident's positioning.

On 7/19/17 at 1:15 p.m. the PT was interviewed about Resident #10's lack of lower leg/feet support in the Broda chair. The PT stated she reviewed Resident #10 in the Broda chair and stated the lower leg portion of the chair should be partially raised. The PT stated, "The chair can adjust." The PT stated the lower section of the chair "needs to be part way up to support the lower legs and partially raise the feet." The PT stated the resident's ankle range of motion was "a little tight" but the resident received passive range of motion six days a week. The PT stated nursing staff needed to be educated about the chair positioning.

These findings were reviewed with the administrator and director of nursing during a meeting on 7/19/17 at 5:00 p.m.

F 323 SS=G 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES — F 323

(d) Accidents.
The facility must ensure that -

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(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to provide supervision to prevent an accident resulting in harm for one of 24 residents in the survey sample: Resident # 24; and also failed to ensure handrails were in good repair on two of three units in the facility.

1. Resident #24, assessed with impaired safety awareness, impaired vision and limited functional range of motion on one side, fell from her wheelchair while outside unsupervised during early morning hours and suffered a hip fracture.

1. Resident #24 no longer resides in the facility.
The identified hand rails on second and third floor living areas have been repaired.
2. A quality review conducted by DCS/designee of residents who "porch sit" for safety considerations. A quality review was performed by the Maintenance Director of hand rails for sharp edges. Follow up based on findings of review.
3. Re-education by the staff development nurse/designee on ensuring residents who "porch sit" are safe to do so independently. In addition, staff re-educated by the staff development nurse/designee on notification to maintenance when hand rails need to be repaired.
A quality review to be performed by the DCS/designee for safety consideration of residents who "porch sit". This review to include five residents weekly x 3 months then monthly.

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F 323	Continued From page 18 2. Facility staff failed to ensure the safe condition of handrails. Handrails had damaged areas with sharp exposed edges on the second floor and third floor living units. Findings include: Resident # 24 was admitted to the facility 6/11/03 with a readmission date of 3/4/14. Diagnoses for Resident # 24 included, but were not limited to: dementia, high blood pressure, left-side weakness due to history of stroke, and schizoaffective disorder (a mental health disorder including schizophrenia and mood disorder symptoms). The most recent MDS (minimum data set) was a quarterly review dated 10/7/16 and had Resident # 24 assessed as having moderate impairment in cognition with a total summary score of 09 out of 15. The clinical record was reviewed 7/19/17 beginning at 10:00 a.m. A nurses' note dated 10/16/16 at 7:00 a.m. documented the following: "Approximately 6:36 a.m. resident had went downstairs to the lobby, in which resident does everyday and throughout the day, resident went down this morning and went outside through the automatic sliding doors, resident is independently mobile once assisted by [one] into her wheelchair, she uses left sided legrest while up in wheelchair due to post CVA (stroke) though does use right upper and lower extremity to wheel herself, resident lost control of her wheelchair when going outdoors and wheelchair appeared to go down the sidewalk, which does have an incline, and proceeded onto the blacktop approximately 10-15	F 323	In addition, a quality review to be performed by the Maintenance director/designee of hand rails in the facility. This will be performed five times a week for three months then monthly. 4. Results of the reviews to be brought to monthly QAPI committee monthly. Quality Review schedule modified based on findings. The committee to recommend revisions to the plan as indicated to sustain substantial compliance. 5. September 3, 2017	

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feet before wheelchair flipped over, resident was assisted immediately by employees (several) coming into work that morning. After interviewing multiple staff members, it is known for sure that resident was not outside at 6:30 a.m. per staff, whom reported to work at this time parking in the nearby parking lot which has 100% view of the facility entrance where resident was noted to have fallen. 1st CNA whom arrived to assist resident arrived at 6:36 a.m. and noticed a wheelchair in the entrance drive of the facility, once she reached resident's side employee called into facility for nurses, nurse arrived outside and phoned 911 immediately, resident was assessed by several nurses, 911 EMT's arrived within approximately 5 minutes and took over assessing pt., pt. was not moved until EMT's were ready to transport her to local hospital, resident was noted to have some abrasions/ injuries to her face, unsure what other injuries may have as well, writer notified DON immediately as well as calling RP, whom did not answer, message was left. Charge nurse for 7 p.m.-7 a.m. spoke with hospital person, history and physical and med list given to EMT's."

10/16/16 8:30 a.m. "VDH, APS,Ombudsman all notified of above incident."

10/16/16 8:40 a.m. "[name of doctor] notified of fall, ..."

10/16/16 9:30 a.m. "writer spoke to hospital charge nurse, nurse verified that resident had broken her left hip and was being admitted, charge nurse also verified that they did speak with RP."

The care plan for Resident # 24 was then

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reviewed. The care plan for safety included: "Focus: The resident has the potential for injury related to poor safety awareness, history of stroke with left sided weakness, impaired vision, dementia with behaviors, communication deficit where she usually understands,.....history of falls as evidenced by decreased mobility." Under "Goals" documented "The resident will not injure themselves in a fall through next review. The resident will not sustain serious injury through next review." (It should be noted here that due to the clinical record reviewed as a closed record, the electronic portion for the care plan did not indicate a date as a discharged resident). Interventions for the safety care plan included "Assess resident ability with hot liquids; Be sure call light within reach; Encourage resident to report any safety concerns to nurse; Maintain clear pathway, free of obstacles...."

However, there was not a care plan to address the resident going outside nor interventions how staff were going to address keeping the resident safe for that activity.

On 7/19/17 at 10:45 a.m. the DON (director of nursing) was interviewed about the incident. The DON stated "[name of resident # 24] usually went outside to 'porch sit' she did that all through the day; she had not been assessed to be an elopement risk." The DON was asked for the investigation of the incident. The DON also asked at that time if surveyors were looking at a harm level deficiency, would we tell them. This surveyor told the DON that the survey team was considering harm for this particular resident.

On 7/19/17 at 10:45 a.m. the DON (director of nursing) was interviewed about the incident. The

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DON stated "[name of resident # 24] usually went outside to 'porch sit' she did that all through the day; she had not been assessed to be an elopement risk." The DON was asked for the investigation of the incident.

The investigation was reviewed, to include witness statements. The witness statements were consistent in several staff documenting that upon arriving to work between 6:40 a.m. and 6:50 a.m. an empty wheelchair was observed near the front entrance of the facility, and the resident was observed on the ground. Depending upon the time of arrival, staff either observed the resident on the ground, or observed the emergency staff already in place. There were no witness statements from staff already in the building on the night shift; therefore, it was not known by staff interviewed what time the resident actually left the building; only when she was found by staff arriving for the day shift. The DON confirmed staff on the floor did not see the resident leave the floor. (The resident was on the second floor during her stay; the only elevator to accommodate a wheelchair was located towards the back side of the unit).

On 7/19/17 at 1:45 p.m. LPN (licensed practical nurse) # 2, who was the current unit manager, was interviewed about the incident. LPN # 2 was still working in the facility, and had been a witness to the incident. LPN # 2 stated "I've worked here for years, and knew the resident fairly well as I worked here since 2001, and she was a resident here from 2003 until that incident. She would go all over the building once staff got her up, dressed, and in her wheelchair. She mainly just stayed within the building, but would also go to the lobby to look for her daughter. She was

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always telling me that her daughter was coming to visit, and she wanted to go to the lobby to look for her. Sometimes I would go down to the lobby with her so I could show her that her daughter wasn't down there, and get her to come back upstairs. I do remember telling the previous unit manager, who is no longer here, that she shouldn't be allowed to go downstairs unattended. She had never done anything before, but she had dementia and you just never know when a thought hits them what they'll do, but I was told that was against her rights. She had never gone outside at that time of morning before."

On 7/19/17 at 3:15 p.m. the receptionist, who has a desk in the front lobby, was asked if she was working the morning the resident went outside and fell. The receptionist stated "Well, I come to work between 7 a.m. and 7:30 a.m. so I would not have seen her exit the building. I was not working the day that happened, but I saw her here in the lobby almost daily, but I never saw her go outside."

On 7/19/17 during an end of the day meeting with facility staff beginning at 4:50 p.m. the administrator and DON were informed of the above findings and the potential for harm. The administrator and DON appeared to understand the significance of the event.

On 7/20/17 at approximately 10:00 a.m. the DON asked this surveyor if she could present additional information of the incident. This surveyor said yes, and the DON brought in a copy of minutes from a quality assurance meeting which had been held after Resident # 24 had fallen. The documentation included a plan of

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action for the provision of supervision to prevent accidents, elopements, and falls with injuries. The action plan was dated with a date of compliance 10/20/16. The DON asked if past noncompliance could be considered. This surveyor advised the DON that due to other current deficient practice falling within the same area, past noncompliance could not be considered. The DON verbalized her understanding.

No further information was provided prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY.

2. Facility staff failed to ensure the safe condition of hand rails. Hand rails had damaged areas with sharp exposed edges on the second floor and third floor living units.

On 7/20/17 at 7:30 a.m. the second floor living unit was inspected. When exiting the small elevator on the second floor there was a broken, separated section of hand rail at the corner below the directory sign. On the second floor unit identified as 2 N/S, the hand rail outside room 210 had a crescent shaped crack (about 1 1/2 inches long) along the bottom with a sharp pointed edge exposed along the rail. There was an approximately 3/4 inch gap in the hand rail outside of room 212 where sections of the rail had separated. The hand rail section between rooms 214 and 216 had a very sharp edge along the bottom about midway the rail. This section of rail had two broken places where the rail sections connected. Near the entrance to the courtyard

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	495243	A. BUILDING _____ B. WING _____	C 07/20/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 area the corner section of the hand rail was separated. Residents were observed on this unit ambulating and self-propelling in wheelchairs along the hallways. On 7/20/17 at 7:50 a.m. the licensed practical nurse unit manager (LPN #6) was shown the damaged, unsafe handrail sections and interviewed about the rails. LPN #6 stated the damaged areas were sharp and she had not noticed them before. LPN #6 stated she would get maintenance to repair the rails. On 7/20/17 at 8:10 a.m. the third floor living unit identified as 3 N/S was inspected. The hand rail outside room 306 had a sharp exposed corner where the rail section was damaged. This was shown to the maintenance director at the time of the observation. The maintenance director stated he was not aware of the damaged hand rails until today. These findings were reviewed with the administrator and director of nursing during a meeting on 7/20/17 at 11:45 a.m.	F 323		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 441	**F441** 1. LPN #1 and LPN #4 were re-educated by the director of clinical services on proper hand washing during medication pass.	

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F 441	Continued From page 25	F 441	2. A quality review conducted by the DCS/designee of current licensed nurses performing medication pass to ensure proper hand hygiene. Follow up and re-education based on findings. 3. Re-education provided by the staff development /designee to licensed nurses on proper hand hygiene during medication pass. A quality review to be performed by DCS/designee to ensure proper hand hygiene during medication pass for three licensed nurses weekly x 3 months then monthly. 4. Results of the quality reviews brought to QAPI committee meeting monthly. Quality Review schedule modified based on findings. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. September 3, 2017	

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

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

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

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

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

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

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

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

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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 observation, facility document review and staff interview, the facility staff failed to follow infection control practices during the medication pass observation. Two nurses failed to perform hand hygiene between residents when administering medications.

The findings include:

1. After preparing and administering oral medications to a resident, licensed practical nurse (LPN) #4 failed to perform hand hygiene prior to preparing and administering medicines to the next resident during a medication pass observation.

On 7/19/17 at 7:40 a.m. LPN #4 was observed administering medications to Resident #17. LPN #4 discarded the medicine cup the resident put to her mouth when taking the medicines and also touch the resident's personal water cup when giving the medicines. LPN #4 discarded cups in the trash bin on the medication cart. Without

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performing hand hygiene, LPN #4 prepared and then administered oral medications to Resident #15. LPN #4 touched the resident's medicine cup in addition to handing the resident her personal cup of water.

On 7/19/17 at 8:00 a.m. LPN #4 was interviewed about the lack of hand hygiene between residents during the medication pass observation. LPN #4 stated she thought she only needed to perform hand hygiene after "every third person." LPN #4 stated after using hand sanitizer she was supposed to wash her hands after "every so many" but she did not remember exactly that protocol. LPN #4 stated she could not recall the exact protocol for hand sanitizer and/or hand washing.

On 7/19/17 at 8:10 a.m. the director of nursing (DON) was interviewed about hand hygiene during the medication pass. The DON stated nurses were supposed to perform hand hygiene between residents when giving medications or providing care.

The facility's policy titled Handwashing (effective 9/6/16) stated, The CDC [Centers for Disease Control] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel)... Hand hygiene should be performed...Before initiating a clean procedure...Before and after patient care...After contact with inanimate objects (including medical equipment) in the immediate patient vicinity..."

The Lippincott Manual of Nursing Practice 10th edition states on page 1083, "Hand hygiene is the

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single most recommended measure to reduce the risks of transmitting microorganisms... Hand hygiene should be performed between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles..." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 7/19/17 at 5:00 p.m.

2. LPN (licensed practical nurse) # 1 failed to perform hand hygiene prior to the preparation and administration of oral medications during a medication pass and pour observation.

On 7/19/17 beginning at 7:40 a.m. a medication pass and pour observation was conducted with LPN # 1. LPN # 1 was observed as medications were prepared and administered to a resident. LPN # 1 left the resident room without washing her hands, and did not use hand sanitizer prior to preparing and administering medications to the next two residents. LPN # 1 discarded medicine cups and water cups each resident touched and/or put to their mouth in the trash receptacle on the medication cart. As LPN # 1 left the third resident room, she retrieved the hand sanitizer from the top of the med cart and sanitized her hands. This surveyor advised LPN # 1 that it was noted she did not perform hand hygiene between the first three residents. LPN # 1 stated "Do you have to do that every time? Down home we don't.....I think maybe we are supposed to after every third resident?" This surveyor asked if it was known what the policy for handwashing was, and LPN # 1 stated she was not sure.

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F 441	Continued From page 29 On 7/19/17 at 8:10 a.m. the director of nursing (DON) was interviewed about hand hygiene during the medication pass. The DON stated nurses were supposed to perform hand hygiene between residents when giving medications or providing care. The facility's policy titled Handwashing (effective 9/6/16) stated, The CDC [Centers for Disease Control] defines hand hygiene as cleaning your hands by using either handwashing (washing with soap and water), antiseptic hand wash, or antiseptic hand rubs (i.e. alcohol-based sanitizer including foam or gel)... Hand hygiene should be performed...Before initiating a clean procedure...Before and after patient care...After contact with inanimate objects (including medical equipment) in the immediate patient vicinity..." These findings were reviewed with the administrator and director of nursing on 7/19/17 during an end of the day meeting beginning at 4:50 p.m. (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.	F 441		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 514	**F 514** 1. Resident #15, had physician order for Senna clarified and a physician clarification order written for Senna.	

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F 514	Continued From page 30 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain an accurate clinical record for one of 24 residents in the survey sample. Resident #15's clinical record documented an inaccurate physician's order for the medication Senna. The findings include: Resident #15 was admitted to the facility on 8/1/16 with diagnoses that included pneumonia,	F 514	2. A quality review completed by the DCS/designee of current physician orders for accuracy. Clarification orders written as indicated by findings 3. Re-education provided by the staff development nurse/designee to current licensed nurses on correctly updating the Physician Order Sheet(POS) with current medications prior to the physician signing the physician order sheet. A quality review to be performed by the DCS/designee during monthly change over of physician order sheets for accuracy monthly times 3 months then quarterly. 4. Results of the quality reviews to be brought to QAPI committee meeting monthly. Quality Review schedule modified based on review findings. The committee will recommend revisions to the plan as indicated to sustain substantial compliance. 5. September 3, 2017	

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urinary tract infection, chronic kidney disease and heart failure. The minimum data set (MDS) dated 4/27/17 assessed Resident #15 as cognitively intact.

Resident #15's clinical record documented a physician's order dated 6/3/17 to discontinue the medication Senna scheduled to be given each day as a bowel aid. The order stated to change the Senna to be given each day only as needed. The resident's medication administration record for June 2017 documented the Senna was discontinued as ordered and the medication was listed as an as needed medication.

The physician's order summary sheet signed by the physician on 7/5/17 documented an order for Senna to be administered each day for bowel management. This order sheet was reviewed and signed by the nursing unit manager on 6/22/17. The resident's medication administration record for July 2017 documented no scheduled Senna administered.

On 7/19/17 at 8:05 a.m. the licensed practical nurse (LPN #4) administering medications to Resident #15 was interviewed about the conflicting Senna orders. LPN #4 stated the order for Senna was changed in June (2017) from scheduled to as needed as requested by the resident. LPN #4 stated the order must not have been corrected on the physician order summary sheet.

On 7/19/17 at 8:10 a.m. the director of nursing (DON) presented a clarification order stating the Senna should be given only as needed and not scheduled. The DON stated the physician order summary sheet was not correct and should have

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F 514	Continued From page 32 reflected the change in Senna to as needed medicine. These findings were reviewed with the administrator and director of nursing during a meeting on 7/20/17 at 11:45 a.m.	F 514		