STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495183	A. BUILDING _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTH CARE CENTER AT BRANDERM	2100 BRANDERMILL PKWY MIDLOTHIAN, VA 23112

(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 TD THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION OATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 5/17/16 through 5/19/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Survey/Report will follow. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and 5 closed records (Residents # 13 through #17).	F 000	This plan of Correction constitutes the facility's written allegations of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan of Correction is submitted to meet requirements established by state and federal law.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	**F-225** 1) In order to correct the findings identified by the inspectors regarding facility staff failing to re-verify licensure/certification with the Department of Health Professions after a license/certification has expired **The following actions have been implemented:** 2) Immediately upon receiving the deficiency we notified our HR department that we needed to add language to our policy that specifically dealt with the re-verification of every licensure or certification through the DOH.	

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

Administrator 6-3-16

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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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: Based on staff interview, facility documentation review and observation, the facility staff failed to notify the State Agency (SA) of a fire at the facility. A dryer fire occurred, sometime in October, 2015 and the facility did not notify the SA. The findings included: During interviews to assess facility staff knowledge of emergency procedures, the evening nursing supervisor was interviewed, 5/18/16 at 3:45 p.m. The nursing supervisor stated there had been a fire in the facility's laundry, caused by lint, and she had put the fire out with the fire extinguisher. She further stated the fire had occurred about six months ago. During general observations, the laundry was observed. Other C, the laundry worker stated 5/19/16 at 8:50 a.m., she had been working at the time of the dryer fire. Other C stated she thought	F 225	3) Our HR team and myself drafted new language to our policy and in-serviced all Directors and Supervisors of the change and explained the importance of strict compliance. (revised policy is enclosed) 4) The administrator, or their designee, will conduct random audits of employee files to ensure compliance. This will be done twice weekly X 6 weeks and then randomly with additional in-servicing as needed. All Findings will be addressed and forwarded to the QA/QI team for processing according to the facility QA/QI policy by 6/20/2016 6/20/16 **F 225** 1) In order to correct findings identified by the inspectors regarding reporting events to the State Agency. We have increased the availability of incident reports and in-serviced staff on filling out reports for every event, no matter how minor.	

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F 225	Continued From page 2 it was "maybe at the end of October (2015)." Other C stated she and one of the nurses smelled smoke and upon checking in the laundry, realized there was a fire in the dryer. Other C stated the bottom of the dryer was opened and flames were noticed on the bottom of the dryer, with part of the lint filter melted through. Other C stated after she and the nurse put the fire out with the fire extinguisher, facility security had arrived and disconnected the gas line and electric lines of the dryer. Maintenance checked the dryer the next day and called a contractor to come and check on the dryer. Other B, the maintenance director was interviewed 5/19/16 at 9:40 a.m. Other B stated the contractor determined lint had gotten up near the burner and caused a "flash." Other B stated he did not consider the dryer fire to be a true fire, however he had not been at the facility at the time of the fire. Other B stated the dryer was relatively new and he had been unaware that the top of the dryer could be moved so the areas around the burner could be cleaned. Other B stated he could not remember when the dryer fire occurred and he stated he would try and find out when the fire occurred. As of the end of the survey, 5/19/16 at 12:45 p.m., no further information was provided, including when the fire actually occurred. The dryer was observed 5/19/16 at 8:50 a.m. Black scorched marks could be observed on the bottom of the dryer. The lint screen was clean and Other C stated the lint area was checked and cleaned three times a day. When asked for verification that the SA had been informed of the fire in the dryer, the administrator stated no verification had occurred, 5/19/16 at	F 225	**The following actions have been implemented:** 2) In order to prevent future occurrences incident reports will be reviewed weekly to determine if incidents need to be reported to SA. Those records will be reviewed every week x 4 weeks, then every 2 weeks x 8 weeks and periodically thereafter. 3) All Staff will be in-serviced on the facility's protocol in filling out incident reports and submitting them timely to supervising manager. 4) The administrator or designee will review any incident reports to verify need to report. Discrepancies will be promptly reported to the SA. 5) Findings will be addressed and forwarded to the QA/QI team for processing according to the facility QA/QI policy before 6/20/2016.	6/20/16

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F 225	Continued From page 3 11:10 a.m. The administrator stated she had been led to believe that no true fire had occurred. The administrator was unaware that the results from the fire were still visible in the dryer. Review of the facility's policy entitled "Abuse Investigation and Reporting:" 13. "Unusual occurrences" include: a. Any event involving a resident that is likely to result in legal action b. Medication errors that result in the resident being hospitalized or dying c. Suicides-attempted or successful d. Death or serious injury associated with the use of restraints e. Ingestion of toxic substances requiring medical intervention. f. Accidents or injuries of known origin that are unusual, such as a resident exiting the nursing home and sustaining an injury on facility property, or a resident being burned. g. Resident procuring and ingesting enough medication to result in an overdose. h. Any unusual event involving a resident or residents that my result in media coverage. PROCEDURE 1. Any reasonable suspicion of a crime against a resident or alleged violations involving theft, fraud, mistreatment, neglect or abuse, including injuries of an unknown origin and "unusual occurrences", misappropriation of resident property or funds must be reported to the Health Care Facility administrator or his/her designee.	F 225		

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F 225	Continued From page 4 3. c. The Health Care Facility Administrator or his/her designee will prepare the Facility Reported Incident form and fax to the OLC (Office of Licensure and Certification-SA). Facility reports to the OLC should contain sufficient detail to demonstrate that a thorough investigation was conducted including, but not limited to: 1. Date of incident; 2. Names of resident, staff, or individuals involved; 3. Location of and description of the injury to the resident; 4. Location and description of the injury to the resident; 5. Immediate corrective action taken to protect the resident from further injury; 6. Mechanisms in place to prevent recurrence of the incident, including date of review of facility policies and procedures; and 7. Documentation of report to Adult Protective Services, law enforcement, or the Department of Health Professions, as appropriate." The administrator and DON (director of nursing) were informed of the failure of the facility to report an "unusual occurrence", a dryer fire, to the SA 5/19/16 at 11:10 a.m.	F 225		
F 273 SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the	F 273	**F-TAG – 273** 1) In order to correct findings identified by the inspectors regarding MDS Coordinator failing to complete an Admission (MDS) and Resident Assessment in a timely manner.	

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F 273	Continued From page 5 facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an admission MDS (minimum data set) RAI (Resident assessment instrument) in a timely manner for two Residents (Residents #11 and #12) in a survey sample of 17 Residents. 1. Resident #11 was admitted to the facility on 4/12/16 and as of 5/19/16, an admission assessment had not been completed; and 2. Resident #12 was admitted to the facility 4/29/16 and as of 5/19/16 no admission assessment had been completed. The findings included: 1. Resident #11 was admitted to the facility was admitted to the facility 4/12/16 and as of 5/19/16, an admission assessment had not been completed. Resident #11, a female, was admitted to the facility 4/12/16. Her diagnoses included right shoulder replacement, anxiety, chest pain, arteriosclerotic heart disease, atrial fibrillation, hypothyroidism, ileus, hypertension, hyperlipidemia, polyarthritis, caudidal esophagitis, type II diabetes mellitus, Parkinson's. dementia, insomnia, functional dyspepsia, Vitamin B 12 deficiency, dry eye, edema, and centralized pain syndrome.	F 273	**The following actions have been implemented:** 2) Upon discovery of Resident #11 and Resident #12 not having a completed admission assessment, an audit was generated immediately to identify any other overdue admission assessments. 3) The admission assessment for Resident #11 and Resident #12 was completed immediately and the MDS Coordinator was in-serviced immediately as. 4) In order to address how the facility will identify other residents having the potential to be affected by this deficient practice, all admission assessments were audited and reviewed by the MDS Coordinator, and Director of Nursing before survey exit.	

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F 273	Continued From page 6 Review of Resident #11's clinical record revealed as of 5/19/19, no MDS RAI assessment had been completed. Entries were evident in the electronic clinical record that MDS had been started, however no admission (or any of the other started) MDS had been completed. LPN (licensed practical nurse) A, the MDS coordinator, stated 5/18/16 at 11:02 a.m., "I am behind in completing my MDS." LPN A stated she had been at the facility a "couple of months." Guidance provided at "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual, V. 1.13 October, 2015 p. 2.16: The Admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 if: · this is the resident ' s first time in this facility, OR · the resident has been admitted to this facility and was discharged return not anticipated, OR · the resident has been admitted to this facility and was discharged return anticipated and did not return within 30 days of discharge. " The administrator and DON (director of nursing) were informed of the failure of the staff to complete an admission MDS RAI assessment within 14 days of admission for Resident #11, 5/19/16 at 11:10 a.m. 2. Resident #12 was admitted to the facility 4/29/16 and as of 5/19/16 no admission assessment had been completed.	F 273	5) In order to prevent future occurrences of not following the RAI Manual for timely assessments, all MDS Coordinators will be in-serviced on the RAI Manual regarding timely MDS assessments, and the facility's protocol on Minimum Data Set. (MDS), which is comprehensive (admission) completed no later than the 14th day of the resident's admission. 6) The Administrator, or Designee, will audit weekly x six (6) weeks every MDS admission assessment due date, and thereafter every month x (3) months until consistency and compliance is achieved. Completion date: 6/20/16	6/20/16

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F 273	Continued From page 7 Resident #12, a female, was admitted to the facility 4/29/16. Her diagnoses included spinal stenosis, ascorbic acid anemia, constipation, hypertension, post laminectomy, gastroesophageal reflux disease, hyperlipidemia, muscle weakness, anxiety, depression, osteoporosis, osteoarthritis and edema. A thorough review of Resident #12's clinical record revealed no admission assessment had been completed as of the end of the survey 5/19/16 at 12:45 p.m. There was indication the assessment had been started. The administrator and DON were informed of the failure of the staff to complete an admission MDS RAI assessment within 14 days of admission to the facility for Resident #12, 5/19/16 at 12:45 p.m.	F 273		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274	**F-TAG – 274** 1) In order to correct findings identified by the inspectors regarding MDS Coordinator failing to complete an admission MDS RAI assessment within 14 days of admission after a significant change.	

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F 274	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete a significant change MDS (minimum data set) RAI (Resident assessment instrument) assessment in a timely manner for two Residents (Residents #4 and #10) in a survey sample of 17 Residents. 1. For Resident #4, a significant change assessment with an ARD (assessment reference date) of 2/7/16 was not completed until 2/25/16 (18 days later); and 2. For Resident #10, the facility staff was due to complete a Significant Change Assessment on 2/11/16, which wasn 't completed and submitted until 3/2/16. The findings included: 1. For Resident #4, a significant change assessment with an ARD (assessment reference date) of 2/7/16 was not completed until 2/25/16 (18 days later). Resident #4, a female, was admitted to the facility 3/28/14. Her diagnoses included atrial fibrillation, hypertension, hyperlipidemia, anxiety, depression, and Alzheimer's dementia. Resident #4's most recent MDS with an ARD of 2/7/16 was coded as a significant change assessment. Resident #4 was coded as having short and long term memory deficits and required total assistance in making everyday life decisions. She was coded as requiring extensive to total assistance of one to two staff members to perform her activities of daily living. The	F 274	**The following actions have been implemented:** 2) Upon discovery of Resident #4 and Resident #10 not having a completed assessment after a significant change, an audit was generated immediately to identify any other overdue significant change assessments, an in-service was conducted with the MDS Coordinator. 3) In order to address how the facility will identify other residents having the potential to be affected by this deficient practice, all significant change assessments were audited and reviewed by the MDS Coordinator, and Director of Nursing before survey exit.	

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F 274	Continued From page 9 significant change assessment was signed by the RN (registered nurse) as being completed 2/25/16, 18 days after the ARD. LPN (licensed practical nurse) A, the MDS coordinator, stated 5/18/16 at 11:02 a.m., "I am behind in completing my MDS." LPN A stated she had worked at the facility a "couple of months." Guidance was provided for the completion of a significant change assessment in "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual V 1.13 October, 2015 page 2-22 The MDS completion date (Item Z0500B) must be no later than 14 days from the ARD (ARD + 14 calendar days) and no later than 14 days after the determination that the criteria for a SCSA (significant change in status) were met. This date may be earlier than or the same as the CAA(s) (care area assessment summary) completion date, but not later than." The administrator and DON (director of nursing) were informed of the failure of the staff to complete a significant change assessment within 14 days of the ARD of 2/7/16 for Resident #4, 5/19/16 at 11:10 a.m. 2. Resident #10 was a 76 year old who was admitted to the facility on 4/3/14. Resident #10's diagnoses included Hypertension, Hypothyroidism, Generalized Anxiety Disorder, and Unspecified Convulsions. The Minimum Data Set, which was a Significant Change Assessment, with an Assessment Reference Date of 2/11/16 was reviewed.	F 274	4) In order to prevent future occurrences of not following the RAI Manual for timely assessments with significant changes, all MDS Coordinators will be in-serviced on the RAI Manual regarding timely MDS assessments, and the facility's protocol on Minimum Data Set (MDS) Assessment completion date regarding a significant change must be no later than the 14th calendar date after determination that significant change in status has occurred. 5) The Administrator, or Designee, will audit weekly x six (6) weeks every MDS assessment with a significant change, and thereafter every month x (3) months, and randomly until consistency and compliance is achieved. Completion date: 6/20/16	6/20/16

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F 274	Continued From page 10 Resident #10 was coded as having severely impaired cognition. For Resident #10, the facility staff was due to complete this Significant Change Assessment on 2/11/16, which wasn't completed and submitted until 3/2/16. On 5/17/16 an interview was conducted with the MDS Coordinator (Licensed Practical Nurse A). When asked why the Significant Change Assessment wasn't done in a timely manner, the MDS Coordinator stated, "I'm behind in my schedule". When asked what was the importance of submitting the assessment timely, she stated, "It is used for payment to the facility,and compliance purposes." When asked to state the timeline that she used in completing the assessment, the MDS Coordinator submitted the following timeline: 1/29/16 - Notified of significant weight loss by the Dietary Department. 2/4/16 - Resident Significant Change Assessment entered 2/11/16 - Significant Change Assessment Reference Date 3/1/16 - Assessment Completed 3/2/16 - Assessment Submitted On 5/19/16 at 12 noon the facility Administrator (Employee B) was informed of the findings. No further information was received.	F 274		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive	F 275		

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F 275	Continued From page 11 assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for one resident (Resident #9) of 17 residents in the survey sample to complete an annual RAI/MDS (Resident Assessment Instrument/Minimum Data Set assessment) timely. Resident #9 had an initial MDS completed on 5/8/15. An annual MDS should have been completed within 366 days; as of 5/19/16 it had not been completed, thereby being 11 days overdue. The findings included: Resident #9 was admitted to the facility on 5/1/15 with the diagnoses of, but not limited to, Parkinson's disease, chronic obstructive pulmonary disease (COPD), enlarged prostate and urinary retention. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/3/16. The MDS coded Resident #9 with severe cognitive impairment; required extensive assistance with most activities of daily living; and coded as having a catheter (for urinary continence). Resident #9's initial admission assessment had an ARD of 5/8/15. The annual assessment had an ARD of 5/4/16 but as of 5/19/16 it was not completed for submission.	F 275	**F-TAG – 275** 1) In order to correct findings identified by the inspectors regarding MDS Coordinator failing to complete an annual MDS assessment in a timely manner. **The following actions have been implemented:** 2) Upon discovery of Resident #9 not having a completed annual assessment, an audit was generated immediately to identify any other overdue annual assessments. 3) The Annual assessment for Resident #9 was completed immediately and in-service conducted with MDS Coordinator. 4) In order to address how the facility will identify other residents having the potential to be affected by this deficient practice, all annual assessments were audited and reviewed by the MDS Coordinator, and Director of Nursing before survey exit.	

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F 275	Continued From page 12 On 5/18/16 at approximately 3:35 p.m. an interview was conducted with the MDS Coordinator, Licensed Practical Nurse-A (LPN-A). LPN-A was informed of the late annual MDS. When asked why it wasn't completed, LPN-A stated, "I'm behind on my schedule." When asked the importance of completing an MDS timely, LPN-A stated "To track the status of the guest (resident), for payment, and for compliance purposes." Facility policy titled "MDS 3.0 Completion" included: "...b) Annual Assessment-completed using an ARD no >366 days from the most recent prior comprehensive assessment AND no >92 days from the most recent quarterly assessment (counting ARD to ARD)..." On 5/19/16 at 11:10 a.m. the Administrator and Director of Nursing were informed of the annual MDS not done timely. No further information was provided by the facility staff.	F 275	5) In order to prevent future occurrences of not following the RAI Manual for timely assessments, all MDS Coordinators will be in-serviced on the RAI Manual regarding timely annual assessments, and the facility's protocol on Minimum Data Set (MDS). Assessment annual completion dates must be no later than: Annual – ARD plus 14 calendar days, and the ARD must be no more than ninety-two (92) days from the ARD of the prior quarterly assessment and no more than 366 days from the prior admission assessment. 6) The Administrator, or Designee, will audit weekly x six (6) weeks every MDS annual assessment due date, and thereafter every month x (3) months until consistency and compliance is achieved. Completion date: 6/20/16 **F- TAG – 276**	6/20/16
F 276	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed for 4 residents (Resident #1, #3, #2, & #7)	F 276		

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F 276	Continued From page 13 of 17 residents in the survey sample, to complete a quarterly Minimum Data Set (MDS) assessment timely. 1. For Resident #1, the facility staff failed to complete a quarterly MDS (Minimum Data Set) within 92 days after a significant change assessment with an ARD (Assessment Reference Date) of 1/11/16. The quarterly MDS had an ARD of 4/12/16 but was not completed until 5/18/16. 2. For Resident #3, the facility staff failed to complete and submit a Quarterly Minimum Data Assessment which was due on 4/27/16. 3. For Resident #2, the facility staff failed to complete a Quarterly Minimum Data Assessment in a timely manner. Section G was not completed. 4. For Resident #7, the facility staff failed to complete a quarterly MDS (minimum data set) RAI (Resident Assessment Instrument) after an annual assessment with an ARD (assessment reference date) of 12/30/15 and the end of the survey 5/19/16. The findings included: Resident #1 was admitted to the facility on 9/19/13 with the diagnoses of, but not limited to, dementia, chronic obstructive pulmonary disease (COPD), macular degeneration and hypertension. The most recent MDS was a quarterly assessment with an ARD of 4/12/16 coded Resident #1 with severe cognitive impairment; required limited assistance from staff for bed	F 276	1) In order to correct findings identified by the inspectors regarding MDS Coordinator failing to complete a Quarterly MDS Assessment in a timely manner. **The following actions have been implemented:** 2) Upon discovery of Resident #1, #3, #2, & #7 not having a timely completed Quarterly MDS Assessment, an audit was generated immediately to identify any other overdue Quarterly Assessments. The Quarterly Assessments for Resident #1, #3, #2, & #7 were completed immediately and in-service conducted with the MDS Coordinator. 3) In order to address how the facility will identify other residents having the potential to be affected by this deficient practice, all quarterly assessments were audited and reviewed by the MDS Coordinator, and Director of Nursing before survey exit.	

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F 276	Continued From page 14 mobility and dressing; and extensive assistance from staff for transfers, toilet use and personal hygiene. On 5/18/16 Resident #1's clinical record was reviewed. The review revealed a completed significant change MDS with an ARD of 1/11/16. The quarterly MDS, with an ARD of 4/12/16, was not completed until 5/18/16 which was greater than the required 92 days since the significant change MDS. On 5/18/16 at approximately 3:35 p.m. an interview was conducted with the MDS Coordinator, Licensed Practical Nurse-A (LPN-A). LPN-A was informed of the late quarterly MDS. When asked why it wasn't completed timely, LPN-A stated "I'm behind on my schedule." When asked the importance of completing an MDS timely, LPN-A stated "To track the status of the guest (resident), for payment, and for compliance purposes." Facility policy titled "MDS 3.0 Completion" included: "...d) Quarterly Assessment-completed using an ARD no > (greater than) 92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD)..." On 5/19/16 at 11:10 a.m. the Administrator and Director of Nursing were informed of the quarterly MDS not done timely. No further information was provided by the facility staff.	F 276	4) In order to prevent future occurrences of not following the RAI Manual for timely quarterly assessments, all MDS Coordinators will be in-serviced on the RAI Manual regarding timely MDS Quarterly Assessments, and the facility's protocol on Minimum Data Set. (MDS). 5) The Administrator, or Designee, will audit weekly x six (6) weeks every MDS Quarterly Assessment due date, and thereafter, every month x (3) months, until consistency and compliance is achieved. Completion date: 6/20/16	6/20/16

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F 276	Continued From page 15 2. For Resident #3, the facility staff failed to complete and submit a Quarterly Minimum Data Set Assessment which was due on 4/27/16. Resident #3 was an 84 year old who was admitted to the facility on 9/21/15. Resident #3's diagnoses included Hypertension, Acute Kidney Failure, Iron Deficiency, and Muscle Weakness, Generalized. The Minimum Data Set, which was a Quarterly Assessment, with an Assessment Reference Date of 1/20/16 was reviewed. Resident #3 was coded as having intact cognition. Resident #3's next Quarterly Assessment was due on 4/27/16. As of the 5/19/2016, the last day of the survey, the assessment had not been completed. On 5/17/16 an interview was conducted with the MDS Coordinator (Licensed Practical Nurse A). When asked why the Quarterly Assessment wasn't done in a timely manner, the MDS Coordinator stated, "I'm behind in my schedule". When asked what was the importance of submitting the assessment timely, she stated that it was used for payment to the facility, and compliance purposes. On 5/17/16 at 12 Noon, the facility Administrator (Employee B) was informed of the findings. No further information was received. 3. For Resident #2, the facility staff failed to complete a quarterly Minimum Data Set (MDS)assessment for Section G was not completed.	F 276		

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F 276	Continued From page 16 Resident #2 was admitted to the facility on 1/15/16. Her diagnoses included dementia, stroke, diabetes and hypertension. One MDS assessment had been competed for Resident #2. This was a 5 day admission assessment with an assessment reference date (ARD) of 1/22/16. Resident #2 was coded with no cognitive impairment and requiring assistance with activities of daily living. Resident #2 was due to have a quarterly MDS assessment completed in April 2016. This assessment had an ARD of 4/22/16. The assessment was not complete. Section G (Functional Status) was blank. On 5/18/16 at 9:45 a.m., the MDS coordinator was asked about the assessment. She stated that the assessment was not complete and was supposed to be done in 7 days (of ARD). The assessment was 20 days over due. The Administrator and Director of Nursing were notified of the MDS issue at the end of day meeting on 5/18/16. 4. For Resident #7, the facility staff failed to complete a quarterly MDS (minimum data set) RAI (Resident Assessment Instrument) after an annual assessment with an ARD (assessment reference date) of 12/30/15 and including the end of the survey on 5/19/16. Resident #7, a female, was initially admitted to the facility 2/8/15 and readmitted after a hospitalization 4/29/16. Her diagnoses included anemia, hypertension, dementia, Parkinson's, anxiety, and depression.	F 276		

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F 276	Continued From page 17 Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/30/15 was coded as an annual assessment. She was coded as having memory deficits and required moderate assistance with making daily life decisions. She was also coded as needing supervision to limited assistance of one staff member to perform her activities of daily living. Review of the clinical record revealed no completed assessment within 92 days of the annual assessment noted above. Documentation was evident a quarterly assessment was in the process of being completed, however as of 5/19/16 (141 days after the ARD of the annual assessment) the assessment had not been completed. LPN (licensed practical nurse) A, the MDS coordinator, stated 5/18/16 at 11:02 a.m., "I am behind in completing my MDS." LPN A stated she had been at the facility a "couple of months." Guidance was provided in "Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual V 1.13 October, 2015 p. 2-31 The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident ' s status between comprehensive assessments to ensure critical indicators of gradual change in a resident ' s status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA	F 276		

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F 276	Continued From page 18 assessment of any type." The administrator and DON (director of nursing) were informed in the failure of the staff to complete a quarterly assessment within 92 days of the previous assessment, 5/31/16 at 11:10 a.m.	F 276		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed for one resident (Resident #8) of 17 residents in the survey sample to clarify physician ordered parameters for as needed oxygen. Resident #8 was ordered oxygen at 2-5 liters per minute (l pm) as needed however the facility staff failed to clarify parameters in which to use specific liters per minute. The findings included: Resident #8 was admitted to the facility on 1/28/14 with the diagnoses of, but not limited to, dementia, cerebrovascular accident (CVA-stroke), hypertension and anxiety. The most recent Minimum Data Set (MDS) was an annual assessment with an Assessment Reference Date (ARD) of 3/2/16. The MDS	F 281	**F-TAG – 281** 1) In order to correct findings identified by the inspectors regarding staff failing to set parameters for oxygen use: **The following actions have been implemented:** 2) Upon discovery of Resident # 8 having as needed oxygen without specific parameters of liter use, the resident was assessed and found not to be in any distress.	

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F 281	Continued From page 19 coded Resident #8 with severe cognitive impairment; required extensive assistance from staff for bed mobility, transfers, toileting and hygiene; required limited assistance from staff for dressing and eating. On 5/17/16 at 7 p.m. Resident #8 was observed in a wheelchair, self propelling in the facility sensory activity room. She was not wearing oxygen nor was she in visible respiratory distress. On 5/18/16 at 10:45 a.m., Resident #8's clinical record was reviewed. The review revealed a renewed physician's order dated 4/25/16 which read: "oxygen @2-5 l pm as needed Dx: (diagnosis) 786.05-Shortness of breath..." The Treatment Administration Record (TAR) had the oxygen transcribed as ordered and had no documented use for the months of April and May 2016. On 5/18/16 at 2:40 p.m., the Administrator and Director of Nursing (Employee-A) were informed of the oxygen order that did not give direction on the exact amount of liters to be administered for what indication. When asked what she would expect the nurses to do regarding the oxygen order, Employee-A stated she, "Would expect oxygen to be D/C'd (discontinued)." Guidance given from Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305 read: Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Therefore you need to assess all orders; if you find one to be erroneous or	F 281	3) In order to address how the facility will identify other residents having the potential to be affected by this alleged deficient practice, the resident's physician and Hospice Company was notified to write orders for specific parameters of oxygen use. The resident's care plan was updated with the specific parameters of oxygen use and the facility's policy on Oxygen Therapy was updated to have the Physician state specific oxygen parameters when prescribing oxygen use. 4) In order to prevent future incidents with residents using oxygen as needed, the Director of Nursing, or designee, will review weekly x six (6) consecutive weeks, residents' records that have oxygen use, and thereafter, every month x three (3) months. Completion date: 6/20/16	6/20/16

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F 281	Continued From page 20 harmful, further clarification from the health care provider is necessary. Facility policy titled "Oxygen Therapy" included: "POLICY: ...Oxygen is considered a drug, and the order to administer must be written by a medical doctor. The physician will need to indicate the amount of oxygen to be given..." On 5/19/16 at 11:10 a.m., review of Resident #8's physician orders were reviewed and contained the un-clarified order for oxygen 2-5 l pm. The Director of Nursing was informed and stated, "I don't know why hospice puts in a range like that without parameters.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide care and services, per physician's orders, for two Residents (Residents #7 and #12) in a survey sample of 17 Residents. 1. For Resident #7, the facility staff failed to administer Hydralazine per physician's orders;	F 309	**F-TAG – 309** 1) In order to correct findings identified by the inspectors regarding staff failing to administer Hydralazine to Resident # 7 per physicians' orders and for Resident # 12, staff failing to perform an assessment after the administration of pain medication.	

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F 309	Continued From page 21 and 2. For Resident #12, the facility staff failed to perform an assessment after the administration of pain medication. The findings included: 1. For Resident #7, the facility staff failed to administer Hydralazine per physician's orders. Resident #7, a female, was initially admitted to the facility 2/8/15 and readmitted after a hospitalization 4/29/16. Her diagnoses included anemia, hypertension, dementia, Parkinson's, anxiety, and depression. Resident #7's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/30/15 was coded as an annual assessment. She was coded as having memory deficits and required moderate assistance with making daily life decisions. She was also coded as needing supervision to limited assistance of one staff member to perform her activities of daily living. Resident #7 was observed during initial tour of the facility 5/17/16 at approximately 7 p.m. She was out of bed and in her wheelchair, brushing her teeth. Resident #7 was alert, oriented to person and place, and verbally responsive. Resident #7 was also observed 5/18/16 at 2:25 p.m. She was lying on her bed resting. Resident #7 was alert and verbally responsive. Review of Resident #7's clinical record revealed signed physician's orders that included:	F 309	**The following actions have been implemented:** 2) Upon discovery of Resident #7 not having as needed blood pressure medication according to the physicians prescribed order, the resident was immediately assessed for any acute distress. No negative outcome was identified by the alleged deficient practice. 3) In order to address how the facility will identify other residents having the potential to be affected by this alleged deficient practice, all as needed blood pressure parameter orders were audited and reviewed before survey exit for correct physician guidelines. 4) In order to prevent future occurrences of not following the physicians orders on as needed blood pressure medications and	

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F 309	Continued From page 22 "2/12/16 Monitor blood pressure ever 6 hours and follow PRN (as needed) order for SBP (systolic blood pressure) > (greater than)160 PRN. Hydralazine 25 mg (milligram) tablet give 1 tablet by oral route every 6 hours for SBP (systolic blood pressure) >160 PRN (as needed)." Accompanying entries were noted on the eMAR (electronic medication administration record) with no evidence Hydralazine was administered when Resident #7's systolic blood pressure was greater than 160 mmHg (millimeters of mercury): 5/10/16 at 12 noon 166/69 5/12/16 at 6 p.m. 166/71 5/17/16 at 6 p.m. 180/74 A thorough review of Resident #7's clinical record revealed no evidence Resident #7 was absent from the facility nor refused Hydralazine. www.nlm.nih.gov revealed: "Hydralazine is used to treat high blood pressure. Hydralazine is in a class of medications called vasodilators. It works by relaxing the blood vessels so that blood can flow more easily through the body. High blood pressure is a common condition and when not treated, can cause damage to the brain, heart, blood vessels, kidneys and other parts of the body. Damage to these organs may cause heart disease, a heart attack, heart failure, stroke, kidney failure, loss of vision, and other problems. Take hydralazine at around the same times every day. Follow the directions on your prescription label carefully, and ask your doctor or pharmacist	F 309	parameters, an in-service was conducted by the Director of Nursing and Nursing not following specific physician's orders. The facility's Blood Pressure Policy was reviewed by all licensed nursing staff, along with the Medication Administration Policy. The Director of Nursing will randomly audit and review five (5) resident's medication records weekly for four (4) consecutive weeks to verify compliance in following physician's orders pertaining to blood pressures, and then, monthly x three (3) months. Completion date: 6/20/16 5) In order to correct findings identified by the inspectors regarding staff failing to perform a pain assessment before and after pain medication on Resident # 12, the resident was assessed and found not to be in any pain.	6/20/16

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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 309	Continued From page 23 to explain any part you do not understand. Take hydralazine exactly as directed. Do not take more or less of it or take it more often than prescribed by your doctor. Hydralazine controls high blood pressure but does not cure it. Continue to take hydralazine even if you feel well. Do not stop taking hydralazine without talking to your doctor." When interviewed, the DON (director of nursing) stated she would review the clinical record to determine if Hydralazine was administered, 5/19/16 at 11:10 a.m. Review of the facility's policy entitled "Medication Administration Policy" included: "PROCEDURE: 5. The right time-the licensed nurse will check the medication order to ensure that the medication is given at the right time. The prescriber will identify the time that the medication is to be given." Guidance for nursing standards for the administration of medication is provided by "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 705: Professional standards, such as the American Nurses Association's Nursing : Scope and Standards of Nursing Practice (2004) apply to the activity of medication administration. To prevent medication errors, follow the six rights of medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication 2. The right dose 3. The right client 4. The right route 5. The right time 6. The right documentation."	F 309	6) In order to address how the facility will identify other residents having the potential to be affected by this alleged deficient practice, all pain medications were audited and reviewed for before and after pain assessments. 7) In order to prevent future occurrences of not following the facility's pain assessment protocol, all licensed staff will be in-serviced on Resident Pain Assessments and the facility's protocol Policy on Pain Management. The Director of Nursing, or Designee will make weekly inspections of the residents' medication records x six (6) weeks and every month x three (3) months until consistency is achieved. Completion date: 6/20/16	6/20/16

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	495183	A. BUILDING _____ B. WING _____	05/19/2016

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F 309	Continued From page 24 Same source: "Fundamentals of Nursing, 7th Edition, Potter-Perry, p. 699, Sometimes the prescriber orders a medication to be given only when a client requires it. This is a prn order. Use objective and subjective assessment and discretion in determining whether or not the client needs the medication...When administering medications, document the assessment made and the time of medication administration. Make frequent evaluation of the effectiveness of the medication, and record findings in the appropriate record." The administrator and DON were informed of the failure of the staff to administer Hydralazine when Resident #7's systolic blood pressure was greater than 160 mmHg on 5/10, 5/12, and 5/17/16. As of exiting the facility 5/19/16 at 12:45 p.m., no further information was provided. 2. For Resident #12, the facility staff failed to perform an assessment after the administration of pain medication. Resident #12, a female, was admitted to the facility 4/29/16. Her diagnoses included spinal stenosis, ascorbic acid anemia, constipation, hypertension, post laminectomy, gastroesophageal reflux disease, hyperlipidemia, muscle weakness, anxiety, depression, osteoporosis, osteoarthritis and edema. While Resident #12 had been admitted 4/29/16, no MDS had been completed. Her admitting nursing assessment revealed she was alert, oriented and verbally responsive. Resident #12 was continent of bowel and bladder and required minimal assistance of one staff member to perform her activities of daily living. She was	F 309		

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F 309	Continued From page 25	F 309		

assessed as having no pain at the time of admission. Additionally she was noted to be able to understand others and to make her needs known.

Resident #12 was observed during initial tour of the facility 5/17/16 at approximately 6:50 p.m. She was lying on her left side in bed. Resident #12 stated she had been admitted to the facility after having back surgery.

Resident #12 was also interviewed 5/18/16 at 2:02 p.m. She was out of bed and in an easy chair, watching television. Resident #12 was alert, oriented and verbally responsive.

Review of Resident #12's clinical record revealed she had been admitted to the facility after having surgery on her back. Her admitting orders included:

"4/29/16 Norco 5 mg (milligram)-325 mg tablet 1 tablet by oral route every 4 hours as needed for pain."

Review of Resident #12's eMAR and nursing note documentation revealed no assessment was provided either prior to or after administering Norco 5 mg/325 mg on the following days: 5/1/16 at 9:31 a.m., 5/2/16 at 2:50 a.m., 5/2/16 at 11:19 a.m., 5/2/16 at 5:01 p.m., 5/2/16 at 9:50 p.m., 5/6/16 at 5:45 p.m., 5/6/16 at 10:25 p.m., 5/9/16 at 8:02 a.m., 5/9/16 at 4:50 p.m., 5/9/16 at 10:15 p.m., 5/10/16 at 4:34 p.m., 5/10/16 at 10:02 p.m., 5/11/16 at 6:07 p.m., 5/11/16 at 10 p.m., 5/12/16 at 7:52 a.m., 5/12/16 at 12:29 p.m., 5/12/16 at 4:16 p.m., 5/12/16 at 10:17 p.m., 5/13/16 at 8:09 a.m., 5/13/16 12:32 p.m. 5/13/16 at 12:32 p.m., 5/13/16 at 6:16 p.m., 5/14/16 at 4:41 p.m.,

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F 309	Continued From page 26 5/15/16 at 4:34 p.m., 5/15/16 at 10:34 p.m., 5/17/16 at 9:13 a.m., 5/17/16 at 12:58 p.m., 5/17/16 at 4:53 p.m. LPN F, a charge nurse, stated 5/19/16 at 8:15 a.m., a pre and post assessment should be completed whenever a PRN pain medication is administered. LPN F stated the staff would document the assessments on the MAR or in the nursing notes. Guidance is provided in "Fundamentals of Nursing 7th Edition, Potter-Perry, p. 1082, Evaluation of pain is one of many nursing responsibilities that require effective critical thinking. The client's behavioral responses to pain-relief interventions are not always obvious. Evaluating the effectiveness of a pain intervention requires you to evaluate the client after an appropriate period of time...Do not expect the client to volunteer the information. Evaluate psychological as well as physiological responses to pain." The administrator and DON were informed of the failure of the staff to assess Resident #12 prior to and after the administration of Norco 5 mg/325 mg on the days and times indicated, 5/19/16 at 11:10 a.m.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	**F-TAG – 315** 1) In order to correct findings identified by the inspectors regarding staff failing to provide indwelling urinary catheter care in a manner to prevent the spread of infection on Resident # 9.	

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F 315	Continued From page 27 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed for one resident (Resident #9) of 17 residents in the survey sample, to provide indwelling urinary catheter care in a manner to prevent the spread of infection. Resident #9's indwelling urinary catheter bag and tubing was not properly secured to the bed and was directly on the floor mat beside the bed. An indwelling urinary catheter, sometimes referred to as a Foley catheter, is a thin sterile tube inserted into the bladder to drain urine. The findings included: Resident #9 was admitted to the facility on 5/1/15 with the diagnoses of, but not limited to, Parkinson's disease, enlarged prostate and urinary retention. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 2/3/16. The MDS coded Resident #9 with severe cognitive impairment; required extensive assistance with most activities of daily living; and coded as having a catheter (for urinary continence). During initial tour of the facility on 5/17/16 at 6:35 p.m., Resident #9 was observed sleeping in bed.	F 315	**The following actions have been implemented:** 2) Upon discovery of the resident's large catheter collection bag on floor mat, the catheter bag was removed off the resident's floor mat. 3) In order to address how the facility will identify other residents having low beds with urinary catheter bags and the potential to be affected, a clean basin will be utilized to place the resident's urine collection bag in to create a barrier between the floor and bed area. A large clip will be utilized to hold the catheter bag & tubing off the floor. No negative outcome was identified by the alleged deficient practice.	

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F 315	Continued From page 28 The bed was in low position, approximately 2 inches from the floor with a floor mat on the left side of the bed. A catheter bag was observed with dark yellow urine it lying on the floor mat with part of the catheter tubing touching the floor mat. There was no barrier underneath the bag or tubing. On 5/18/16 at 3:25 p.m., Resident #9 was observed lying in bed, the bed was in low position and fall mats were next to the bed. No catheter bag or tubing was observed. When asked if he still had a catheter, Resident #9 patted his left leg and stated "Right here" which indicated he had a leg bag for urine collection. An interview was conducted with Licensed Practical Nurse-B (LPN-B). When asked who changes the large catheter collection bag to the leg bag, LPN-B stated "The CNA's do (certified nursing assistants)." LPN-B was shown how Resident #9's catheter bag and tubing was positioned on initial tour. She stated "If they come out of the room with a large bag, it would be covered but normally they'd have a leg bag unless the urologist ordered otherwise." A request for the facility catheter policy was made." On 5/19/16 at 10:00 a.m. an infection control interview was conducted with Registered Nurse-A (RN-A). When asked about proper positioning of a catheter bag when in bed, RN-A stated the catheter "Supposed to be off the floor and of that nature." Resident #9's catheter bag and tubing observation was discussed. RN-A explained that she gave the staff a different type of clip, large and white (shown) to attach to the bag string to hold it up. Discussed with RN-A that the bed is so low and with the floor mat in use, the bag	F 315	4) In order to prevent future incidents with residents with low beds and urinary catheters, all licensed staff will be in-serviced on the facility's protocol and policy on Preventing UTI'S, Appropriate Use of Indwelling Catheters, and the Infection Control Policy. The Director of Nursing, or Designee, will conduct random visits to residents' rooms with indwelling catheters every week x six (6) weeks and every month x three (3) months to ensure that compliance is achieved. Completion date: 6/20/16	6/20/16

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F 315	Continued From page 29 might still touch the floor. Review of facility policy titled "Appropriate Use of Indwelling Catheters" included: "11. If the resident is lying in bed, the foley (catheter) itself must not touch the floor at any time. This includes the resident's foley and tubing." No further information was provided by the facility staff.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to provide a safe environment on one of two units (the long term care unit). The hydrocollator, a device used to provide moist hot pack therapy, was stored in an unlocked room. The findings included: During general observations tour of the facility, the therapy gym was observed 5/18/16 at 1:22 p.m. Other A, the therapy manager stated the	F 323	**F 323** 1) In order to correct findings identified by the inspectors regarding staff failing to ensure that resident environment remains as free of accidents hazards as possible. The therapy hydrocollator was placed in a room with a locking door for security.	

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F 323	Continued From page 30 therapy department was in the process of being renovated. When asked, Other A stated the facility had a hydrocollator and it was being stored in the old therapy area. Other A showed the hydrocollator to the surveyor. The old therapy gym was entered easily with the door swinging inward and unlocked. Another door, close to the entry door was entered and the hydrocollator was sitting next to the wall. The door to that room was labeled as being a toilet. The hydrocollator was on and the log on the top indicated the water was 169 degrees Fahrenheit on 5/18/16. The log further indicated the temperature was maintained between 167 degrees to 169 degrees Fahrenheit. Other A stated the hydrocollator had been kept in the room since the renovations were in progress. No workman or work appeared to have been done in either the old therapy gym or the toilet room where the hydrocollator was stored. The hydrocollator was also observed 5/19/16 at 1:38 p.m. Both doors were unlocked and no staff were in the old therapy gym. Residents were observed independently mobile, both in wheelchairs and ambulating, near the door to the old therapy gym during both observations. Guidance for the safe storage of a hydrocollator was found at www.physical-therapy.advanceweb.com: "Electrotherapy equipment must be inspected and calibrated. A temperature and cleaning log for the hydrocollator should be present. And there should be a safeguard in place so the hydrocollator can't be accessed by a resident without a therapist	F 323	**The following actions have been implemented:** 2) In order to prevent future occurrences of an environment remaining free of accident hazards, staff was in-serviced on the importance of keeping this door locked at all times and the key kept with therapy to monitor its access. 3) The Administrator or designee will monitor that the door is locked daily for 6 weeks weekly, for 4 weeks then randomly for 3 months until compliance is reached. 4) Findings will be addressed and forwarded to the QA/QI team for processing according to the facility QA/QI policy before 6/20/2016.	6/20/16

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F 323	Continued From page 31 present." When interviewed the administrator stated the door should remain locked at all times, 5/19/16 at 11:10 a.m. The administrator and DON (director of nursing) were informed of the failure of the staff to ensure the hydrocollator was stored in a secure area that could not be accessed by Residents, 5/19/16 at 11:10 a.m.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review the facility staff failed to use effective hair restraints. Staff were observed in the kitchen with hair partially covered with a hair net. Contracted repairmen were observed in the kitchen without wearing effective hair restraints. The diet aide was at the prep table. The diet manager was carrying food out to the auxillary dining room. There was preparation of the food when the maintenance men walked thru the kitchen.	F 371	**F 371** 1) In order to correct the findings identified by the inspector, we have created a policy and procedure on hair restraint use in the kitchen, as per U.S. Public Health Service food code. **The following actions have been implemented:** 2) Corrections were made to our hair net policy (revised copy attached) and all staff has been in-serviced to adhere to this policy.	

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F 371	Continued From page 32 The findings included: An initial tour of the main kitchen was conducted in the presence of the Dietary Manager on 5/17/16 at 6:25 p.m.. The Dietary Manager wore a hair restraint, but it did not effectively cover her short hair. Hair between the hair line and middle top of the head was exposed. The Dietary Manager was observed in the small long term care kitchen on 5/18/16 at 11:40 a.m. during lunch service. Again, her hair was not effectively restrained. On 5/18/15 at 11:45 a.m., a dietary aide was observed in the main kitchen. She wore a hair net, but her bangs were not covered. At this time, a younger man in street clothes walked into and through the kitchen. He wore a base ball cap. He had curly hair that hung out the back of the cap about 2 inches. Another man walked through the kitchen without a hair restraint. Kitchen staff identified the man as a contractor who was working on the walkin freezer. The hair restraint issue was reviewed with the dietary manager on 5/19/16 at 8:10 a.m. She stated that a hair restraint should be worn by anyone entering the kitchen. She stated that she did not know the repair man was in the kitchen the previous day. The facility policy "Personal Hygiene" was reviewed. The policy read "2. A clean and neat personal appearance is required. Practice good hygiene and hair control. All workers are to wear hair restraints when in kitchen areas. All food handling employees must use effective hair restraints to prevent the contamination of food or food contact surfaces."	F 371	3) Additional hair restraint stations have been purchased and placed at all kitchen entrances. 4) In-service training includes observation of personnel effectively wearing hair restraints according to the policy. The CDM or designee will monitor that the policy is being properly followed weekly for 6 weeks, randomly for 3 months until compliance is reached. Completion date: 6/20/2016 6/20/16	

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F 371	Continued From page 33 The Administrator was notified of the issue at the end of day meeting on 5/19/16.	F 371		

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F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State licensure inspection was conducted 5/17/16 through 5/19/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code Survey/Report will follow. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12), and 5 closed records (Residents # 13 through #17).	F 000	RECEIVED JUN 07 2016 VDH/OLC	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Resident Assessment 12 VAC 5-371-250 (B.1) Cross-Reference to F-273 12 VAC 5-371-250 (B.2) Cross-Reference to F-274 12 VAC 5-371-250 (B.3) Cross-Reference to F-275 12 VAC 5-371-250 (C) Cross-Reference to F-276 Nursing Director 12 VAC 5-371-200 (B) Cross-Reference to F-281	F 001	12 VAC 5-371-250 (B.1) Resident Assessment – Please cross reference to Federal tag PoC F-273 12 VAC 5-371-250 (B.2) Resident Assessment – Please cross reference to Federal tag PoC F-274 12 VAC 5-371-250 (B.3) Resident Assessment – please cross reference to Federal tag PoC F-275 12 VAC 5-371-250 (C) Resident Assessment – please cross reference to Federal tag PoC F-276 12 VAC 5-371-200 (B) Nursing Director – please cross reference to Federal tag PoC F-281	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 6-3-16

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HEALTH CARE CENTER AT BRANDERM	2100 BRANDERMILL PKWY MIDLOTHIAN, VA 23112

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F 001	Continued From Page 1 Nursing Services 12 VAC 5-371-220 (A,B) Cross-Reference to F-309 12 VAC 5-371-220 (C) Cross-Reference to F-309 Maintenance and Housekeeping 12 VAC 5-371-370 (A) Cross-Reference to F-323 Dietary and Food Service 12 VAC 5-371-340 (A) Cross-Reference to F-371 12 VAC 5-371-140 E 3(A) Based on staff interview and facility documentation review, the facility staff failed for three employees (11, 14 and 17) of 15 licensed and certified employees to re-verify licensure/ certification with the Department of Health Professions (DHP) after a license/ certification expiration. The findings included: Employee records were reviewed on 5/19/16 at 9:15 a.m. with the Human Resources staff. Employee 11's Certified Nursing Assistant (CNA) certification was originally verified on 5/18/15. The certification expired on 12/31/15. The facility staff did not re-verify with DHP that the certification was	F 001	12 VAC 5-371-220 (A,B) Nursing Services – please cross reference to Federal tag PoC F-309 12 VAC 5-371-220 (C) Nursing Services – please cross reference to Federal tag PoC F-309 12 VAC 5-371-370 (A) Maintenance and Housekeeping – please cross reference Federal tag PoC F-323 12 VAC 5-371-340 (A) Dietary and Food Service – please cross reference Federal tag PoC F-371 **12 VAC 5-371-140 E 3(A)** 1) In order to correct the findings identified by the inspectors regarding facility staff failing to re-verify licensure/certification with the Department of Health Professions after a license/certification has expired The following actions have been implemented: 2) Immediately upon receiving the deficiency we notified our HR department that we needed to add language to our policy that specifically dealt with the re-verification of every licensure or certification through the DOH.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495183	A. BUILDING _____ B. WING _____	05/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 001	Continued From Page 2 in good standing once it had expired. Employee 11 did submit a copy of the renewed certification once received. Employee 14's Registered Nurse license was originally verified on 11/25/14. It expired on 11/30/15. The facility staff did not re-verify with DHP that the license was in good standing once it had expired. Employee 14 did submit a copy of the renewed license once received. Employee 17's Certified Nursing Assistant (CNA) certification was originally verified on 5/18/15. The certification expired on 10/31/15. The facility staff did not re-verify with the DHP that the certification was in good standing once it had expired. Employee 17 did submit a copy of the renewed certification once received. The Human Resources staff stated that the facility accepted a copy of the renewed license/ certification in place of re-verifying the license/ certification with the DHP. She also stated that the facility would not allow an employee to work until their renewed license or certification was provided. The Administrator was notified of the issue at the end of meeting on 5/19/16.	F 001	3) Our HR team and myself drafted new language to our policy and in-serviced all Directors and Supervisors of the change and explained the importance of strict compliance. (revised policy is enclosed) 4) The administrator, or their designee, will conduct random audits of employee files to ensure compliance. This will be done twice weekly X 6 weeks and then randomly with additional in-servicing as needed. All Findings will be addressed and forwarded to the QA/QI team for processing according to the facility QA/QI policy by 6/20/2016	