STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR REVISED	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

(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	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 10/4/16 through 10/6/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey.

The census in this 90 certified bed facility was 61 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents #1 through #13 and #18 through 20 and 4 closed record reviews (Residents #14 through #17).

F 221 SS=D 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS

F 221

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility documentation review, observation, and clinical record review, the facility staff failed to ensure one Resident (Resident #8) in a survey sample of 20 Residents was free from unnecessary physical restraints.

After a trial reduction of the use of bilateral hand mittens revealed no targeted behavior for the mittens, the facility staff failed to decrease their use for Resident #8.

The findings included:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Upon notification of the deficiency, Resident #8 mittens were discontinued based on there being no targeted behavior justifying the use of mittens.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents with mittens or restraints have the potential to be affected by this deficiency. A 100% audit of the residents

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

Brenda L. Buenaventa L.N.H. Administrator 10-26-2016

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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Resident #8, a male, was admitted to the facility 6/4/13. His diagnoses included dementia, traumatic brain injury, glaucoma, gastroesophageal reflux disease, dysphagia, incontinence, self injurious behavior, cerebrovascular disease, and hard of hearing.

Resident #8's most recent MDS (minimum data set) with an ARD (assessment reference date) of 8/15/16 was coded as a quarterly assessment. Resident #8 was coded as having short and long term memory deficits and required total assistance in making daily life decisions. He was coded as requiring total assistance of one to two staff members to perform his activities of daily living. He was also coded as requiring the use of limb restraints daily.

Resident #8 was observed during initial tour of the facility, 10/4/16 at approximately 2:02 p.m. He was lying on his back with the head of the bed elevated. Resident #8 had bolsters on both sides of his his upper and lower body. Tied mittens were noted on both hands and his heels were floated. Resident #8's eyes were closed and he appeared to be sleeping.

Resident #8 was also observed 10/4/16 at 8:57 a.m. He was lying on his back with the head of the bed elevated.. His head was turned to the left and mittens were observed on both of his hands. Bolsters were observed around Resident #8.

Resident #8 was also observed 10/5/16 at 10:20 a.m. Two staff members were performing ADL (activities of daily living) care. The staff stated Resident #8 wore the mittens all of the time. They stated the mittens were removed every two

with a restraint trial reduction was reviewed to ensure that the trail reduction observation data sheets reflected the resident's targeted behavior for the need of mittens or other restraints.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The Restraint Reduction Team will review the restraint trail reduction behavior data monthly. If the data shows the resident has no targeted behavior for the use of mittens or other restraint, a physician order will be obtained to discontinue the restraint or reduce the restraint to the target behavior as necessary for resident safety.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Restraint Reduction Team Leader will conduct 100% audits of the trail restraint reduction behavior data sheets, monthly. Audits will focus on the physician's order to reduce or eliminate restraints and to ensure the restraint was reduced or eliminated from the resident as planned. Reports will be submitted monthly to the HDMC Quality Manager. Quarterly

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hours. The staff removed the mittens and Resident #8 was wearing palmar protectors. The palms of both hands were observed with no redness noted in the palms.

Review of Resident #8's clinical record revealed signed physician's orders that included:

"Mittens on both hands at all times except during personal care to prevent self injurious behavior of pulling tube out."

The order was on the most recently signed physician's orders signed 9/8/16. Resident #8 had a gastrostomy tube. A gastrostomy tube (PEG tube) is a soft flexible tube surgically inserted through the abdominal wall into the stomach to administer medications, nutrition, and hydration for a Resident that is unable to swallow.

The decision was made by the interdisciplinary team to attempt a gradual reduction of the use of the mittens by Resident #8 and a physician's order was evident:

"7/28/16 Trial reduction of bilateral mittens; Remove and leave off until 7/29/16 at 7 am. Resident order to resume on 7/29/16 at 7 am."

Review of the "Protective/Medical Device Monitoring Form" dated 7/28/16 indicated the staff initiated the trial observation of Resident #8 not having mittens on both of his hands beginning 7/28/16 at 7 a.m. Documentation on the form revealed Resident #8 had no incidents of "targeted behavior" from 7 a.m. (when the mittens were removed) on 7/28/16 through 7 a.m. on 7/29/16. His targeted behavior was "pulling peg tube."

reports will be submitted and discussed during the Medical Executive Committee meetings.

5. Include dates when the corrective action will be completed.

10-28-2016

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The facility monitoring form indicated a "Trail (sp) reduction conducted on 7/28/16 no behavior observed."

The form also indicated:

"Reduction: 8/11/16 Plan remove mittens after education staff on stepping back after instructing patient what you plan to assist him with. Allow him time to calm down."

Review of Resident #8's care plan revealed the care plan had been revised on 8/17/16 to include:

"Restraint use

d/t (due to) Dementia, TBI (traumatic brain injury) Post MVA (motor vehicle accident), Altered mental status, agitation with behavior problems

Goals/Objectives

Patient will less (sp) than 1-2 episodes of striking when touched through 11/17/16

Interventions

Mittens on both hands prevent self injury"

A thorough review of Resident #8's clinical record revealed no evidence that the recommendations of the interdisciplinary team were implemented to include discontinuing the use of bilateral hand mittens.

When interviewed, 10/5/16 at 4:02 p.m., the acting DON (director of nursing) stated the staff had completed the trial assessment to decrease

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F 221	Continued From page 4 or discontinue the use of bilateral mittens for Resident #8. The DON stated she did not know why the mittens were not discontinued. RN (registered nurse) A stated 10/5/16 at 4:02 p.m., she was responsible for implementing and educating the staff regarding discontinuing the use of bilateral mittens for Resident #8. RN A stated she had been in "the middle of care plan training" and had not had time to educate the staff regarding Resident #8. The administrator, acting DON, and ADM C were informed of the failure of the staff to ensure Resident #8 was free from unnecessary restraints, 10/5/16 at 11:04 a.m. The administrator stated that the recommendation to discontinue the use of the bilateral mittens was not implemented.	F 221		
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	F 225	1. <u>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</u> The allegation instigating Case # 748-2016-0015 on Resident #10 was reported after normal business hours on Sept. 23, 2016. Therefore, HWDMC did not count Sept. 23 as one of the five allotted working days as no investigation could have commenced until the following Monday. A copy of the criminal background report for Employee #5 was obtained from the state police.	

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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 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 clinical record review, the facility staff failed for one resident (Resident #10) of 20 residents in the survey sample, to timely report an allegation of abuse to the state agency and failed to ensure a criminal background check was completed for one of five staff members.

1. Resident #10's final report was submitted six days after the allegation was reported.
2. Employee #5's criminal background check indicated that the employee had a criminal history. The facility could not show that they reviewed the criminal history record.

F 225

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

Any allegation reported at the close of the normal work day could lead to a miscounting of the five allotted working days for an investigation.

No resident was affected or harmed by this deficiency. Employee files of Hiram W. Davis Medical Center were checked for criminal background reports and ensured compliance.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Regardless of the time an allegation is reported, the date of the report will be counted as the first allotted work day for investigation. The Facility Director will monitor compliance to ensure that all investigations are submitted within five working days in accordance with regulations.

The Human Resource Analyst II will continue to check for criminal background check prior to employment. A copy of the employee's criminal background report will be dated, initialed and a copy will be retained to show that the criminal background report has been reviewed.

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The findings included:

Resident #10 was admitted to the facility on 9/23/16. Diagnoses included: severe intellectual disability, left shoulder dislocation, seizure disorder and cardiomyopathy.

Resident #10 was in the facility less than 14 days and an MDS (minimum data set, an assessment) had not been completed. The resident was observed in the bed on 10/6/16 at 8:45 AM, and had mitts on both hands due to self injurious behavior and was non responsive.

Review of the clinical record revealed a nurses note dated 9/23/16, which read: "Transport did not bring patient to floor...left hand caught behind arm rest of wheelchair during transportation.. left hand swollen and puffy..physician ordered X-Ray." An X-Ray was obtained on 9/23/16 at 2:27 PM and showed "Suspect for glenohumeral dislocation." The event was reported to the OLC (office of licensure and certification) on the same day. The final report was sent to the OLC on 9/30/16, which was six working days from the initial report.

On 10/6/1610:45 AM, an interview was conducted with Administration (C). He stated, "It happened after business day (on a Friday)."

On 10/6/16 at 12:00 PM, the Administrator and DON (director of nursing) were notified of above findings. Administration (C) stated, "we will try to complete these in four days.

2. Employee #5's criminal background check indicated that the employee had a criminal

F 225

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The Facility Director will monitor compliance to ensure that all investigations are submitted within five working days in accordance with regulations. 100% monthly audits of completed investigations to insure timely submission will be conducted by the HWDMC Lead Investigator and reported to the Facility Director for review. This data will be shared with Medical Executive Committee quarterly.

The Human Resources Director will monitor compliance. One hundred percent monthly audits of criminal background reports of new employee hired will be conducted by HR Analyst and submitted to the HR Director for review. Monthly data will be submitted to HWDMC Quality Manager and reported to the Medical Executive Committee quarterly.

5. Include dates when the corrective action will be completed.

10-28-2016

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history. The facility could not show that they reviewed the criminal history record.

Employee #5 was hired at the facility on 8/10/16. As part of the criminal background check, Employee #5's finger prints were submitted to the Virginia State Police on 7/27/16.

A printout dated 8/9/16 from the Virginia State Police website was included in Employee 5's file. The "Status" section of the print out is the section that indicates if the employee was charged of any crimes. The "status" section on Employee #5's print out read "Transaction Is Being Processed."

On 10/6/16 at 10:45 a.m., an interview was held with Employee D, Human Resources. Employee D was asked if Employee #5's criminal history report had been reviewed. Employee D stated that when a criminal background check read "Transaction Is Being Processed", this meant that the employee had been charged with a crime. Employee D stated that she would receive a copy of the criminal history report from the state police and shred it after she reviewed the document. Employee D was asked why she did not keep the criminal history information in the employee file. She stated it was against the law to keep the document after it had served it's purpose.

Employee D was asked how she could show the survey team that she had reviewed the criminal history report for Employee #5. She stated that the document may still be in with the documents that needed to be shredded. After looking through the shredded documents, Employee D was unable to provide the criminal history report

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F 225	Continued From page 8 for Employee #5. The Administrator was notified of the issue on 10/6/16 at 11:30 a.m. No further information was provided. The facility abuse prevention policy was reviewed. It read "Human Resources guidelines and procedures for the screening of applicants for employment at (name of facility): screening includes drug testing for safety sensitive positions and a criminal background check of all applicants."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record, the facility staff failed to ensure the abuse policy was in accordance with the Federal regulations. The abuse policy was not in accordance with the federal regulations. The findings included: On 10/6/16 at approximately 10:00 AM, the abuse policy was revived. Under section D: Reporting Allegations of Abuse/Neglect, read as followed:	F 226	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The cited language was removed from the policy and additional language was added to ensure that all allegations are investigated. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. Any allegation reported prior to policy revision could have possibly gone uninvestigated. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The cited language was removed from the policy and additional language was added to	

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F 226	Continued From page 9 "The Facility Director (or designee) will determine if an allegation of abuse/neglect warrants investigation in accordance with this policy... Should the Director determine that the allegation is valid, she (or her designee) will: Appoint a qualified investigator." On 10/6/16 at 10:20 AM, an interview was conducted with the abuse coordinator (Administration C) was conducted. He stated, "We report all allegations of abuse, We will change the policy." On 10/6/16 at approximately 12:00 PM, the Administrator and DON (director of nursing) were notified of above findings.	F 226	ensure that all allegations are investigated. All allegations will be investigated. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Facility Director will monitor compliance to ensure that all allegations are investigated in accordance with regulation, standards, and facility policy. 5. Include dates when the corrective action will be completed.	
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, and clinical record review the facility staff failed for 1 resident (Resident #5) of 20 residents in the survey sample to provide a physician ordered diet containing a cheese sandwich and orange juice. Resident #5 had a physician order for a cheese sandwich and 3 containers of orange juice with	F 309	10-07-2016 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #5 diet order for a cheese sandwich and orange juice was added to her diet card on the tray line and meal trays. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents at HWDMC with orders for specific diets have the potential to be affected by this deficiency. 100% of resident's diet orders were reviewed and a list was forwarded to food service manager to ensure each	

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each meal tray. She did not receive these food items on her lunch tray served 10/5/16.

The findings included:

Resident #5, an 81 year old, was admitted to the facility on 5/7/13. Her diagnoses included schizophrenia, hypertension, chronic kidney disease, anemia, and osteoporosis.

Resident #5's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9/5/16. She was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment and required extensive assistance with activities of daily living. Her weight was 93 pounds.

Resident #5 also had a significant change Minimum Data Set assessment with an assessment reference of 6/7/16. On the assessment, Resident #5 was coded to have a significant weight loss, not prescribed by a physician. Her weight was 90 pounds.

Resident #5's physician orders were signed on 9/15/16. The "Diet Orders" section included "Consistency soft diet regular 1 cheese sandwich & 3 personal containers of OJ (orange juice) with each tray."

Resident #5 was observed on 10/5/16 at 11:30 a.m. eating lunch in the dining room. She was seated in her wheel chair. Her meal tray included chopped barbeque chicken sandwich, green vegetable, peaches, raspberry jello, and a bottle of water. There was no cheese sandwich on the tray. There was no orange juice on the tray.

resident receive the ordered diets based on physician's order. The food service manager reconciled the diet list with each resident's diet card on the tray line to ensure all food preferences are added to the diet card.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

A new policy and procedure to notify the dietary department of each resident's diet, any specific food preferences and any dietary changes was developed. All new diet changes will be faxed immediately to the diet office. All nurses have been in-serviced on the new procedure. The food service manager will ensure that all necessary staff in the dietary department is made aware of the new procedure. All diet order notification forms will be faxed to the diet office. A standardized diet order template has been implemented for use by personnel including, but not limited to, physicians, SLP and Registered Dietitian Nutritionist.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

An audit tool was created in which 100% of residents dietary orders will be checked

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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 OATE
F 309	Continued From page 11	F 309		

Licensed Practical Nurse C (LPN C) was watching over the table where Resident #5 was seated. LPN C was asked if Resident #5 ever had orange juice on her tray. LPN C stated that sometimes the kitchen would send orange juice on the tray. When asked if Resident #5 would drink the water on the tray, LPN C stated that Resident #5 doesn't really like water.

On 10/6/16 at 9:00 a.m., the Registered Dietitian was asked to provide a copy of Resident #5's diet order that was on file in the kitchen. The cheese sandwich and orange juice was not included on the diet print outs. The Registered Dietitian stated that the orders for the orange juice and cheese sandwich were not current and had been carried over from the previous facility where Resident #5 lived. It was reviewed with the Registered Dietitian that the physician had signed the ordered on 9/15/16. The Registered Dietitian stated that she has informed the doctor that the order needed to be removed from the physician order sheet.

The Registered Dietitian was asked if Resident #5 received these items on her tray because she would not drink water or had experienced weight loss. The Registered Dietitian stated no.

On 10/6/16 at 11:30 a.m., Resident #5's diet order was reviewed with the Administrator. She was notified that the orange juice and cheese sandwich had not been observed on the lunch tray. The Administrator was informed that the Registered Dietitian stated that the order was an old order that needed to be removed from the physician order sheet. The Administrator stated that the diet system did not have the capability to add the ordered food items into the system.

monthly by the Registered Dietician and submitted to the Clinical Nutrition Manager for verification that all food preference orders are noted on the resident's diet card on the tray line. Reports will be submitted monthly to the HDMC Quality Manager. Quarterly reports will be submitted and discussed during the Medical Executive Committee meetings.

5. Include dates when the corrective action will be completed.

10-28-2016

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	495113	A. BUILDING _____ B. WING _____	10/06/2016

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #5) of 20 residents in the survey sample to ensure a safety device was in place.

Resident #5 had a physician order for a chair alarm. She was observed in her wheel chair without the alarm.

The findings included:

Resident #5, an 81 year old, was admitted to the facility on 5/7/13. Her diagnoses included schizophrenia, hypertension, chronic kidney disease, anemia, and osteoporosis.

Resident #5's most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 9/5/16. She was coded with a Brief interview of Mental Status score of 3 indicating severe cognitive impairment and required extensive assistance with activities of daily living.

Resident #5's physician orders were signed on 9/15/16. Included in the section titled "Protective

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

A chair alarm for Resident #5 was applied. All staff was made aware that Resident # 5 order for chair alarm for wheelchair safety. The assigned nurses were instructed to check to make sure chair alarm is in place while is up in wheel chair.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

All residents with chair alarms have the potential to be affected by this deficiency. All residents with safety alarm orders were reviewed by the Charge Nurses to ensure safety alarms are in place as ordered.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

Nursing Supervisors will in-service their Licensed Nurses and CNAs regarding monitoring residents with chair alarm safety devices to ensure they are in place per physician's orders. The personal care flow sheets will be noted to reflect chair alarm

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F 323 Continued From page 13

Device" read "Chair alarm for wheelchair safety & bed alarm for bed safety 24 hr (hour) x 30 days".

Resident #5 was observed on 10/5/16 at 11:30 a.m. eating lunch in the dining room. She was seated in her wheel chair. There was no chair alarm attached to the wheel chair.

Licensed Practical Nurse C (LPN C) was watching over the table where Resident #5 was seated. LPN C was asked if Resident #5 had a chair alarm attached to her wheelchair. LPN C stated that there was no wheel chair alarm attached to the chair. When asked if Resident #5 was supposed to have a chair alarm, LPN C stated no.

At the end of day meeting on 10/5/16, the Administrator and Director of Nursing were notified that Resident #5 was observed without a chair alarm in place. They were informed that LPN C stated that Resident #5 did not require an alarm. The facility staff were asked to verify if Resident #5 required a chair alarm.

The facility staff did not provide any follow up information regarding Resident #5's chair alarm.

F 371 SS=E 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

F 323

orders for those residents with orders. CNAs will be required to document that the alarm is in place. The nurse assigned will also document on the protective device sheet to note the chair alarm is in place. A green falling star will be placed on the wheel chairs of residents requiring a chair alarm to serve as visual reminder to nursing staff to ensure chair alarm is in place. These measures will be reflected on the resident's plan of care.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The assigned LPNs per wing/unit will make rounds daily/per shift to conduct audits of residents who are out of bed have the chair safety alarm in place as ordered. Non-compliance will be corrected immediately to apply safety alarm. Audits will be submitted monthly to the Shift Supervisors who will review the audits and take appropriate actions. Monthly audits will be submitted to the HWDMC Quality Manager. Quarterly reports will be submitted and discussed during the Medical Executive Committee meeting.

5. Include dates when the corrective action will be completed.

10-28-2016

F 371

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

No residents were specifically found to have been affected by the deficient practice; however, the expired food items and food boxes with frozen liquid were disposed immediately. All kitchen staff was informed to

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F 371	Continued From page 14	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview the facility staff failed to store food in a sanitary manner.

In the walkin freezer, expired food items were available for use and frozen liquid from the cooling unit was observed on food boxes.

The finding included:

A tour of the main kitchen was conducted on 10/4/16 at 1:50 p.m. Upon entering the walk in freezer, a loud clanking noise was observed. The cooling unit included 6 fan units. Ice was built up on each fan. The noise came from the rotating fan blades hitting the ice build up. The freezer measured appropriate temperature.

The Registered Dietitian (RD) was present during the freezer observation. When asked if the facility had a problem with the freezer unit, the RD stated yes. She stated that the ice build up occurred on a daily basis and that the dietary staff cleared the ice daily. The RD stated that no food was stored under the cooling unit.

A cart of food was under the cooling unit at this time. The cart included three full pans labeled "peeled bananas" that were dated 6/17/16-9/16/16. The cart also included a full pan of sausage links with the plastic wrapping ripped open and a full pan of meat balls labeled with the date 9/23/16. A bucket was on top of the pans of food in the cart. The bucket was half full of solid

F 371

inspect and dispose expired food items immediately and to be cognizant of the dripping liquid therefore move boxes away from the area.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

The CSH Kitchen provides food and nutrition services to all residents of Hiram W. Davis Medical Center; all residents receiving food trays have potential to be affected by the same deficient practice. Therefore an immediate formal inspection will be implemented to include all areas of the department.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

A sanitation audit will be conducted monthly and results reviewed with Food Production Manager.
The focus of the audit will include but not be limited to, checking for expired food items and immediate disposal, ensure no dripping liquid on any food boxes and ensure food is stored in a sanitary manner. The monthly audit will include all areas of the Food and Nutrition Service department.

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F 371 Continued From page 15

ice.

A tall food rack was in front of the cooling unit. A box of chicken nuggets was on the rack. The top of the box was frozen over with a sheet of ice. Another rack to the right of the cooling unit included a box of hamburger patties. The hamburger patties were in a bag. The bag was open and the hamburger patties were exposed.

After the tour, the issues with the freezer were reviewed with the Food Service Director (FSD). The FSD stated that the issue with the cooling unit and ice build up in the freezer were an ongoing problem. The FSD stated that frozen foods should be discarded after three months. He agreed that the food items in the freezer past their expiration date should have been discarded.

At the end of day meeting on 10/5/16, the Director of Nursing and Administrator were notified of the freezer issues.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS
SS=D

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and

F 371

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The RDN or designee assigned to HWDMC will conduct monthly sanitation audit and will ensure all Food and Nutrition Services staff is adhering to labeling/dating standards. Non-compliance will be corrected immediately. The HWDMC Infection Control Practitioner and/or designee will conduct unannounced rounds in the Kitchen once a month to conduct audits of dates/labels. Unannounced rounds and audits will be conducted with the Food Service Director or designee. Collected data will be reported by HWDMC to the Quality Management Director monthly, compiled and reported to the Medical Executive Committee.

5. Include dates when the corrective action will be completed.

11-18-2016

F 441

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The nurse administering the medications was immediately re-educated on the proper way to administer medications to prevent spread of infection as noted in Nursing Clinical Procedure 99, *Medication Administrations* and Infection Control SOP 1.1, *Hand Hygiene*.

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F 441	Continued From page 16 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. 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 ensure an effective infection control program was implemented during medication administration for one Resident (Resident #18) in a survey sample of 20 Residents. For Resident #18, LPN (licensed practical nurse) B dropped a medication on the top of the medication cart, picked the pill up with bare hands and put it in the pill splitter, after splitting picked the pill up with his bare hands and put the	F 441	2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving medications have the potential to be effected by this deficient practice. All nurses were re-educated on the proper way to administer medications to prevent spread of infection as noted in Nursing Clinical Procedure 99, *Medication Administrations* and Infection Control SOP 1.1, *Hand Hygiene*. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Clinical Educator/Infection Control Nurse will provide mandatory training to all licensed nursing staff to ensure an effective infection control program is implemented and followed during medication administration. The training will focus on hand hygiene procedure before and after medication administration and in addition appropriate disposal of any medication dropped on the medication cart surface. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.	

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F 441	Continued From page 17	F 441		

pill in the medication cup. LPN B also failed to perform hand hygiene after removing gloves.

The findings included:

Resident #18, a male, was admitted to the facility 5/4/84. His diagnoses included profound intellectual disability, seizure disorder, gastroesophageal reflux disease, and self injurious behavior, by scratching himself.

Resident #18's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/16/16 was coded as a quarterly assessment. Resident #18 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. He was coded as requiring total assistance of one to two staff members to perform his activities of daily living.

Resident #18 was observed during medication pour and pass observation beginning 10/5/16 at 9:10 a.m. LPN B reviewed the MAR (medication administration record) and removed the medications to be administered from the medication cart. LPN B opened one package of Phenytoin 50 mg (milligram) and dropped the pill on top of the medication cart. LPN B picked the pill up with his bare hands and put the Phenytoin 50 mg tablet in the pill splitter. After splitting the medication, LPN B picked the pill out of the splitter, putting one half in the medication cup and discarding the other half. Located on the top of the medication cart was the pill splitter, pill crusher, MAR, pens, medication cups, water pitcher and various other items.

LPN B prepared the rest of the medications. As

The Nursing Shift Supervisors will conduct unannounced weekly medication observations audits on medication nurses to ensure infection prevention compliance during medications passes until 100% compliance for three consecutive months. Any deficient practice will be corrected on the spot and retraining as needed. Reports will be submitted monthly to the HWDMC Quality Manager. Quarterly reports will be submitted and discussed during the Medical Executive Committee meeting.

5. Include dates when the corrective action will be completed.

10-28-2016

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Resident #18 was to receive 75 mg of Phenytoin, LPN B opened another Phenytoin 50 mg and placed it in the medication cup. LPN B crushed both the whole tablet and the half tablet. Picking up all of the prepared medication cups and six cups with 15 ml (milliliter) of water, LPN B entered Resident #18's bedroom.

LPN B donned a pair of gloves. After checking for residual, LPN B administered all of the medications through Resident #18's gastrostomy tube finishing at 9:25 a.m. A gastrostomy tube was a soft flexible tube surgically inserted through the abdominal wall and into Resident #18's stomach. A gastrostomy tube is utilized to administer medications, nutrition, and hydration to a Resident that is unable to swallow.

After administering the medications, LPN B removed his gloves and signed for the medications he administered on the MAR. LPN B donned a pair of gloves, cleaned the tray he carried all of the medications into Resident #18's bedroom on, and removed his gloves. LPN B then performed hand hygiene with hand sanitizer.

When interviewed 10/6/16 at 8:52 a.m., LPN B appeared to be unaware he should not administer medications after being dropped on the medication cart and not touching medications with his bare hands. LPN B stated he should clean his hands after removing gloves.

RN (registered nurse) B stated LPN B should have discarded the medication after the Phenytoin had dropped on the medication cart. LPN B also stated no medication should be touched with bare hands and LPN B should have performed hand hygiene after removing his

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F 441	Continued From page 19	F 441		

gloves. RN B was identified as being the facility's infection control coordinator.

RN B stated the facility's handwashing policy was based on "CDC's" guidance.

Guidance is provided in "MMWR (Morbidity and Mortality Weekly Report, CDC, March 25, 2002, p. 32,

Recommendations
1. Indications for handwashing and hand antisepsis

J. Decontaminate hands after removing gloves."

Additionally, same source, page 30, "The following caveats regarding use of gloves by HCWs (health care workers) must be considered. Personnel should be informed that gloves do not provide complete protection against hand contamination. Bacterial flora colonizing patients may be recovered from the hands of <30% of HCWs who wear gloves during patient contact (50,58). Further, wearing gloves does not provide complete protection against acquisition of infections caused by hepatitis B virus and herpes simplex virus (359,360). In such instances, pathogens presumably gain access to the caregiver ' s hands via small defects in gloves or by contamination of the hands during glove removal."

Additionally, guidance regarding touching medications prior to administration:

Guidance is provided in "Fundamentals of

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F 441	Continued From page 20 Nursing 7th Edition, page 652, Use your critical thinking skills to prevent an infection from developing or spreading. Implement procedures to minimize the numbers and kinds of organisms that could be possibly transmitted. Eliminating reservoirs of infection, controlling portals of exit and entry, and avoiding actions that transmit microorganisms prevent bacteria from finding a new site to grow. Proper use of sterile supplies, barrier precautions, standard precautions, transmission -based precautions and proper hand hygiene are examples of methods to control the spread of microorganisms." The administrator, acting DON (director of nursing), and risk manager were informed of the failure of LPN B dropping Phenytoin on the medication cart and ultimately administering the medication, touching Phenytoin with bare hands, and failing to perform hand hygiene after removing gloves, 10/6/16 at end of day conference.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Upon notification of the deficiency, Resident #2 left arm was assessed on 10/5/16. The second wound on the left arm was documented on the pressure ulcer form. The interdisciplinary care plan was updated to reflect the changes.	

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F 514	Continued From page 21	F 514		

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation and clinical record review, the facility failed to document a stage 2 pressure ulcer for one resident (Resident #2) in a sample of 20 residents.

For Resident #2, the facility failed to document assessment of, plan of care for a second wound on the left arm which was a stage 2 pressure ulcer.

The Findings included;

Resident #2 was admitted to the facility on 5-10-13. Diagnoses included; Profound Mental retardation (MR), spastic cerebral palsy, seizure disorder, Crohn's disease, vitamin D deficiency, gastrostomy tube for feeding, and self injurious behaviors. All skin risk assessments revealed that Resident #2 was at risk for skin breakdown, and had one stage 3 pressure ulcer on the left elbow, which had first been identified 5-12-16.

The most recent minimum data set (MDS) assessment was a quarterly assessment, with an assessment reference date of 8-10-16. Resident #2 was coded with severe cognitive impairment. Resident #2 required total assistance of one to two staff members with activities of daily living, to include bed mobility and transferring.

Review of the previous full MDS, which was a significant change comprehensive assessment, dated 6-17-16 revealed an entry area M0150. The entry described Resident #2 as at risk of

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

LPNs will complete skin inspections head to toe, front to back on every resident on each shift daily and document on the flow sheet changes. Any changes on the resident's skin are reported to the Charge Nurse and MD. Any changes on the resident skin will be accurately documented, readily accessible and systematically organized in the nursing progress notes.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The wound nurse and MD will follow up on all reported wounds during daily rounds. The wound nurse and MD will assess and accurately document, have readily accessible and systematically organized all reported wounds. The Charge Nurse will document on interdisciplinary care plan the plan put in place to address the wound.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 514	Continued From page 22	F 514		

developing pressure ulcers, and at area M0210, the Resident was coded as having one unstageable pressure ulcer.

Review of the resident's comprehensive care plan for one "stage 2 ulcer left elbow", was initially developed and dated 5-12-16 when the pressure ulcer was identified. The interventions were; 1) Air mattress, 2) Mitten on right hand only to prevent from scratching face and biting hand, 3) Derma-saver palm roll in left hand, 4) position on left side or back, not on right side. The care plan was revised on 6-22-16, and the single wound on the left elbow was described as "unstageable". One new intervention for "Blue donut on left arm above elbow" appeared in the document at this time. On 7-1-16 the care plan was again updated, with no changes to the skin interventions, however, the single wound was described as a stage 3 pressure ulcer. On 8-10-16 the entire care plan was rewritten, and the single left elbow wound continued to be described as a stage 3 pressure ulcer. This document had a hand written entry which stated "Impaired skin integrity, initiate wound protocol, wound care as prescribed by physician, bilateral mittens, reassess for improvement or worsening." This is the first time a treatment was mentioned, and the care plan did not indicate if this was related to the pressure ulcer or to superficial scratches the Resident had self inflicted, which were also denoted on the previous care plans. No further updates or revisions were made to the skin care plan from the 8-10-16 care plan to the time of survey on 10-6-16.

Review of the weekly "Pressure Ulcer Assessment Guide" (PUAG), which was the document that the wound care Registered Nurse

The wound nurse will conduct a 100% audit of the pressure ulcer assessment sheets, monthly. The audit will focus on assessment, plan of care and treatment provided to ensure all reported ulcers are accurately documented in nursing progress notes, pressure ulcer assessment form and interdisciplinary care plan. The audit will also include if these documents are readily accessible and systematically organized. Reports will be submitted monthly to the HDMC Quality Manger. Quarterly reports will be submitted and discussed during the Medical Executive meetings.

5. Include dates when the corrective action will be completed.

10-28-2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495113	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HtRAM W DAVIS MEDtCAL CTR REVtSED	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

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(RN A) completed each week, describing each wound, revealed that the single left elbow pressure ulcer was the only wound that Resident #2 had.

The (PUAG) skin assessment sheets revealed the following:

On 5-12-16 the Resident was identified with a stage 2 pressure ulcer to the left elbow. Measurements and descriptions were included. On 6-3-16 the Resident was identified with an unstageable pressure ulcer (the same wound which had worsened) to the left elbow. Measurements and descriptions were included. On 7-1-16 the Resident was identified with a stage 3 pressure ulcer (the same wound which had worsened) to the left elbow. Measurements and descriptions were included. After the 7-1-16 assessment, and until the time of survey weekly assessments were completed and the staging and documentation remained at a single stage 3 pressure ulcer to the left elbow.

From 5-12-16 until 10-3-16 the weekly (PUAG) skin assessment forms were completed with no mention of a second wound on the left arm.

On 10-5-16 at 11:30 a.m., wound care & measurement observations were conducted with the treatment nurse (LPN E). LPN E performed the measurement, of the healing stage 3 elbow wound, and it measured 1.0 cm (centimeters) x 1.0 cm x 0 cm depth, indicating improvement in the wound healing. There was a second wound observed, which measured 0.5 cm x 0.5 cm, with a darkened skin layer, scab like. The wound bed was not visible. There was a space of intact, healthy, undisturbed, epidermal tissue, which was

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	495113	A. BUILDING _____ B. WING _____	10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIRAM W DAVIS MEDICAL CTR REVISED	26317 WEST WASHINGTON STREET PETERSBURG, VA 23803

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F 514	Continued From page 24	F 514		

not involved in either wound, between the two distinct wounds. This healthy tissue measured 0.5 cm, and separated the two wounds. No drainage or odor was present and the wound edges were pink around the circumference of both wounds.

Physicians order sheets, and "Patient referral for consultation" forms revealed that on 6-2-16 the Certified wound nurse and doctor ordered to clean the single unstageable left elbow wound with "Saline and apply Iodosorb gel, and cover with folded 4 x 4, and secure with tape." On 7-9-16 the recommendations and order were "Continue current wound care, Continue use of donut to keep pressure off, Paper tape only, and apply bard skin protection to surrounding skin prior to taping foam dressing." On 8-12-16, and 9-16-16, the certified wound nurse again saw Resident #2 and made recommendations for the single left elbow wound. On the most recent recapitulation of physician's orders signed on 10-4-16, the treatment order for the single wound was "Santyl ointment apply daily and as needed to left elbow ulcer. There was no mention of a second wound.

Review of nursing progress notes revealed no documentation of the single Left elbow ulcer, nor was there a description of a second wound for the months of September, or October 2016.

On 10-5-16 at 4:30 p.m. the wound nurse (RN A), was interviewed and stated the second wound had been found "Last week" and was found as a "Blood blister, which would be considered a stage 2 pressure injury". She stated she could not see the base of the wound, and could not tell if it was a deep tissue injury or not. She was asked to provide documentation of the wound

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	495113	A. BUILDING _____ B. WING _____	10/06/2016

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assessments, descriptions, and treatment for the wound, as none could be found identifying it in the clinical record. She responded that she knew it was there, however, had not documented it.

Facility policies for "Pressure Ulcer General Treatment Examples/Guidelines", and "Pressure Ulcer Prevention, Assessment and Monitoring" were reviewed and revealed:
- "All Residents will have a skin risk assessment.....LPN's will complete skin inspection head to toe, front to back on every resident on each shift daily and document on flow sheet changes. Any changes on the resident's skin is reported to the charge nurse and MD (doctor) and documented on the notes."
- "A Stage 2 pressure ulcer is a partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater."
- For stage 2 pressure ulcers, Notify the MD (Medical Doctor)...., Develop a plan of care.....Obtain individualized wound care orders...., and protect the area. Document; Date/time of wound care, location of wound, appearance of wound, type of wound treatment, patient response, ...monitor recorded data."

No assessment documentation was completed for the second left arm wound, no care plan was completed for the second wound.
Guidance was given, in "Medical Surgical Nursing, Vol 1, Ignatavicius and Workman, page 123, "To maintain healthy skin, the body must have adequate food, water, oxygen intake, intact waste removal mechanisms; sensation; and functional mobility. Changes in any of these variables can lead to rapid and extensive skin breakdown. If the client cannot protect or maintain the skin, the nurse must be able to assess and plan for his or her needs. The nurse

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monitors the client to determine the risk of skin breakdown before it occurs." *Anytime a pressure ulcer is identified a Weekly Pressure Ulcer Record must be completed."
On 10-5-16, and 10-6-16 at the end of day conferences, the administrator, wound nurse, and Director of Nursing were informed of evidence indicating a second undocumented stage 2 pressure injury had occurred for Resident #2. No other documentation was available to be provided by the facility.

On 10/15/16, at approximately 11:00 AM, a second wound observation was completed with the wound care nurse. The wound care nurse went to the room and viewed the wounds. The second wound had a darkened skin layer which was wiped off during cleaning and was revealed to be a soft skin layer (from the top layer of a blister) and revealed intact wound base that was very slightly pink.

COMMONWEALTH of VIRGINIA

Virginia Department of Fire Programs

Melvin D. Carter
EXECUTIVE DIRECTOR

State Fire Marshal's Office
Central Region
1005 Technology Park Drive
Glen Allen, VA 23059-4500
Phone: 804/ 371-0220
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Kathaleen Creegan-Tedeschi, Director
Office of Licensure/Certification
Division of Long Term Care
Virginia Department of Health
9960 Mayland Drive
Perimeter Center Suite 401
Henrico, VA 23233

RE: Hiram W Davis Medical Ctr
26317 West Washington Street
Petersburg, VA 23803
File Number: C-5743-001
CMS Certification Number: 495113
Event ID Number: Y22821

The attached report is forwarded to you with the following comments:

I. SURVEY [X]

[X] Recommend certification based on compliance with Life Safety Code.
[ ] Recommend certification based on acceptable POC.
[ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
[ ] Recommend certification based on compliance with LSC by requested continuous waiver.
[X] Recommend certification based on compliance with LSC by requested Time Limited waiver.
[ ] Recommend certification based on satisfactory results from application of the FSES.
[ ] Do not recommend certification.

11. POST SURVEY [ ]

[ ] All deficiencies corrected:

[ ] All deficiencies not corrected:

- [ ] Recommend certification based on acceptable POC
- [ ] Recommend certification based on acceptable POC and a scope and severity of C or less with no revisit required.
- [ ] Recommend certification based on approved or requested continuous waiver.
- [ ] Recommend certification based on approved or requested Time Limited waiver.
- [ ] Do not recommend certification.

If you have any questions or if we may be of further assistance, please contact me at 804-371-0220

Sincerely,

Ronald C. Reynolds - JJC

Ronald C. Reynolds
Interim State Fire Marshal

Survey Date: 10/26/2016 **SOD Sent:** 12/1/16 **POC Rec ' d:** 12/7/16 **POC to HQ:** 12/27/2016
Highest Scope/Severity: E **(N/A is one option)**

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

C-5743-110

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
495113 K1	Hiram Davis W. Medical Center	10/26/16 * K4

K6 DATE OF PLAN APPROVAL: 1978

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS: 2

NUMBER OF THIS BUILDING: 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 [16] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]
1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [6]
4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]
7 PROMPT
8 SLOW
9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: [ ] K56: [ ]

ENTER E – SCORE HERE

K5: [ ] e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1.	A2.	A3.	A4.	A5.
[ ]	[✓]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A.	B.	C.
[✓]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

* MANDATORY

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

C-5743-110

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
495113 K1	Hiram W. Davis Medical Center	10/26/16 * K4

K6 DATE OF PLAN APPROVAL: 1/1/2008

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS: 2

NUMBER OF THIS BUILDING: 04

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 [17] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]
1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [6]
4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]
7 PROMPT
8 SLOW
9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: [ ] K56: [ ]

ENTER E – SCORE HERE

K5: [ ] e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1.	A2.	A3.	A4.	A5.
[ ]	[✓]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A.	B.	C.
[✓]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

* MANDATORY