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PRINTED: 09/29/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495216	A. BUILDING _____ B. WING _____	C 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid abbreviated survey was conducted 09/07/16 through 09/08/16. Corrections are required for compliance with the following 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 120 certified bed facility was 106 at the time of the survey. The survey sample consisted of 2 current Resident reviews (Residents #3 through #4) and 2 closed record reviews (Residents #1 through #2).

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 staff interview and clinical record review it was determined the facility staff failed to follow physician's orders for diabetic care and daily weights for 1 of 4 residents (Resident #2.)

Findings:

Facility staff failed to follow physician's orders for diabetic care (obtaining and reporting blood sugar

F 000 **The statements included are not an admission and do not constitute agreement with the alleged decifiencies herein. The plan of correction is completed in compliance of state and federal regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.**

F 309 **Resident #2 is no longer in the facility.**

Current residents were audited for correct input of orders to monitor daily weights and also for perimeters with blood sugar monitoring.

Licensed staff were educated on the process of how to put orders in the computer system so daily weights could be monitored and also on the perimeters included with diabetic orders by 10-6-16

The Unit Manager/designee will monitor order listing report daily to assure that weight orders are in the system and weight changes are monitored daily. The Unit Manager/designee will monitor blood sugars daily by using the vital signs report to assure that blood sugars are not outside of the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/5/2016

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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F 309	Continued From page 1 readings) and daily weights. The resident's closed clinical record was reviewed on 9/7/16 at 1:00 PM. Resident #2 was admitted to the facility on 8/1/16. Her admission diagnoses included anemia, coronary artery disease, cellulitis, diabetes (insulin dependent), heart failure, cirrhosis, renal failure, pneumonia, hypertension, and anxiety This resident was discharged on 8/26/16--after family members escorted her outside the facility to visit her personal physician. The progress notes documented the following on 8/26/16. "Resident's husband and daughter came in around 9 PM and said resident had been admitted to the (name of hospital) Husband and daughter packed up resident's belongings and loaded them in car....." The resident's MDS (minimum data set) assessment, dated 8/8/16, documented the resident with minimal cognitive impairment. The resident required staff assistance for all the ADLs (activities of daily living) with the exception of eating--which required set-up and oversite only. The MDS documented 2 unstageable pressure areas/deep tissue injuries on admission. The resident's CCP (comprehensive care plan) implemented on 8/2/16 included the resident was dependent on staff due to the diagnoses of pleural effusion, chronic kidney disease, coronary artery disease, congestive heart disease, diabetes II, cellulitis, chronic anemia, unsteady gait, edema bilateral lower extremities, SOB (short of breath) exertion, pain, cirrhosis, with hypertension and pneumonia. Interventions for staff (with regards to diabetic care) included	F 309	**perimeter and MD has been notified per orders.** **Any non-compliance will be reported to the QA committee for tracking and progressive disciplinary action as needed.** Administrator 10/5/16	

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1. Monitor/document/report any signs or symptoms of hyperglycemia (high blood sugars.)
2. Monitor/document/report any signs or symptoms hypoglycemia (low blood sugar.)
3. Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.

The resident's CCP (comprehensive care plan) implemented on 8/11/16 documented the resident's congestive heart failure as an issue to be addressed by staff. The interventions included Weights as ordered.

Resident #2's physician's orders, signed and dated by the physician on 8/1/16, included:
1. "Insulin Detemir Solution 100 unit/ml. Inject 20 units subcutaneously at bedtime for diabetes. Notify MD for BS (blood sugar) <60 or >400 mg/dl."
2. "Novolog Flexpen solution Pen-injector ....inject as per sliding scale.....notify MD for BS <60 or >400...."
3. Daily weights were added to the physician's orders on 8/17/16. Staff were to call MD if greater than a 2 pound gain in 24 hours or greater than a 5 pound gain in 2 days.

The resident's MAR (medication administration record) was reviewed for the entire stay. The record documented the resident's blood sugars were greater than 400 on 8/6, 8/8 and 8/19/16. There was no clinical documentation that staff nurses notified the physician of these incidents as per his order.

The clinical record contained a weight summary sheet for Resident #2. The weights were obtained weekly between 8/1/16 (202 lbs) through 8/25/16

Administrator 10/5/16

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F 309	Continued From page 3 (195 lbs.). At no time was the resident observed to gain more than 2 pounds in 24 hours or >5 pounds in 2 days. On 9/8/16 at 8:30 AM the CN (corporate nurse) and DON (director of nursing) were informed of the surveyor's findings. No additional information was provided with regards to the MD notification of blood sugar parameters or the assessment of daily weights. This was a complaint deficiency.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined the facility staff failed to follow physician's orders for pressure ulcer care for 1 of 4 residents (Resident #2.) Findings: Facility staff failed to follow physician's orders for pressure ulcer care. The resident's closed clinical	F 314	**Resident #2 is no longer in the facility.** **Current resident with pressure ulcer orders were audited to assure treatments were appropriate and set up in system for correct documentation. Current residents were also audited to assure that the weekly skin assesments were set up in the computer system.** **Licensed staff were educated on the documentations of treatments and also on doing weekly skin assessments 10-6-16** **The Unit Managers/designee will monitor for holes on the treatment records and weekly skin assesments not being done by using the missed assessment report daily.** **Any non-compliance will be reported to the QA committee for tracking and progressive disciplinary action.**	

Administrator 10/5/16

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F 314	Continued From page 4	F 314	**Date of compliance- October 10, 2016.**	

record was reviewed on 9/7/16 at 1:00 PM.

Resident #2 was admitted to the facility on 8/1/16. Her admission diagnoses included anemia, coronary artery disease, cellulitis, diabetes (insulin dependent), heart failure, cirrhosis, renal failure, pneumonia, hypertension, and anxiety.

This resident was discharged on 8/26/16--after family members escorted her outside the facility to visit her personal physician. The progress notes documented the following on 8/26/16, "Resident's husband and daughter came in around 9 PM and said resident had been admitted to the (name of hospital.) Husband and daughter packed up resident's belongings and loaded them in car....."

The resident's MDS (minimum data set) assessment, dated 8/8/16, documented the resident with minimal cognitive impairment. The resident required staff assistance for all the ADLs (activities of daily living) with the exception of eating--which required set-up and oversite only. The MDS documented 2 unstageable pressure areas/deep tissue injuries on admission.
The resident's CCP (comprehensive care plan) implemented on 8/11/16 documented pressure areas on the sacrum and right buttocks r/t immobility and potential for further skin impairment r/t immobility. The interventions included educating the resident/family/caregivers as to the causes of skin breakdown; including: transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning.

CCP interventions (for skin care) to staff included:
1. Float heels while in bed as indicated.

Administrator
10/5/16

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2. Keep skin clean and dry.
3. Moisture barrier cream as needed for protection of skin.
4. Pericare with incontinence episodes.
5. Pressure reduction mattress.
6. Pressure reduction surface to wheelchair.
7. Provide assist with turn and reposition as indicated.
8. Weekly skin assessments.

Documentation in the clinical record indicates all care-planned interventions except weekly skin assessments were provided. Two skin assessments were found and were dated 8/10/16 and 8/24/16. A comprehensive nursing assessment (including skin assessment) was acquired on admission.

The 8/1/16 "Admission Assessment/Screening-Nursing" documented the following skin issues/pressure areas:
1. Callous Left heel - Length-1.3 cm (centimeters) x Width-1.3 cm x Depth-0.0 cm.
2. Supected deep tissue injury/pressure sacrum - Length 1.8 cm x Width 2.5 cm x Depth 0.0 cm.
3. Supected deep tissue injury/pressure sacrum - Length 1.0 cm x Width 0.4 cm x Depth 0.0 cm.
4. Callous Right lateral foot - Length 1.0 cm x Width 1.0 cm x Depth 0.0 cm.

The skin assessment, dated 8/25/16, included the following wounds and measurements:
1. Left butttock 1.0 x 2.0 x 0.1
2. Coccyx 0.6 x 0.2 x 0.1

The aforementioned are improvements on wounds assessed on admission.

Resident #2's physician signed and dated the

Jeannie J Fink
Administrator
10/5/2016

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following orders on the day of admission, 8/1/16:
1. Apply skin prep to left heel every shift for callous.
2. Apply skin prep to right lateral foot every shift for callous.
3. DTI (deep tissue injury) on sacrum: clean with dwc (distilled water cleanser), pat dry, assess wound and apply agb (Allevyn Gentle Foam Border Dressing) daily. Every shift for dti.
4. On 8/3/16 the physician changed the order (see #3.) for the WOUND #1, #2 on the sacrum: clean with dwc, pat dry, assess wound and apply every day shift every Tuesday, Thursday, Saturday for dti.

The TARs (treatment sheets) were reviewed for the resident's entire stay. The physician's orders to treat Wound #1, #2 on the sacrum were not documented as completed on 8/16, 8/18, 8/20, 8/23, 8/25/16. There was no evidence in the clinical record that these treatments had been provided as ordered.

The TARs documented the skin prep to the left heel callous was not completed by nursing staff on 8/2-3, 8/7-8, 8/11-12, 8/15, 8/17, 8/20, 8/22, or 8/23/16. No clinical record evidence was found to indicate the treatment was provided as ordered by the physician.

On 9/18/16 at 8:30 AM the CN (corporate nurse) and DON (director of nursing) were informed of the surveyor's findings. No additional evidence was presented to document the treatments were provided as ordered by the physician.

This was a complaint deficiency.

Jeannette J Frank
Administrator
10/5/16