STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. BUILDING _____ B. WING _____	R 03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETH SHOLOM HOME OF VIRGINIA	1600 JOHN ROLFE PARKWAY RICHMOND, VA 23233

(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 revisit survey to the standard survey ending 1/19/18 was conducted 3/6/18 through 3/7/18. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated. Corrected deficiencies are identified on the CMS-2567B. The census in this 116 certified bed facility was 78 at the time of the survey. The survey sample consisted of 10 current resident reviews (Residents 101 through 110).	{F 000}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	{F 657}		4/20/18

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

Electronically Signed | 03/30/2018

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{F 657}	Continued From page 1 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. 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 #103) of 10 residents in the survey sample to revise the care plan. For Resident #103, an intervention to address the risk of falls was not removed from the care plan after the facility staff decided the intervention was no longer necessary. The findings included: Resident #103, a 93 year old, was admitted to the facility on was admitted to the facility on 9/18/14. Her diagnoses included dysphagia, insomnia, anorexia, constipation and dementia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 12/20/17. She was coded with a Brief Interview of Mental Status score of 12 indicating moderate cognitive impairment. She required assistance with activities of daily living. The care plan was reviewed on 3/6/18 at 2:00 p.m. The "falls" care plan dated 12/27/17 read that "(resident) is at risk for falls r/t (related to) short term memory loss r/t dementia". One of the "Approaches" included "Place bed controller at foot of bed." Resident #103 was observed on 3/6/18 at 4:00	{F 657}	F657 – Care Plan Timing and Revision 42 CFR 483.21(b)(2) As noted in the deficiency statement, the care plan for resident #103 was updated on 3/7/17. The intervention for the call bell placement remains unnecessary. All residents' care plans are required to reflect the current needs of the resident, and all are potentially affected. To facilitate efficient communication between the staff caring for our residents, and the licensed staff who are updating the care plans, the facility will initiate a "Care Alert" form. This form will be provided at each nursing unit to provide documentation of resident changes that may require initiating, altering, or discontinuing interventions on the resident's care plan. Nursing staff will receive inservice training on the purpose of the form and proper completion. The Care Alert form will be provided to the Unit Managers on a daily basis (Monday through Friday) and the weekend supervisors (Saturday and Sunday), who will update the resident care plan within 24 hours of reviewing the documented change.	

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{F 657}	Continued From page 2 p.m. The resident was sleeping in the bed. The bed controller was located next to her right elbow. On 3/7/18, a copy of the care plan was requested. It was documented on the "falls" care plan that the document was revised on 3/6/18 at 4:06 p.m.. The approach regarding the bed controller had been removed by Licensed Practical Nurse A (LPN A). An interview was conducted with the Director of Nursing (DON) and LPN A on 3/7/18 at 12:20 p.m. At this time, LPN A was asked if she removed the bed controller approach from the falls care plan the previous afternoon. She stated yes. When asked why she just removed it from the care plan on 3/7/18, she stated that the Unit Manager told her that the approach was no longer necessary to prevent falls. The DON stated that it was decided in January after the last survey that the need for the bed controller to be placed at the foot of the bed was no longer necessary. When asked if it was ok that the care plan was just revised on 3/6/18, the DON stated no. She said it should have been removed when the decision was made in January. The Administrator and DON were notified of the issue on 3/7/18 at 1:10 p.m.	{F 657}	On a monthly basis, the Director of Nursing or her designee will take the Care Alert forms submitted to the Unit Managers, and compare 10% of them to the resident care plans, to validate that the communication is being used in a timely fashion to revise the care plans. The DON will also give a quarterly report to the QA Committee regarding the effectiveness of this plan of correction; the Committee is charged with taking any additional steps necessary to achieve and sustain compliance with care planning requirements.	
{F 812} SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	{F 812}		4/20/18

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{F 812}	Continued From page 3 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to effectively wear a hair restraint in the kitchen. The facility Dietician failed to effectively wear a hair restraint while working in the kitchen, which did not cover all of her shoulder length hair. The Findings included: On 3/6/18 at 2:00 P.M. an observation was conducted of the facility kitchen. The Dietician (Other A) was working in the kitchen during preparation to prepare the dinner meal, along with the her supervisor, the Resource Manager (Other B). The Dietician's hairnet did not effectively cover all of her hair. She had long shoulder length hair, and approximately 1 square inch thick section of her hair hung on her shoulders. When the Resource Manager was asked if the Dietician's hairnet was on properly, and effectively restraining her hair, he said "No". He then reached over and touched her hair, attempting to put all of the hair inside of the	{F 812}	F-812 Food Procurement, Store/Prepare/Service – Sanitary 42 CFR 483.60(i)(1)(2) The Registered Dietitian, whose hair was not completely restrained by her hair net, has reviewed the deficiency and the policy requirement to “sufficiently cover/restrain all lengths of hair.” The Dietitian is now taking the additional measure of using hair pins to secure the length of her hair. Hair that is not properly restrained could potentially affect food being served to all residents, if that hair transfers to food being prepared in the kitchen. The facility will place mirrors at the hair net dispensers so that personnel who are applying their hair restraints can check themselves prior to entering the kitchen and verify that all hair is covered by their hair nets. Dietary staff have been inserviced on 1)	

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{F 812}	Continued From page 4 hairnet. When asked about the importance of restraining the hair, The Resource Manager stated, "I think its fair to say that it would not fall onto food." The Dietician stated that she was the designated person who trained the facility staff on the importance of wearing hair restraints, she stated, "I did the hair restraint training. I know that my hair was sticking out. Sometimes I wear a ponytail and 2 hairnets." A facility cook (Other C) was also present. When asked about the importance of wearing hair restraints, he stated that it was important to keep hair out of food because of bacteria contamination." On 3/7/18 a review was conducted of the facility policy regarding hair restraints. It was dated 3/7/18. It read, " Hair nets will be worn by all female staff - sufficiently to cover/restrain all lengths of hair. Hair nets are to be applied upon entering the kitchen, and to be worn at all times while in the kitchen." On 3/7/18 the facility Administrator (Administration A) was notified of the findings. He presented documentation of an inservice training that was completed on 3/7/18. The Administrator stated that the facility cook conducted the training of his supervisors, the Dietician, and the Resource Manager regarding the facility policy on hair restraints.	{F 812}	the procedure for using the mirrors to check hair net application and 2) their responsibility to inform their co-workers or supervisors of they observed that anyone's hair is no longer completely restrained by their hair net. The VP of Quality Assurance will visit the kitchen, unannounced, at least once a week to verify that all personnel have their hair adequately restrained. Any variances from this standard will be reported to and addressed by the dietary manager. Any employee with repeat offenses will be subject to disciplinary action.	