STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit survey to the first revisit survey which was conducted on 3/14/18 through 3/16/18 was conducted 4/18/18 through 4/19/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567 - B. The census in this 190 certified bed facility was 172 at the time of the survey. The survey sample consisted of 16 current resident reviews, Residents #201 through #216.	{F 000}	RECEIVED MAY 01 2018 VDH OLC	
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	{F 656}	**F656:** **Development/Implement Comprehensive Care Plan** 1. Resident #201 clarification order for dressing change to right arm pit obtained 4/18/18. Resident #201 continues to receive wound care and dressing change per physician orders. Care plan updated to reflect the care needs of resident #201's wound care to right arm pit 4/19/18.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 4-30-18

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 656}	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined facility staff failed to follow the care plan for two of 16 residents in the survey sample, Resident #201 and Resident #210. 1. The facility staff failed to administer wound care treatment as ordered by the physician and as on the plan of care for Resident #201. 2. The facility staff failed to follow the plan of care and provide a dressing treatment to Resident #210's left toe on 4/17/18.	{F 656}	Resident #210 wound care to left toe completed 4/18/18 per physician order. Resident #210 continues to receive wound care per physician order. LPN #2 re-educated by the Director of Nursing (DON) regarding following physician orders and the plan of care r/t residents requiring wound care on 4-18-18. LPN #1 re-educated by the DON regarding ensuring residents wound care is completed per physician order without omission on the Treatment Administration Record (TAR) 4/18/18.	

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{F 656} Continued From page 2

The findings include:

1. Resident #201 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to: heart failure, irregular heart beat, dementia, anemia and seizures.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/11/18 coded the resident as having short and long term memory problems and as severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

An observation of Resident #201 was made on 4/18/18 at 10:00 a.m. The resident was lying in bed. He did not have a shirt on and multiple scabbed and opened areas were noted on and in his right armpit. The skin around the areas was very reddened. There were scabbed areas on the inner aspect of the elbow. The skin around the area was very reddened.

An observation of Resident #201 was made on 4/18/18 at 1:30 p.m. The resident was lying in bed. His skin was exposed as before. There were scabbed areas on the inner aspect of the elbow. The skin around the area was very reddened. There were no dressings on the open areas.

Review of the resident's care plan initiated on 3/30/18 documented, "Focus. (Name of resident) has impaired skin integrity of the right arm pit and chest...from autoimmune disease. Interventions. Administer treatments as ordered and monitor for effectiveness.

{F 656}

2. Quality review of current resident's care plan completed by the MDS Coordinator /DON/Unit Manager (UM)/designee to ensure the care plan is followed regarding residents requiring wound care. Follow up based on findings. Quality review of current resident's TAR completed by the DON/UM/designee to ensure treatments are completed per physician order without omission on the TAR. Follow up based on findings.

3. Licensed nurses re-educated by the DON/ MDS Coordinator /designee to ensure the care plan is followed regarding residents requiring wound care. Licensed nurses re-educated by the DON/designee to ensure wound care is completed per physician order without omission of documentation on the TAR.

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{F 656} Continued From page 3

Review of the April 2018 physician's orders documented, "BETAMETHASONE DIPROPIONATE (1) 0.05% CREAM. APPLY TO AREAS AND COVER WITH DRY DRESSING EVERY DAY." The start date was documented as 6/5/17.

Review of the physician's order dated 3/29/18 documented, "Cleanse right armpit with soap + water pat dry apply bacitrican (sic) [2] and place AB pad (large soft gauze pad) until healed."

Further review of the physician's orders dated 4/9/18 documented, "Bactroban (3) to underarm (R) (right) side and crease of (R) arm daily. Stage 2 (4) wound."

Review of the April 2018 (TAR) treatment administration record and treatment administration record documented, "BETAMETHASONE DIPROPIONATE 0.05% CREAM. APPLY TO AREAS AND COVER WITH DRY DRESSING EVERY DAY." The start date was documented as 6/5/17. The nurses signed off that the treatment was completed.

Review of the April 2018 TAR documented, "Cleanse right armpit with soap + water pat dry apply bacitrican (sic) and place AB (abdominal) pad (large soft gauze pad) until healed." The nurses signed off that the treatment was completed. There was no documented evidence of the 4/9/18 physician order for the bactroban on Resident #201's April 2018 TAR.

An interview was conducted on 4/18/18 at 4:00 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. When asked what treatment was administered to Resident #201's right armpit

{F 656}

4. MDS Coordinator/DON/designee to conduct quality monitoring through Morning Clinical Meeting to ensure the care plan is followed regarding residents requiring wound care 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
DON/designee to conduct quality monitoring through Morning Clinical Meeting to ensure wound care is completed per physician order without omission on the TAR 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance 5-3-18.

{F 656} Continued From page 4 {F 656}

and elbow area, LPN #2 stated, "I put some cream on it. I'll show you." LPN #2 opened the treatment cart and took out a tube of betamethazone dirpriop. LPN #2 stated, "I put some of this on a gauze and put it on the areas." When asked if she put an AB pad under the arm, LPN #2 stated, "No. I just leave the gauze that I had the medication on there." When asked what size gauze she used, LPN #2 showed this writer a two inch by two inch gauze. When asked to review the treatment administration order for the 3/29/18 right armpit wound care, LPN #2 stated, "Oh. I didn't follow that one. It is more specific than the one I used." When asked which order she should follow, LPN #2 stated, "The most recent order." When asked if she had followed the physician's order, LPN #2 stated she had not.

An interview was conducted on 4/18/18 at 4:15 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked why residents had care plans, RN #2 stated, "Residents have care plans so we can tailor the care we provide for them." When asked who used the care plan, RN #2 stated, "All the staff." When asked if staff were expected to follow the care plan, RN #2 stated yes they should.

An interview was conducted on 4/18/18 at 4:30 p.m. with LPN #1. When asked why residents had care plans, LPN #1 stated, "To take care of the patient." When asked who used the care plan, LPN #1 stated, "All the staff." When asked if staff were expected to follow the care plan, LPN #1 stated they were.

On 4/18/18 at 5:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the

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{F 656}	Continued From page 5	{F 656}		

findings at that time.'

Review of the facility's policy titled, "Plans of Care" documented, "Policy: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the residents and/or resident representatives(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Procedure: Develop and implement an individualized Person-Centered comprehensive plan of are by the Interdisciplinary Team...

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (5)

(1). Betamehasone dipriop -- Betamethasone Dipropionate Cream (Augmented), 0.05% is a high-potency corticosteroid indicated for relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses in patients 13 years and older. This information was obtained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=26588834-b3c1-571f-e054-00144ff8d46

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{F 656} Continued From page 6 {F 656}

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(2). Bacitracin -- Prevents infections in minor cuts, burns or scrapes. This information was obtained from:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009198/?report=details

(3). Bactroban -- Mupirocin is a topically used antibiotic from a strain of Pseudomonas fluorescens. It has shown excellent activity against gram-positive staphylococci and streptococci. The antibiotic is used primarily for the treatment of primary and secondary skin disorders, nasal infections, and wound healing. This information was obtained from:
https://pubchem.ncbi.nlm.nih.gov/compound/Mupirocin#section=Top

(4). Stage 2 wound -- Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). This information was obtained from:
http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

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{F 656} Continued From page 7 {F 656}

(5) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.(5) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.
2. The facility staff failed to follow the plan of care and provide a dressing treatment to Resident #210's left toe on 4/17/18.

Resident #210 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to chronic kidney disease, high blood pressure, psychotic disorder with hallucinations, type two diabetes mellitus, and peripheral nervous system disorder. Resident #210's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/17/18. Resident #210 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #210 was coded as requiring extensive assistance from one to two staff members with most ADLS (activities of daily living).

Review of Resident #210's wound care note dated 4/16/18 documented the following: "Arterial Wound (1) of the left, second toe- initial evaluation...Primary dressing (s): Santyl (2) apply once daily for 30 days. Secondary dressing: Dry protective dressing apply once daily for 30 days. Factors complicating wound healing: Polyneuropathy in diabetes, diabetes mellitus -type two."

Review of Resident #210's clinical record revealed the following order dated 4/16/18: "apply santyl once daily for 30 days to the left second

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{F 656} Continued From page 8 {F 656}

toe. Indication: arterial wound of the left second toe."

Review of Resident #210's April 2018 TAR (treatment administration record) revealed a hole; missing signature on 4/17/18, indicating that that dressing was not completed that day on 7-3 shift.

Review of Resident #210's care plan dated 10/26/17 and revised on 4/16/18 documented in part, the following: "4/5/18 non pressure area on left second toe...interventions: Administer treatments as ordered and monitor effectiveness."

On 4/18/18 at 3:35 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if he could show this writer Resident #210's dressing to her foot. Resident #210's dressing to her left foot documented the following date "4/16/18." Resident #210 stated, "That hasn't been changed since the doctor saw it." When asked if LPN #1 had worked the 7-3 shift on 4/17/18, LPN #1 stated that he did. When asked who was responsible for changing dressings, LPN #1 stated that the nurse assigned to the resident that shift was responsible. When asked why he did not change Resident #210's dressing on 4/17/18, LPN #1 stated that he was probably behind on his shift. LPN #1 stated yesterday was his first day on the unit.

On 4/18/18 at 4:35 p.m., a further interview was conducted with LPN #1. When asked the purpose of the care plan, LPN #1 stated that the purpose of the care plan was to know how to take care of each resident. LPN #1 stated, "The plan of care of the patient." LPN #1 stated that all staff had access to the care plan. When asked in

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{F 656} Continued From page 9

{F 656}

what circumstances the care plan would not be followed, LPN #1 stated that if the care plan was not accurate. When asked if the care plan was followed if the dressing to Resident #210's toe was not completed on 4/17/18, LPN #1 stated that the care plan wasn't followed.

On 4/18/18 at 4:35 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

No further information was provided prior to exit.

According to Potter and Perry's, Fundamentals of Nursing, 7th Edition, page 269 states "A written care plan communicates nursing care priorities to other health care professionals. The nursing care plan enhances the continuity of care by listing specific nursing interventions needed to achieve the goals of care. The complete care plan is the blueprint for nursing action. It provides direction for implementation of the plan plus the framework for evaluation of the client's response to nursing actions."

(1) Arterial Wounds (ulcers) occur because of inadequate perfusion of skin and subcutaneous tissue at rest. Arterial occlusive disease, common among smokers, diabetics and the elderly, can lead to claudication, rest pain and gangrene, in addition to localized ulceration. This information was obtained from The National Institutes of Health.
https://www.ncbi.nlm.nih.gov/pubmed/8716033.

(2) SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the

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{F 656} Continued From page 10 {F 656}

microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>)

Based on observation, staff interview, clinical record review and facility document review, it was determined facility staff failed to follow the care plan for two of 16 residents in the survey sample, Resident #201 and Resident #210.

1. Facility staff failed to administer wound care treatment as ordered by the physician and as on the plan of care for Resident #201.

2. For Resident #210, facility staff failed to follow the plan of care and provide a dressing treatment to her left toe on 4/17/18.

The findings include:

Resident #201 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to: heart failure, irregular heart beat, dementia, anemia and seizures.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/11/18 coded the resident as having short and long term memory problems and was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

An observation of Resident #201 was made on 4/18/18 at 10:00 a.m. The resident was lying in bed. He did not have a shirt on and multiple scabbed and opened areas were noted on and in

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{F 656} Continued From page 11 {F 656}

his right armpit. The skin around the areas was very reddened. There were scabbed areas on the inner aspect of the elbow. The skin around the area was very reddened.

An observation of Resident #201 was made on 4/18/18 at 1:30 p.m. The resident was lying in bed. His skin was exposed as before. There were scabbed areas on the inner aspect of the elbow. The skin around the area was very reddened. There were no dressings on the open areas.

Review of the resident's care plan initiated on 3/30/18 documented, "Focus. (Name of resident) has impaired skin integrity of the right arm pit and chest...from autoimmune disease. Interventions. Administer treatments as ordered and monitor for effectiveness. There were no dressings on the open areas.

Review of the April 2018 physician's orders documented, "BETAMETHASONE DIPROPIONATE (1) 0.05% CREAM. APPLY TO AREAS AND COVER WITH DRY DRESSING EVERY DAY." The start date was documented as 6/5/17.

Review of the physician's order dated 3/29/18 documented, "Cleanse right armpit with soap + water pat dry apply bacitrican (sic) [1] and place AB pad (large soft gauze pad) until healed."

Further review of the physician's orders dated 4/9/18 documented, "Bactroban (2) to underarm (R) (right) side and crease of (R) arm daily. Stage 2 (3) wound."

Review of the April 2018 (TAR) treatment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 656} Continued From page 12

{F 656}

administration record and treatment administration record documented, "BETAMETHASONE DIPROPIONATE 0.05% CREAM. APPLY TO AREAS AND COVER WITH DRY DRESSING EVERY DAY." The start date was documented as 6/5/17. The nurses signed off that the treatment was completed.

Review of the April 2018 TAR documented, "Cleanse right armpit with soap + water pat dry apply bacitrican (sic) and place AB pad (large soft gauze pad) until healed." The nurses signed off that the treatment was completed. There was no evidence of documentation of the 4/9/18 physician order for the bactroban.

An interview was conducted on 4/18/18 at 4:00 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. When asked what treatment was administered to Resident #201's right armpit and elbow area, LPN #2 stated, "I put some cream on it. I'll show you." LPN #2 opened the treatment cart and took out a tube of betamethazone dirpriop (4). LPN #2 stated, "I put some of this on a gauze and put it on the areas." When asked if she put an AB pad under the arm, LPN #2 stated, "No. I just leave the gauze that I had the medication on there." When asked what size gauze he used, LPN #2 showed this writer a two inch by two inch gauze. When asked to review the treatment administration order for the right armpit wound care, LPN #2 stated, "Oh. I didn't follow that one. It is more specific than the one I used" When asked which order she should follow, LPN #2 stated, "The most recent order." When asked if she had followed the physician's order, LPN #2 stated she had not.

An interview was conducted on 4/18/18 at 4:15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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{F 656}	Continued From page 13	{F 656}		

p.m. with RN (registered nurse) #2, the MDS coordinator. When asked why residents had care plans, RN #2 stated, "Residents have care plans so we can tailor the care we provide for them." When asked who used the care plan, RN #2 stated, "All the staff." When asked if staff were expected to follow the care plan, RN #2 stated yes they should."

An interview was conducted on 4/18/18 at 4:30 p.m. with LPN #1. When asked why residents had care plans, LPN #1 stated, "To take care of the patient." When asked who used the care plan, LPN #1 stated, "All the staff." When asked when staff would not follow the care plan, LPN #2 stated, "If the order is changed." When asked if staff were expected to follow the care plan, LPN #1 stated they were.

On 4/18/18 at 5:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings at that time.'

Review of the facility's policy titied, "Plans of Care" documented, "Policy: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the residents and/or resident representatives(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Procedure: Develop and implement an individualized Person-Centered comprehensive plan of are by the Interdisciplinary Team...

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77

{F 656} Continued From page 14 {F 656}

documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1)

(1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77.

1. Bacitracin -- Prevents infections in minor cuts, burns or scrapes. This information was obtained from:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009198/?report=details

2. Bactroban -- Mupirocin is a topically used antibiotic from a strain of Pseudomonas fluorescens. It has shown excellent activity against gram-positive staphylococci and streptococci. The antibiotic is used primarily for the treatment of primary and secondary skin disorders, nasal infections, and wound healing. This information was obtained from:
https://pubchem.ncbi.nlm.nih.gov/compound/Mupirocin#section=Top

3. Stage 2 wound -- Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not

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	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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{F 656}	Continued From page 15 visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ 3. Betamehasone dipriop -- Betamethasone Dipropionate Cream (Augmented), 0.05% is a high-potency corticosteroid indicated for relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses in patients 13 years and older. This information was obained from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=26588834-b3c1-571f-e054-00144ff8d46c	{F 656}		
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.	F 657	**F657: Care Plan Timing and Revision** 1. Care plan updated on 4-18-18 to reflect the care needs of resident #209. 2. Quality review of current resident's care plans completed by the MDS Coordinator /DON/UM/designee to ensure	

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	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 657 Continued From page 16

(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 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, facility document review and clinical record review, it was determined the facility staff failed to review and revise the care plan for one of 16 residents in the survey sample, Resident #209.

The facility staff failed to review and revise Resident #209's care plan to reflect the physicians order to discontinue one on one care.

The findings include:

Resident #209 was admitted to the facility on 2/9/18 and readmitted on 3/29/18 with diagnoses that included but were not limited to: stroke, dementia, anxiety, high blood pressure and diabetes.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment

F 657

residents requiring 1:1 supervision are provided per the plan of care.
Quality review of current resident's care plans completed by the MDS Coordinator /DON/UM/designee to ensure residents Care Plans reflect current plan of care Follow up based on findings.

3. Licensed nurses re-educated by the DON/ MDS Coordinator /designee to ensure the care plan is followed regarding residents requiring 1:1 supervision. Licensed nurses re-educated by the DON/ MDS Coordinator /designee to ensure the care plan is accurate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ____ B. WING ____	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 657 Continued From page 17

reference date) of 3/23/18 coded the resident as having scored an eight on the brief interview for mental status indicating the resident was severely impaired cognitively. The resident needed assistance from staff for activities of daily living except for eating which the resident could perform after the tray was set up.

An observation of the resident was made on 4/18/18 at 1:45 p.m. Resident #209 was propelling herself in the wheelchair in the hallway.

Review of the care plan initiated on 3/28/18 and revised on 4/10/18 documented, "Focus. (Name of resident) exhibits inappropriate behaviors related to Disruptive behaviors. Intervention. Redirect inappropriate behaviors as needed and 1:1 (one to one) supervision."

Review of the 4/4/18 physician's orders documented, " D/C (discontinue) 1 on 1 supervision."

An interview was conducted with LPN #3, the resident's nurse. When asked if the resident was on one to one supervision, LPN #3 stated, "No."

An interview was conducted on 4/18/18 at 4:15 p.m. with RN (registered nurse) #2, the MDS coordinator. When asked who reviewed and revised the care plan, RN #2 stated, "The IDT (interdisciplinary team) and the nurses can do it." When asked how the MDS staff are made aware of changes in the resident's care and physician's orders, RN #2 stated, "Every day we update the care plan. A representative from our department goes to the morning clinical meeting and we would revise them (care plan) then." RN #2 was asked to review Resident #209's care plan for the

F 657

4. MDS Coordinator/DON/designee to conduct quality monitoring through Morning Clinical Meeting to ensure the care plan is accurate and followed regarding residents requiring 1:1 supervision 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance: 5-3-18.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 18	F 657		

one on one supervision. When asked if Resident #209 was on one to one supervision, RN #2 stated, "I would have to check." When informed the physician had discontinued the one to one supervision on 4/4/18, RN #2 stated, RN #2 stated, "I don't know how we missed that. We need to update it."

On 4/18/18 at 5:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

Review of the facility policy titled, "Plans of Care" documented, "Policy: An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the residents and/or resident representatives(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Procedure: Review, update and/or revise the comprehensive plan of care based on changing goals, preferences and needs of the resident and in response to current interventions...The interdisciplinary team shall ensure the plan of care addresses any resident needs and that the plan is oriented toward attaining or maintaining the highest practicable physical, mental and psychosocial well-being.

No further information was provided prior to exit.

Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates

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	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 657	Continued From page 19 nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."	F 657	**F658: Professional Standards** 1. Resident #201's clarification order for dressing change to right arm pit obtained 4/18/18. Resident #201's wound care to right arm pit completed per physician order 4/19/18. Resident #201 continues to receive dressing changes per physician orders. 2. Quality review of current resident's TARs completed by the DON/UM/designee to ensure wound care and treatments are completed per physician order without documentation omissions on the TAR. Follow up based on findings. 3. Licensed nurses re-educated by the DON/designee to ensure wound care is completed per physician order without documentation omissions on the TAR.	
{F 658} SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 16 residents in the survey sample, Resident #201. The facility staff failed to transcribe the 4/9/18 physician's order for Resident #201's wound care to the treatment administration record. The findings include: Resident #201 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to: heart failure, irregular heartbeat, dementia, anemia and seizures. The most recent MDS (minimum data set), a	{F 658}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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{F 658} Continued From page 20

quarterly assessment, with an ARD (assessment reference date) of 1/11/18 coded the resident as having short and long term memory problems and as severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living.

An observation of Resident #201 was made on 4/18/18 at 10:00 a.m. The resident was lying in bed. He did not have a shirt on and multiple scabbed and opened areas were noted on and in his right armpit. The skin around the areas was very reddened. There were scabbed areas on the inner aspect of the elbow. The skin around the area was very reddened.

An observation of Resident #201 was made on 4/18/18 at 1:30 p.m. The resident was lying in bed. His skin was exposed as before. There were scabbed areas on the inner aspect of the elbow. The skin around the area was very reddened. There were no dressings on the open areas.

Review of the resident's care plan initiated on 3/30/18 documented, "Focus. (Name of resident) has impaired skin integrity of the right arm pit (sic.) and chest...from autoimmune disease. Interventions. Administer treatments as ordered and monitor for effectiveness.

Further review of the physician's orders dated 4/9/18 documented, "Bactroban (1) to underarm (R) (right) side and crease of (R) arm daily. Stage 2 (2) wound."

Review of the April 2018 medication administration record and treatment administration record failed to evidence

{F 658}

4. DON/designee to conduct quality monitoring through Morning Clinical Meeting to ensure wound care and treatments are completed per physician order without omission on the TAR 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance: 5-3-18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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{F 658} Continued From page 21 {F 658}

documentation of the 4/9/18 physician order for the bactroban.

An interview was conducted on 4/19/18 at 8:20 a.m. with RN (registered nurse) #1, the unit manager and the nurse who wrote the verbal order. When asked to review the order and to review the treatment administration record, RN #1 stated, "It's not on there." When asked about the process staff follows when they received a physician order, RN #1 stated, "You get an order and you fax it to the pharmacy and flag it for the nurse to see it." When asked who would transcribe the order onto the treatment administration record, RN #1 stated, "The nurse who takes it off." When asked about 24 hour chart checks, RN #1 stated, "They should be looking for today's date and the day before to make sure nothing was missed."

On 4/19/18 at 8:35 a.m. ASM (administrative staff member) #3, the divisional education specialist was asked what professional standard the facility used. ASM #3 stated, "Potter and Perry and Lippincott."

On 4/19/18 at 8:45 a.m. ASM #2, the director of nursing was made aware of the findings.

Review of the facility's policy titled, "Physician's Orders" documented, "Procedure: ROUTINE ORDER: The order is transcribed to all appropriate areas (MAR [medication administration record], TAR [treatment administration record], etc) or electronic equivalent."

According to Fundamentals of Nursing, 6th edition, 2001: Patricia A. Potter and Anne Griffin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 658}	Continued From page 22	{F 658}		

Perry; Mosby, Inc., page 852, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order."
In Potter-Perry, Fundamentals of Nursing, 6th edition, page 841, a noted standard of practice is: "When medications are first ordered, the nurse compares the medication recording form or computer orders with the prescriber's written orders." On page 852, regarding the administration of oral medications, "Check accuracy and completeness of each MAR or computer printout with prescriber's written medication order."

No further information was provided prior to exit.

1. Bactroban -- Mupirocin is a topically used antibiotic from a strain of Pseudomonas fluorescens. It has shown excellent activity against gram-positive staphylococci and streptococci. The antibiotic is used primarily for the treatment of primary and secondary skin disorders, nasal infections, and wound healing. This information was obtained from: https://pubchem.ncbi.nlm.nih.gov/compound/Mupirocin#section=Top

2. Stage 2 wound -- Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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{F 658}	Continued From page 23 adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/	{F 658}	**F684: Quality of Care** 1. Resident #201's clarification order for dressing change to right arm pit obtained 4/18/18. Resident #201's wound care and dressing changes to right arm pit completed per physician order 4/19/18. Resident #206 clarification order for skin test (PPD) obtained on 4-18-18. Resident #206 skin test (PPD) administered per physician order on 4-18-18. Resident #210 wound care and dressing changes to left toe (arterial wound) completed 4/18/18 per physician order. Resident #210 continues to receive wound care and dressing changes per physician orders.	
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review it was determined the facility staff failed to ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, for three of 16 residents in the survey sample, Resident's #201, #206 and #210. 1. The facility staff failed to follow the physician's	{F 684}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	**906 THOMPSON STREET ASHLAND, VA 23005**

(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 684}	Continued From page 24 order for wound care for Resident #201. 2. The facility staff failed to follow the physician's order for administering a skin test for Resident #206. 3. The facility staff failed to follow physician's orders and provide a daily treatment to Resident #210's arterial wound on 4/17/18. The findings include: 1. Resident #201 was admitted to the facility on 8/12/15 with diagnoses that included but were not limited to: heart failure, irregular heartbeat, dementia, anemia and seizures. The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/11/18 coded the resident as having short and long term memory problems and was severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily living. An observation of Resident #201 was made on 4/18/18 at 10:00 a.m. The resident was lying in bed. He did not have a shirt on and multiple scabbed and opened areas were noted on and in his right armpit. The skin around the areas was very reddened. There were scabbed areas on the inner aspect of the elbow. The skin around the area was very reddened. There wre no dressing on the open areas. An observation of Resident #201 was made on 4/18/18 at 1:30 p.m. The resident was lying in bed. His skin was exposed as before. There were scabbed areas on the inner aspect of the	{F 684}	2. Quality review of current resident's TAR completed by the DON/UM/designee to ensure wound care is completed per physician order without documentation omissions. Follow up based on findings. Quality review of current resident's TAR completed by the DON/UM/designee to ensure treatments are completed per physician order without documentation omissions. Follow up based on findings. Quality review of current resident's Medication Administration Orders (MARs) regarding residents requiring a skin test (PPD) completed by the DON/UM/designee to ensure skin tests (PPDs) are completed per physician order without omission. Follow up based on findings. Quality review of current resident's MAR's completed by the DON/UM/designee to ensure medications are administered per physician order without omission. Follow up based on findings.	

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	495362	A. BUILDING ______ B. WING ______	R-C 04/19/2018

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{F 684} Continued From page 25

elbow. The skin around the area was very reddened. There were no dressings on the open areas.

Review of the resident's care plan initiated on 3/30/18 documented, "Focus. (Name of resident) has impaired skin integrity of the right arm pit (sic.) and chest...from autoimmune disease. Interventions. Administer treatments as ordered and monitor for effectiveness.

Review of the April 2018 physician's orders documented, "BETAMETHASONE DIPROPIONATE (1) 0.05% CREAM. APPLY TO AREAS AND COVER WITH DRY DRESSING EVERY DAY." The start date was documented as 6/5/17.

Review of the physician's order dated 3/29/18 documented, "Cleanse right armpit with soap + water pat dry apply bacitrican (sic) [2] and place AB (abdominal) pad (large soft gauze pad) until healed."

Further review of the physician's orders dated 4/9/18 documented, "Bactroban (3) to underarm (R) (right) side and crease of (R) arm daily. Stage 2 (4) wound."

Review of the April 2018 (TAR) treatment administration record and treatment administration record documented, "BETAMETHASONE DIPROPIONATE 0.05% CREAM. APPLY TO AREAS AND COVER WITH DRY DRESSING EVERY DAY." The start date was documented as 6/5/17. The nurses signed off that the treatment was completed.

Further review of the April 2018 documented,

{F 684}

3. Licensed nurses re-educated by the DON/designee to ensure wound care is completed per physician order without documentation omissions on the TAR.

Licensed nurses re-educated by the DON/designee to ensure skin tests (PPDs) are completed per physician order without documentation omissions on the MAR.

Licensed nurses re-educated by the DON/designee to ensure treatments are completed per physician order without documentation omissions on the TAR.

Licensed nurses re-educated by the DON/designee to ensure medications are administered per physician order without documentation omissions on the MAR.

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{F 684} Continued From page 26
"Cleanse right armpit with soap + water pat dry apply bacitrican (sic) and place AB pad (large soft gauze pad) until healed." The start date was 3/29/18. The nurses signed off that the treatment was completed.

There was no documented evidence of the 4/9/18 physician order for the bactroban on Resident #201's April 2018, TAR.

An interview was conducted on 4/18/18 at 4:00 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. When asked what treatment was administered to Resident #201's right armpit and elbow area, LPN #2 stated, "I put some cream on it. I'll show you." LPN #2 opened the treatment cart and took out a tube of betamethazone dirpriop. LPN #2 stated, "I put some of this on a gauze and put it on the areas." When asked if she put an AB pad under the arm, LPN #2 stated, "No. I just leave the gauze that I had the medication on there." When asked what size gauze she used, LPN #2 showed this writer a two inch by two-inch gauze. When asked to review the treatment administration order for the right armpit wound care, LPN #2 stated, "Oh. I didn't follow that one. It is more specific than the one I used." When asked which order she should follow, LPN #2 stated, "The most recent order." When asked if she had followed the physician's order, LPN #2 stated she had not.

On 4/18/18 at 5:00 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings at that time.

Review of the facility's policy titled, "Physician Orders" did not specifically address following the

{F 684}

4. DON/designee to conduct quality monitoring through Morning Clinical Meeting to ensure wound care is completed per physician order without documentation omissions on the TAR 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. DON/designee to conduct quality monitoring through Morning Clinical Meeting to ensure treatments are completed per physician order without documentation omissions on the TAR 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. DON/designee to conduct quality monitoring through Morning Clinical Meeting to ensure residents requiring a skin test (PPD) are completed per physician order without documentation omissions on the TAR 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated. DON/designee to conduct quality monitoring through Morning Clinical Meeting to ensure residents medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 684} Continued From page 27
physician's order.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

No further information was provided prior to exit.

1. BETAMETHASONE dirpriop -- Betamethasone Dipropionate Cream (Augmented), 0.05% is a high-potency corticosteroid indicated for relief of the inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses in patients 13 years and older. This information was obtained from:
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=26588834-b3c1-571f-e054-00144ff8d46c

2. Bacitracin -- Prevents infections in minor cuts, burns or scrapes. This information was obtained from:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0009198/?report=details

3. Bactroban -- Mupirocin is a topically used antibiotic from a strain of Pseudomonas fluorescens. It has shown excellent activity against gram-positive staphylococci and streptococci. The antibiotic is used primarily for the treatment of primary and secondary skin disorders, nasal infections, and wound healing. This information was obtained from:
https://pubchem.ncbi.nlm.nih.gov/compound/Mupirocin#section=Top

{F 684}

are administered per physician order without documentation omissions on the MAR 5 times weekly x 2 weeks, 3x weekly x 4 weeks, then 2 x weekly and PRN as indicated.
Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.

5. Date of Compliance: 5-3-18.

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{F 684} Continued From page 28 {F 684}

4. Stage 2 wound -- Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). This information was obtained from: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/

2. The facility staff failed to follow the physician's order for administering PPD skin test (purified protein derivative (1)) a skin test for Resident #206.

Resident #206 was admitted to the facility on 2/2/18 and readmitted on 2/26/18 with diagnoses that included but were not limited to: irregular heartbeat, diabetes and high blood pressure.

The most recent MDS (minimum data set), an admission assessment, with an ARD (assessment reference date) of 2/13/18 coded the resident as being severely impaired cognitively. The resident was coded as requiring assistance from staff for all activities of daily

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{F 684}	Continued From page 29 living.	{F 684}		

Review of the physician's orders dated 4/16/18 documented, "PPD [1], read in 72 hours and repeat in 7 days."

Review of the April 2018 MAR (medication administration record) documented, "PPD." A box was drawn around the date of 4/16/18 indicating the PPD was to be administered on that date. There was no evidence that the PPD had been done as ordered.

An interview was conducted on 418/18 at 4:00 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. When asked what the empty box on the MAR meant, LPN #2 stated, "It wasn't done." Let me go check his arms (for evidence that the PPD had been implanted). LPN #2 and this writer went into Resident #206's room and checked his arms. LPN #2 stated, "No, there's nothing there. I'll have to get a clarification order." When asked if it should have been administered on 4/16/18, LPN #2 stated yes.

An interview was conducted on 4/18/18 at 4:10 p.m. with RN (registered nurse) #2, the unit manager and the nurse who wrote the order. When asked when the PPD should have been administered, RN #2 stated, "That order was taken in the morning. It could have been given anytime." When asked when a PPD would not be administered, RN #2 stated, "We always have it on hand."

On 4/18/18 at 5:00 p.m. ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

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{F 684} Continued From page 30
{F 684}

No further information was provided prior to exit.

1. PPD -- TUBERSOL, Tuberculin Purified Protein Derivative (Mantoux), is indicated to aid diagnosis of tuberculosis infection (TB) in persons at increased risk of developing active disease. This information was obtained from https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=a4a732e9-b8ee-4e6d-8b9a-6a9d2c36bfcd
3. The facility staff failed to follow physician's orders and provide a daily treatment to Resident #210's arterial wound on 4/17/18.

Resident #210 was admitted to the facility on 10/3/16 with diagnoses that included but were not limited to chronic kidney disease, high blood pressure, psychotic disorder with hallucinations, type two diabetes mellitus, and peripheral nervous system disorder. Resident #210's most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/17/18. Resident #210 was coded as being cognitively intact in the ability to make daily decisions scoring 14 out of 15 on the BIMS (Brief Interview for Mental Status) exam. Resident #210 was coded as as requiring extensive assistance from one to two staff members with most ADLS (activities of daily living).

Review of Resident #210's wound care note dated 4/16/18 documented the following: "Arterial Wound (1) of the left, second toe- initial evaluation...Primary dressing (s): Santyl (2) apply once daily for 30 days. Secondary dressing: Dry protective dressing apply once daily for 30 days. Factors complicating wound healing: Polyneuropathy in diabetes, diabetes mellitus -type two."

{F 684} Continued From page 31 {F 684}

Review of Resident #210's clinical record revealed the following order dated 4/16/18: "apply santyl once daily for 30 days to the left second toe. Indication: arterial wound of the left second toe."

Review of Resident #210's April 2018 TAR (treatment administration record) revealed a hole; missing signature on 4/17/18, indicating that that dressing was not completed that day on 7-3 shift.

Review of Resident #210's care plan dated 10/26/17 and revised on 4/16/18 documented in part, the following: "4/5/18 non pressure area on left second toe...interventions: Administer treatments as ordered and monitor effectiveness."

On 4/18/18 at 3:35 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if he could show this writer Resident #210's dressing to her foot. Resident #210's dressing to her left foot documented the following date "4/16/18." Resident #210 stated, "That hasn't been changed since the doctor saw it." When asked if LPN #1 had worked the 7-3 shift on 4/17/18, LPN #1 stated that he did. When asked who was responsible for changing dressings, LPN #1 stated that the nurse assigned to the resident that shift was responsible. When asked why he did not change Resident #210's dressing on 4/17/18, LPN #1 stated he was probably behind on his shift. LPN #1 stated yesterday was his first day on the unit.

On 4/18/18 at 4:35 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) were made aware of

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{F 684} Continued From page 32
the above concerns.

{F 684}

The facility policy titled, "Physician Orders," did not address the above concerns. No further information was presented prior to exit.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients. Therefore all orders must be assessed if one is found to be erroneous or harmful further clarification from the physician is necessary"

(1) Arterial Wounds (ulcers) occur because of inadequate perfusion of skin and subcutaneous tissue at rest. Arterial occlusive disease, common among smokers, diabetics and the elderly, can lead to claudication, rest pain and gangrene, in addition to localized ulceration. This information was obtained from The National Institutes of Health.
https://www.ncbi.nlm.nih.gov/pubmed/8716033.

(2) SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. This information was obtained from: (<http://www.santyl.com/about>)

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COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

April 26, 2018

Ms. Elizabeth Price, Administrator
Ashland Nursing And Rehabilitation
906 Thompson Street
Ashland, VA 23005

RE: Ashland Nursing And Rehabilitation
Provider Number 495362

Dear Ms. Price:

Based on deficiencies cited during the survey ending January 16, 2018, your facility was found not to be in compliance with Federal participation requirements for the long term care Medicare and/or Medicaid programs. On April 19, 2018, surveyors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced second revisit to verify that your facility had achieved and maintained compliance for deficiencies cited during the previous survey. No complaints were investigated during the survey.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The survey findings are reflected on the enclosed Statement of Isolated Deficiencies ("A" Form) and/or the Statement of Deficiencies and Plan of Correction (CMS-2567) and/or the Post-Certification Revisit Report (CMS-2567).

All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g) of the Federal requirements, the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

We had presumed, based on your allegation of compliance, that your facility was in substantial compliance. The April 19, 2018, revisit established the facility continues noncompliance with program requirements, including an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of D), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Wietske G. Weigel-Delano, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Officer's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.state.va.us/OLC/longtermcare/ To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings. **An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

In regards to previously listed potential remedies, by copy of this letter we are notifying the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (DMAS) that this revisit found your facility was not in in substantial compliance with the participation requirements.

Recommended Remedies

The results of the January 16, 2018 survey were forwarded to you under the January 30, 2018, initial letter. At that time, we indicated several remedies could be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (Virginia Department of Medical Assistance Services) if compliance was not achieved. We are, by copy of this letter, notifying the CMS Regional Office and Virginia DMAS that the facility had not achieved compliance with program requirements at the time of the second April 19, 2018, revisit. Those agencies will notify you about any remedy they intend to impose.

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf We will appreciate your participation.

If you have any questions concerning the content of this letter, please contact me at 804/367-2100.

Sincerely,

Wietske G. Weigel-Delano, LTC Supervisor
Division of Long Term Care Services

Enclosures

cc: Roxanne Rocco, Centers For Medicare & Medicaid Services
Joani Latimer, State Ombudsman
Bertha Ventura, Dmas (Sent Electronically)