State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0019	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 03/13/2018 through 03/15/2018. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated. The census in this 109 bed facility was 95 at the time of the survey. The survey sample consisted of 19 current Resident reviews and two (2) closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.	F 001		
	12VAC5-371-160 (C)(3). Please cross reference to F-568.		Please refer to F-568 Plan of Correction	4/20/18
	12VAC5-371-250 (A). Please cross reference to F-656		Please refer to F-656 Plan of Correction	4/20/18
	12VAC5-371-300 (B). Please cross reference to F-658.		Please refer to F-658 Plan of Correction	4/20/18
	12VAC5-371-220 (B). Please cross reference to F-684.		Please refer to F-684 Plan of Correction	4/20/18
	12VAC5-371-220 (C)(1) and (3). Please cross reference to F-686.		Please refer to F-686 Plan of Correction	4/20/18
	12VAC5-371-290 (C). Please cross reference to F-688.		Please refer to F-688 Plan of Correction	4/20/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jean Queen — TITLE: Executive Director — (X6) DATE: 4/5/18

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0019	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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) COMPLETE DATE
F 001	Continued From page 1 12VAC5-371-180 (C)(3). Please cross reference to F-880.	F 001	Please refer to F-880 Plan of Correction	4/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 An unannounced Medicare/Medicaid standard survey was conducted 3/13/18 through 3/15/18. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/13/2018 through 03/15/2018. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow. The census in this 109 certified bed facility was 95 at the time of the survey. The survey sample consisted of 19 current Resident reviews and two (2) closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	**1)** Resident #83 had a drainage bag for catheter placed in privacy bag immediately after finding it was not in a privacy bag. **2)** 100% audit was completed by the clinical interdisciplinary team on all residents who have catheters to ensure that all catheter drainage bags have privacy covers in place. **3)** Director of Nursing and/ or designee provided in-service training to current clinical employees on Residents Rights with emphasis on ensuring all residents with catheters have privacy covers for drainage bags to promote and maintain dignity.	4/20/18

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

Jeeh Queen | Executive Director | 4/5/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to ensure a privacy bag was in place on a catheter for one of 21 residents in the survey sample: Resident # 83. Resident # 83 was observed walking around the facility with a catheter bag uncovered and urine visible to staff, visitors, and other residents. Findings include: Resident # 83 was admitted to the facility 5/1/17 with diagnoses to include, but not limited to: high	F 550	**4)** Interdisciplinary team members will complete weekly audits of all residents who have catheters for 6 weeks to ensure privacy covers are in place, then randomly thereafter. The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 550	Continued From page 2 blood pressure, history of stroke, and flaccid neuropathic bladder. The most recent MDS (minimum data set) was an annual review dated 2/14/18 and had Resident # 83 with severe impairment in cognition with a total summary score of 03 out of 15. During the initial tour of the facility 3/13/18 beginning at 11:00 a.m. Resident # 83 was observed without a privacy cover on the catheter bag. Resident # 83 was observed in his wheelchair with the catheter bag displayed hanging on the side of the wheelchair. On 3/14/18 at 10:45 a.m. Resident # 83 was observed in therapy on a reclining bicycle. The resident's catheter bag was hung on the bicycle visible from the hallway; there was no privacy cover on the bag, and a moderate amount of urine was easily seen by passersby of the therapy gym door. On 3/14/18 at 11:00 a.m. LPN (licensed practical nurse) # 2 was asked about the resident's catheter bag and why there was no privacy cover for it. LPN # 2 stated "Yes, it has a cover; it's a blue flap that folds down on one side." This surveyor and LPN # 2 then examined an example of the blue flap she was describing, and it was noted Resident # 83 did not have that particular type of catheter bag. At that time, the unit manager, RN (registered nurse) # 1 came up the hallway hearing the discussion of the catheter bag and stated "I am having the CNA (certified nursing assistant) put a privacy cover on the bag now. [Name of resident] must have had it changed out at the hospital or at a doctor appointment because what he has is not one of	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 550	Continued From page 3 ours." RN # 1 was asked if it was known how long ago the catheter had been changed. RN # 1 stated she would find out and get back with me. On 3/14/18 at 11:30 a.m. RN # 1 informed this surveyor "[Name of resident] had it changed on 3/12/18." On 3/14/18 during a meeting with facility staff beginning at 3:45 p.m. the administrator and DON (director of nursing) were informed of the above findings. No further information was provided prior to the exit conference.	F 550		
F 568 SS=E	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, the facility staff failed to provide statements of a personal fund account for one of 21 residents in the survey sample. Resident #55 did not receive quarterly statements	F 568	**1)** Resident # 55 was provided a financial statement regarding their resident account with the facility. **2)** The Business Office Manager completed a 100% audit of all residents who have a Resident Account with the facility to ensure a financial statement is received quarterly to the resident or the designed responsible party. **3)** Administrator provided in-service training to the Business Office Manager and Receptionist regarding when quarterly financial statements are to be provided to the resident and/ or designed responsible party. Quarterly statements will be given in the following months: January, April, July, and October.	4/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 568	Continued From page 4 from the facility regarding her personal fund account managed by the facility. The findings include: Resident #55 was admitted to the facility on 4/3/15 with a re-admission on 12/22/15. Diagnoses for Resident #55 included depression, diabetes, anxiety and high blood pressure. The minimum data set (MDS) dated 1/26/18 assessed Resident #55 as cognitively intact. On 3/14/18 at 9:45 a.m., Resident #55 was interviewed about quality of life in the facility. Resident #55 stated during this interview that the facility managed a personal money account for her. Resident #55 stated she had never received statements regarding her account since she had been in the facility. Resident #55 stated she asked "every so often" about her account balance but she did not receive written statements of her account. Resident #55 stated she had to ask in order to know how much money was in her account. On 3/14/18 at 10:11 a.m., the administrator and business office manager were interviewed about statements regarding Resident #55's account. The administrator stated since the facility was the representative payee for incoming money, the resident did not receive a statement regarding her personal funds. The business office manager stated statements were printed each quarter but were not given to the resident. These findings were reviewed with the administrator and director of nursing during a meeting on 3/14/18 at 3:45 p.m.	F 568	**4)** Business office Manager and/or designee will do on-going monitoring through resident interviews and an extra copy of the statement will be placed in the residents charts located in the Business Office. The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 5	F 656		
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 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	F 656	**1)** Care plan on resident #63 was reviewed and updated to reflect current smoking status. **2)** 100% audit of all current residents who smoke was conducted by MDS Coordinators to ensure current care plan accuracy. No other issues identified. **3)** Director of Nursing and/ or designee provided in-service training to MDS coordinators and interdisciplinary team regarding accurate assessments and revisions of care plans. **4)** Interdisciplinary team members will complete weekly care plan audits for all residents who smoke and will continue weekly for 6 weeks to ensure care plans remain accurate then randomly thereafter. The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	4/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 6 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 clinical record review and staff interview the facility staff failed to develop a comprehensive care plan (CCP) to address safe smoking for one of 21 residents in the survey sample: Resident # 63. Findings include: Resident # 63 was admitted to the facility 1/9/17 with diagnoses to include, but were not limited to: adult failure to thrive, diabetes, legal blindness, GERD, depression, and high blood pressure. The most recent MDS (minimum data set) was an annual review dated 1/29/18. Resident # 63 was coded as being cognitively intact with a total summary score of 15 out of 15. The clinical record was reviewed 3/15/18 at 8:00 a.m. Resident # 63 was noted to have had a smoking assessment upon admission to the facility, and quarterly reassessments. The assessments documented that the resident had poor safety awareness, low vision, and required a smoking apron and supervision to safely smoke. The care plan was then reviewed, and revealed no care plan for smoking. On 3/15/18 at 10:04 a.m. RN (registered nurse) # 2, who was an MDS coordinator, was interviewed about the care plan. RN # 2 stated "Yes, he should have a care plan for smoking; he isn't on	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 7 my side of the building anymore, he moved." RN # 2 was then asked if the resident was previously on her side of the building, and since the resident was identified as a smoker on admission, would she have been the staff member to develop the care plan. RN # 2 stated "Well, yes, you're right.....the care plan should have been done at the time of admission. I'm checking on it not because I don't believe you, but because I can't believe I didn't do one!" RN # 2 reviewed the care plan and stated "I don't see one, I'm sorry; there should be one." On 3/14/18 during a meeting with facility staff beginning at 3:45 p.m. the administrator and DON (director of nursing) were informed of the above findings. No further information was provided prior to the exit conference.	F 656		
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 observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of care during medication administration pass for one of 21 residents in the survey sample. A nurse left medications at the bedside and failed to observe Resident #49 consume oral medications during a medication pass observation.	F 658	**1)** The charge nurse was provided one on one education regarding the appropriate process for medication administration with emphasis on facilities policy regarding resident's self-administration of medications. **2)** No current residents have requested to self-administer medications. **3)** Director of Nursing and/ or designee provided in-service training to licensed nurse staff on proper medication administration to residents and the 8 rules of medication pass.	4/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 8 The findings include: Resident #49 was admitted to the facility on 11/07/2016 with the following diagnoses, that included diabetes, anemia, hyperlipidemia, hypertension, GERD (gastro-esophageal reflux disease), and Parkinson's Disease. The minimum data set (MDS) dated 01/18/2018 assessed Resident #49 as cognitively intact. A medication pass observation was conducted on 03/14/2018 at 7:50 a.m. with licensed practical nurse (LPN #3) administering medications to Resident #49. During the observation, LPN #3 administered six medications in tablet form to Resident #49. LPN #3 placed the medication on the over the bed table and left the room without observing Resident #49 consume the medication. The clinical record review included the following medications left at the bedside: 1. Ferrous Gluconate Tablet (27 Fe) MG - Give 1 tablet by mouth two times a day for supplement. 2. Hydrochlorothiazide Tablet 25 MG - Give 1 tablet by mouth one time per day for Hypertension. 3. Metoprolol Tartrate Tablet 25 MG - Give 1 tablet by mouth one time per day for Hypertension. 4. Norvasc Tablet 10 MG (Amlodipine Besylate) - Give 1 tablet by mouth one time per day for HTN (Hypertension). 5. Omeprazole Capsule Delayed Release 20 MG - Give 1 capsule by mouth one time per day for GERD (gastro-esophageal reflux disease). 6. Sinemet Tablet 25-100 MG (Carbidopa-Levodopa) - Give 1 tablet by mouth	F 658	4) Interdisciplinary team members will complete Medication administration observations two time per week for 6 week and as needed thereafter by Director of Nursing/Unit Managers/ and/or designee to ensure facility remains in compliance with state regulations. The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 9 three times a day for Parkinson's. On 3/14/2018 at 8:34 a.m., LPN #3 was interviewed about medication administration to Resident #49. LPN #3 acknowledged she left the medications on the over the bed table and left the room. LPN #3 stated she watched the resident from the door and she knew Resident #49. LPN #3 was asked if Resident #49 had been assessed to self-administer her own medications. LPN #3 stated, "I have always been under the impression if they are with their right mind; they are able to administer the meds themselves. I usually will go back to make sure they take them. I never leave meds with anyone I think is not in their right mind." On 3/14/18 at 2:50 p.m., the director of nursing (DON) was interviewed about the medication administration to Resident #49. The DON stated it is not the facility's expectation to leave the medication on the tray table nor to leave the resident in the room with the medication on the over the bed table. The DON stated Resident #49 had not be assessed to self-administer her medication. The facility's policy titled "6.0 General Dose Preparation and Medication Administration" (revised on 01/01/13) on page two, states "during medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: observe the resident's consumption of the medication(s)." These findings were reviewed with the administrator and director of nursing during a meeting on 3/14/2018 at 3:38 p.m.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 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 and clinical record review, the facility staff failed to follow physician order for one of 21 residents, Resident #7. Resident #7 was not wearing physician ordered TED hose. Findings were: Resident #7 was originally admitted to the facility on 08/09/2016. His diagnoses included but were not limited to: Fracture of right femur, cognitive communication deficit, anxiety chronic obstructive pulmonary disease, seizures, peripheral vascular disease and moderate intellectual disabilities. The most recent MDS, a quarterly assessment with a reference date of 12/27/2017 assessed Resident #7 as moderately impaired in his cognitive status, with a cognitive summary score of "08". The clinical record was reviewed on 03/13/2018. The POS (physician order sheet) contained the following order: "TED hose ON in AM and OFF in	F 684	**1)** Physician order for resident #7 was reviewed and clarified to include the resident to wear tubigrip instead of the ted hose. **2)** 100% audit was completed on all residents with compression stocking's to ensure the correct order is listed. No other issues identified. **3)** Director of Nursing and/ or designee provided in-service training to licensed nurses regarding the process of updating existing orders to reflect changes made per MD request for resident care. **4)** The DON or designee will review all future admissions with residents who have compression stocking orders to assure compliance. Clinical team will continue to monitor residents with compression stocking orders weekly for 6 weeks and then randomly thereafter. The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	4/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 11 the PM every day and evening shift for circulation". The start date for the order was 12/28/2016. On 03/14/2018 this surveyor accompanied LPN (licensed practical nurse) #4 to Resident #7's room to observe a dressing change to a vascular wound on his left shin. Resident #7 was not wearing physician ordered TED hose." LPN #4 was asked about the TED hose. She stated, "He is wearing Tubigrips...that's what the wound clinic ordered...they're the same thing." During a meeting with the DON and the administrator on 03/14/2018 the TED hose for Resident #7 were discussed. The administrator presented documentation from the wound clinic dated 01/03/2018. "Additional orders" listed on the report included: "Tubigrip instructions: Your tubigrip stockings should be in place from just behind your toes to just under the bend of your knee...wear the tubigrip from the time you get up in the morning until you go to bed at night..." The DON was asked which should be in use the TED hose which were ordered on the POS or the Tubigrips that were discussed on the wound clinic note. She stated, "The order on the clinical record is for the TED hose...it was never changed...he should have the TED hose on." No further information was obtained prior to the exit on 03/15/2018.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F 686	1) The skin assessment schedule for resident #20 was reviewed and the order updated to reflect the correct schedule. Resident # 20 stage 4 pressure ulcer was healed on 3/19/18.	4/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 12 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide treatment and services for the prevention of pressure ulcers for one of 21 residents, Resident #20 (resulting in harm); and failed, to follow infection control practices during a dressing change to a pressure ulcer for one of 21 residents, Resident #79. 1. Resident #20 did not have a skin assessment completed for 10 days. When the assessment was completed, Resident #20 had an unstageable (due to necrosis) pressure ulcer behind his right ear from his nasal cannula. The area was debrided by the wound doctor and assessed as a Stage 4 pressure ulcer (HARM). 2. A nurse failed to perform hand hygiene during a dressing change to Resident #79's pressure sores. Findings were: 1. Resident #20 did not have a skin assessment completed for 10 days. When the assessment was completed, Resident #20 had an	F 686	**1)** The skin assessment schedule for resident #20 was reviewed and the order updated to reflect the correct schedule. Resident # 20 stage 4 pressure ulcer was healed on 3/19/18. The charge nurse was provided one on one education regarding proper hand hygiene during wound dressing changes. **2)** 100% audit was completed on current residents to ensure skin assessment order reflected the skin assessment schedule. No other issues noted/ observed regarding employee hand hygiene. **3)** Director of Nursing and/ or designee provided in-service training to current licensed nurses regarding resident skin assessment process and notification of concerns regarding changes to be made. Director of Nursing and/ or designee provided in-service training to current staff on proper hand hygiene and sanitation **4)** The DON and/or designee will review the resident skin assessments during clinical meeting to ensure completion of scheduled assessment. Clinical team will continue to monitor resident's skin assessment weekly for 6 weeks and then randomly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 13 unstageable (due to necrosis) pressure ulcer behind his right ear from his nasal cannula. The area was debrided by the wound doctor and assessed as a Stage 4 pressure ulcer (HARM). Resident # 20 was admitted to the facility on 11/16/2017. His diagnoses included but not limited to: Sepsis with septic shock, acute kidney failure, respiratory failure, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting his right side, dysphagia, and dementia. A significant change MDS (minimum data set) with an ARD (assessment reference date) of 12/21/2017, assessed Resident #20 as being severely impaired in his cognitive status with a cognitive summary score of "03". The skin assessment section of the MDS contained information that Resident #20 was at risk fir skin breakdown, but there was none present at the time of the assessment. Resident #20 was observed during initial tour of the facility on 03/13/2018 at approximately 11:30 a.m. Resident #20 was sitting up in his bed waiting on his lunch tray. A Band-Aid was noted on his right ear. He was asked why the Band-Aid was on his ear. He stated, "I don't know." Resident #20 was wearing a nasal cannula, the tubing around his ear was padded. The clinical record was reviewed on 03/13/2018 at approximately 1:30 p.m. The progress note section contained the following entries: "02/25/2018 15:27 (3:27 p.m.) RN [registered nurse] was notified by CNA [certified nursing assistant] that resident had a pressure injury on	F 686	Hand hygiene observations will be completed twice weekly for 6 week and as needed thereafter by Director of Nursing/Unit Managers/ and/or designee to ensure facility remains in compliance with state regulations. The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 14	F 686		

the upper part of his right ear from the oxygen tubing. Tubing was removed and area was cleansed with normal saline and TAO [triple antibiotic ointment] was applied. RN wrapped foam around both sides to [sic] tubing to provide more cushioning for tubing. U/O [unusual occurrence] completed and placed in manager's box.

02/26/2018 12:28 [p.m.] A skin observation was completed on [name of Resident #20] ...new area identified and will be referred to nursing for intervention. DON/UM [unit manager]/Wound Nurse will be notified for f/u as applicable. Family/RP [Responsible Party] made aware. New area referred to wound nurse/DON/UM for f/u [follow-up]..

02/26/2018 12:46 [p.m.] Notified daughter...regarding wound to right ear from nasal cannula. Drsg intact with wound nurse/MD aware. Oxygen to be weaned of possible. Hospice to be made aware...

02/26/2018 22:09 (10:09 p.m.) ...Assessment: Resident was seen by Wound MD and Nurse today. Unstageable (due to necrosis) of the Right Posterior Ear was seen [sic]. Measurements were 0.7 X 0.7 X 0.1. There was light serous drainage present. 35 % thick yellow necrotic tissue present and 65 % granulation tissue present. Area was surgically debrided today. Resident tolerated procedure wall. Orders for a Hydrocolloid 3 times a week was given. Continue with supplements as ordered. MD, Hospice and RP [responsible party] were notified of the above information.

03/05/2018 14:52 [2:52 p.m.] Resident was seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 15	F 686		

by the wound MD and nurse today. Stage 4 pressure wound of the right posterior ear was seen. Measurements were 0.7 X 0.8 X 0.1. There was light serous drainage present. 30 % thick yellow necrotic tissue present and 70% granulation tissue. Area was surgically debrided today and resident tolerated procedure well. Orders for medihoney and a dry protective dressing QD [every day] was given. Wound has improved since last visit...

03/12/2018 18:52 [6:52 p.m.] Resident was seen by the wound MD and Nurse today. Stage 4 pressure wound of the right posterior ear was seen. Measurements were 9.5 X 0.4 X 0.1 [see corrected measurement note dated 03/14/2018] . There was light serous drainage present. 15 % thick yellow necrotic tissue present. 85% granulation. Area was surgically debrided today. Resident tolerated procedure well. Orders for Medihoney and a dry protective dressing QD times 30 days was given. Wound has improved since last visit...

03/13/2018 08:28 [a.m.] A skin observation was completed...sore behind ears from oxygen tubing resolving...

The POS (Physician Order Sheet) was reviewed. The following order was observed: "11/27/2017 Weekly Skin Observations every Tuesday 7-3 one time a day every Tue schedule weekly skin observations for Nurses to complete every Tuesday on 7-3". Also contained on the POS were the following orders: DNR (12/01/2017), Hospice (12/07/2017) and Oxygen continuous at 2 liters (12/19/2017)

The Weekly Skin Observation sheets were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 16	F 686		

reviewed for February and March 2018. A skin sheet was completed on 02/03/2018 (no new areas), 02/09/2018 (no new areas), 02/16/2018 (no new areas), 02/26/2018 (New area right ear), 03/06/2018 (no new areas), 03/09/2018 (no new areas), 03/13/2018 (no new areas). There was a gap between assessments of ten days from 02/16/2018 until 02/26/2018, when the pressure area behind Resident #20's ear was noted.

The TAR (treatment administration record) was reviewed for February and March. Skin assessments were checked off as completed on 02/06/2018, 02/13/2018, 02/20/2018, 02/27/2018, 03/06/2018 and 03/13/2018. The dates on the TAR did not match the nursing documentation dates in the clinical record or on the weekly skin observation sheets.

The care plan contained the following interventions for the focus area "Skin integrity": Notify nurse of change in skin integrity (revised 8/4/2017), Skin assessments as scheduled, notify MD of changes as indicated (revised 8/4/2017), Refer to wound MD and wound nurse (added 02/26/2018)

At approximately 10:40 a.m., this surveyor accompanied the wound nurse, LPN (Licensed Practical Nurse) #4 to Resident #20's room to observe the dressing change to his right ear. Prior to entering the resident's room, LPN #4 was asked how the pressure area had formed. She stated, from the O2 tubing. LPN #4 was asked about the most recent measurement on the clinical record (03/12/2018) which documented an increase in wound length from 0.7 cm to 9.5 cm. She stated, "I don't think that's correct...I may have entered that incorrectly. I will go back and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 17	F 686		

check it." The dressing change was observed and completed by LPN #4 per physician's orders. The area was pink without drainage. LPN #4 stated that the area was much improved. She stated, she and the wound doctor had done the dressing together on Monday and predicted the area would likely be healed by the coming Monday.

On 3/14/2018 at approximately 11:30 a.m., the pressure ulcer on Resident #20's right ear was discussed with the DON and administrator. The DON was asked about the dates of weekly skin observations on the TAR vs the dates of the weekly skin observation sheets. The DON stated, "The dates on the skin observation sheets are correct and when the assessments were done...the dates should coincide with the dates on the TAR....he moved from one area of the facility to the other...the room he was in had skin assessments done on Tuesday. We moved him in December after his wife passed away. The side that he's on now has skin assessments done on Friday...no one ever changed the assessment day on the order." The DON was asked why nurses where signing off that assessments were completed on dates they were not. She stated, "I don't know." The DON was asked if the 10 days between 02/16 and 02/26/18 was acceptable for weekly assessment. She stated "No."

On 03/15/2018 at approximately 9:00 a.m., LPN #4 spoke with this surveyor. She stated. "I went back and looked at the measurements you asked me about...I entered them incorrectly. I did a note last night with the corrected measurements.

On 03/15/2018, the following additional progress notes were observed in the clinical record:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 18 "03/14/2018 09:55 [a.m.] Hospice Visit Note . Denies pain...Right ear wound being assessed and managed by facility wound nurse... 03/14/2018 23:12 [11:12 p.m.] Correct measurements of the Stage 4 pressure wound of the left ear were 0.5 X 0.4 X 0.1" A copy of the facility policy regarding skin assessments was requested from the DON at approximately 9:15 a.m. She left the conference room and returned stating the facility did not have a policy regarding skin assessments. The clinical record did not contain any information that the pressure ulcer was unavoidable. On 03/15/2018 at approximately 10:45 a.m., and end of survey meeting was held with the DON and the administrator. The above information was discussed. The DON and the administrator were informed that due to the facility's failure to conduct weekly skin assessments and the identification of an unstageable pressure ulcer, after a ten day span between assessments, the survey team had identified harm. No further information was presented prior to the exit conference on 03/15/2018. 2. A nurse failed to perform hand hygiene during a dressing change to Resident #79's pressure sores. Resident #79 was admitted to the facility on 8/22/17 with a re-admission on 11/22/17. Diagnoses for Resident #79 included high blood	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 19	F 686		

pressure, diabetes, kidney disease and dementia. The minimum data set (MDS) dated 2/13/18 assessed Resident #79 with severely impaired cognitive skills.

Resident #79's clinical record documented a physician order dated 3/12/18 for dressing changes/treatments to pressure ulcers on the resident's left heel and left lateral ankle. The orders required cleansing of the pressure ulcers with wound cleanser, application of Silver Hydrogel and a dry protective dressing each day.

On 3/15/18 at 9:39 a.m., licensed practical nurse (LPN) #4 was observed performing dressing changes to Resident #79's left heel/ankle pressure ulcers. LPN #4 washed her hands, put on gloves and removed the old dressings from the left heel and ankle. LPN #4 removed her gloves, put on new gloves and proceeded to cleanse both of the wounds with cleanser applied to gauze. LPN #4 changed gloves, applied the Silver Hydrogel to each wound using a cotton tipped applicator and then applied a protective dressing to each wound. LPN #4 discarded used items including the dirty dressings and then washed her hands.

LPN #4 did not perform hand hygiene following removal of the old dressings and prior to cleansing of the wounds. LPN #4 did not perform hand hygiene between any of the glove changes during the observation.

On 3/15/18 at 9:46 a.m., LPN #4 was interviewed about hand hygiene during the dressing change observation. LPN #4 stated she changed her gloves after removing the soiled dressings but did not perform hand hygiene. LPN #4 stated she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 20	F 686		

usually washed her hands after removing the old dressings but she was "a little nervous." LPN #4 stated hand hygiene was supposed to be performed after removing the soiled dressings and between any glove changes.

The facility's policy titled Dressing, Dry/Clean (revised October 2010) required hand washing after removing of soiled dressings and prior to cleansing wounds. This protocol documented, "...Wash and dry your hands thoroughly...Put on clean gloves. Loosen tape and remove soiled dressing...Pull glove over dressing and discard into plastic or biohazard bag...Wash and dry your hands thoroughly...Pour prescribed cleansing solution over the dry, clean gauze...Put on clean gloves...Cleanse the wound...Apply the ordered dressing and secure with tape...Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly..."

The facility's infection control policy (effective 9/20/17) stated, "It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." This policy stated concerning hand hygiene, "All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after PPE [personal protective equipment] removal, before/after eating, before/after toileting, and before going off duty."

These findings were reviewed with the administrator and director of nursing during a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 686	Continued From page 21 meeting on 3/15/18 at 10:45 a.m.	F 686		4/20/18
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation , staff interview and clinical record review, the facility staff failed to care plan the use of the positioning devices for one of 21 residents, Resident #7. Resident #7 was observed with a wedge between his knees. The wedge was held in place by a Velcro strap that went around his legs, holding them together, immobilized and holding the wedge in place. He was also observed to have a blue pad on the left hand side of his wheelchair for positioning. Both of the positioning devices were implemented by the therapy department at the time of Resident #7's admission in 2016. The	F 688	**1)** Care plan on resident #7 was reviewed and updated to reflect current adaptive equipment and positioning devices. **2)** 100% audit of all current residents who have adaptive equipment and positioning devices was conducted by MDS Coordinators to ensure current care plan accuracy. **3)** Director of Nursing and/ or designee provided in-service training regarding accurate assessments and revisions of care plans to all MDS coordinators, therapy department and interdisciplinary team. A therapy to nursing form has been implemented as a communication tool to alert nursing to changes and/or additions made to resident's current adaptive equipment and/ or positioning devices. The form is given to DON and/ or designee for review and copies are given to the appropriate department manager for implementation into the residents care plan. **4)** Interdisciplinary team members will complete weekly care plan audits for all residents who have adaptive equipment and positioning devices for 6 weeks to ensure care plans remain accurate then randomly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 688	Continued From page 22 devices were not on the comprehensive care plan. Findings were: Resident #7 was originally admitted to the facility on 08/09/2016. His diagnoses included but were not limited to: Fracture of right femur, cognitive communication deficit, anxiety chronic obstructive pulmonary disease, seizures, peripheral vascular disease and moderate intellectual disabilities. The most recent MDS, a quarterly assessment with a reference date of 12/27/2017 assessed Resident #7 as moderately impaired in his cognitive status, with a cognitive summary score of "08". On 03/13/2018 during initial tour of the facility, Resident #8 was observed in a wheelchair propelling himself up the hallway using his arms. His legs were being held together with a white strap, between his knees a black wedge was observed. A blue pad was observed on his left side, between his body and the wheelchair. The clinical record was reviewed on 03/13/2018. The care plan was reviewed. There were no interventions listed for the use of the devices. On 03/13/2018 the administrator and the DON (director of nursing) were asked about the strap around Resident #7's legs. They were asked if the device was a restraint. The DON stated that Resident #7 could remove the strap and the wedge. The administrator stated she would get therapy to speak with this surveyor. On 03/13/2018 at approximately 4:25 p.m., the	F 688	The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 688	Continued From page 23 rehab director was interviewed regarding the devices mentioned above. The rehab director was asked why the strap was in place holding his knees together. She stated that the strap and wedge had been put into place when Resident #7 was admitted to the facility, per his (Resident #7) request to keep his knees from touching. She stated that they (therapy) considered the wedge and strap to be adaptive equipment and an order was not needed. She also stated that the OT (occupational therapist) who worked with Resident #7 was off for the day but she would send her in to speak with this surveyor on the following day (03/14/2018). The rehab director was asked if any other strategies had been tried other than the strap and wedge. She stated, "I think so, but I don't want to speak to that, [name of OT], can best tell you what all has been done." The rehab director was asked what alternatives there might be to the strap and wedge. She stated, "Pillows, but he wants the strap and wedge." On 03/14/2018 at approximately 9:30 a.m. this surveyor spoke with Resident #7 regarding the strap around his legs. He was asked why he had it. He stated, "Keeps foot on pedal", he pointed to the wheelchair foot rest as he was speaking. This surveyor asked if he could undo the strap around his legs. He stated, "They do it." At approximately 10:10 a.m., on 03/14/2018, an interview was conducted with Resident #7's OT and the Rehab director. Per OT (Other staff # 3), Resident #7 was admitted to the facility in 2016 with a hip fracture. The wedge between his knees was originally placed as a hip precaution and to keep bony prominences (his knees) from rubbing together. She stated that he "Adducts his	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 688	Continued From page 24	F 688		

knees together so hard that it pushes his feet off of the foot rests of his wheelchair." She stated that when the wedge between his knees was implemented, Resident #7 was unable to hold wedge in place so the strap added. She continued, we added the lateral support (wedge at his side) because he was leaning to one side, it helps with his positioning in the wheelchair. She stated that the lateral support, the wedge and strap were all considered to be adaptive equipment and a physician's order was not needed. She stated Resident #7 had last been on her case load from February to March (2018) because he needed a smaller wheelchair. The OT was asked who was responsible for the daily implementation of the adaptive equipment used by Resident#7 and who assessed to make sure that he can remove the strap around his legs on an ongoing basis to ensure that it has not become a restraint. She stated, "Nursing is aware of the devices." The OT was asked if any other strategies had been attempted other than the strap around his legs with the wedge between his knees. She stated, "We tried a calf support, he hated it."

At approximately 10:30 a.m., the wound nurse was accompanied to Resident #7's room to observe a dressing change. Resident #7 was observed undoing the strap holding the wedge between his knees in place and removing the wedge. After the dressing change was completed, Resident #7 picked the wedge and strap up and put it back between his knees with the help of staff.

On 03/14/18 at approximately 2:30 p.m., the DON and the administrator were interviewed regarding the devices in place for Resident #7. They were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 688	Continued From page 25 asked how the nursing staff knew what to do as far as the placing the lateral support, and making sure Resident #7 could undo the strap around his legs so that it did not become a restraint and if they were care planned. The administrator stated, "I agree they should be on the care plan and the Kardex." No further information was obtained prior to the exit conference on 03/15/2018.	F 688		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880	**1)** The charge nurse was provided one on one education regarding proper hand hygiene between residents during a medication pass observation. The charge nurse was provided one on one education regarding proper hand hygiene during wound dressing changes. **2)** No other issues noted/ observed regarding employee hand hygiene. **3)** Director of Nursing and/ or designee provided in-service training to current staff on proper hand hygiene and sanitation. **4)** Interdisciplinary team members will complete weekly Hand hygiene observations two times per week for 6 week and as needed thereafter to ensure facility remains in compliance with state regulations. The results of this audit will be brought to monthly Quality Assurance and Performance Improvement (QAPI) meeting for review and revisions as necessary.	4/20/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 880	Continued From page 26 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 880	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control practices during a medication pass and failed to perform proper hand hygiene during a dressing change for one of 21 residents in the survey sample. 1. A nurse failed to perform hand hygiene during a dressing change to Resident #79's pressure ulcers. 2. A nurse failed to perform hand hygiene between residents during a medication pass observation. The findings include: 1. A nurse failed to follow infection control practices regarding hand hygiene during a dressing change to Resident #79's pressure ulcers. Resident #79 was admitted to the facility on 8/22/17 with a re-admission on 11/22/17. Diagnoses for Resident #79 included high blood pressure, diabetes, kidney disease and dementia. The minimum data set (MDS) dated 2/13/18 assessed Resident #79 with severely impaired cognitive skills. Resident #79's clinical record documented a physician order dated 3/12/18 for dressing changes/treatments to pressure ulcers on the resident's left heel and left lateral ankle. The orders required cleansing of the pressure ulcers with wound cleanser, application of Silver	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 880	Continued From page 28 Hydrogel and a dry protective dressing each day. On 3/15/18 at 9:39 a.m., licensed practical nurse (LPN) #4 was observed performing dressing changes to Resident #79's left heel/ankle pressure ulcers. LPN #4 washed her hands, put on gloves and removed the old dressings from the left heel and ankle. LPN #4 removed her gloves, put on new gloves and proceeded to cleanse both of the wounds with cleanser applied to gauze. LPN #4 changed gloves, applied the Silver Hydrogel to each wound using a cotton tipped applicator and then applied a protective dressing to each wound. LPN #4 discarded used items including the dirty dressings and then washed her hands. LPN #4 did not perform hand hygiene following removal of the old dressings and prior to cleansing of the wounds. LPN #4 did not perform hand hygiene between any of the glove changes during the observation. On 3/15/18 at 9:46 a.m., LPN #4 was interviewed about hand hygiene during the dressing change observation. LPN #4 stated she changed her gloves after removing the soiled dressings but did not perform hand hygiene. LPN #4 stated she usually washed her hands after removing the old dressings but she was "a little nervous." LPN #4 stated hand hygiene was supposed to be performed after removing the soiled dressings and between any glove changes. The facility's policy titled Dressing, Dry/Clean (revised October 2010) required hand washing after removing of soiled dressings and prior to cleansing wounds. This protocol documented, "...Wash and dry your hands thoroughly...Put on	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 880	Continued From page 29	F 880		

clean gloves. Loosen tape and remove soiled dressing...Pull glove over dressing and discard into plastic or biohazard bag...Wash and dry your hands thoroughly...Pour prescribed cleansing solution over the dry, clean gauze...Put on clean gloves...Cleanse the wound...Apply the ordered dressing and secure with tape...Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly..."

The facility's infection control policy (effective 9/20/17) stated, "It is a policy of this facility to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections." This policy stated concerning hand hygiene, "All staff shall wash their hands when coming on duty, between resident contacts, after handling contaminated objects, after PPE [personal protective equipment] removal, before/after eating, before/after toileting, and before going off duty."

The Lippincott Manual of Nursing Practice 10th edition on page 1083 states, "Hand hygiene is the single most recommended measure to reduce the risks of transmitting microorganisms...Hand hygiene should be performed between patient contacts; after contact with blood, body fluids, secretions, excretions, and contaminated equipment or articles; before donning and after removing gloves is vital for infection control..." Page 1084 of this reference states, "Gloves are worn to provide a protective barrier and prevent gross contamination of the hands of health care workers; if used properly, they reduce the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 880	Continued From page 30	F 880		

transmission of microorganisms and help prevent cross-contamination within a patient. Wearing gloves does not replace the need for hand hygiene because gloves may have small defects or may be torn during use, and during the removal of gloves hands may become contaminated." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 3/15/18 at 10:45 a.m.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

2. A nurse failed to perform hand hygiene between residents during medication pass observation.

A medication pass observation was conducted on 03/14/2018 at 7:50 a.m. Licensed Practical Nurse (LPN) #3 was observed administering medications during this time to three residents.

On 03/14/2018 at 7:50 a.m., LPN #3 administered an insulin injection and eye drops to the second resident in the medication pass. Without performing hand hygiene, LPN #3 prepared and administered medications to the next resident.

On 3/14/2018 at 8:34 a.m., LPN # 3 was interviewed about hand hygiene between residents during the observed medication pass. LPN #3 stated she usually performed hand hygiene between residents. LPN #3 stated hand hygiene was supposed to be performed between

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495147	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTE AT WAYNESBORO	1221 ROSSER AVE WAYNESBORO, VA 22980

(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 880	Continued From page 31 residents. The facility's policy titled Standard Precautions Infection Control states to perform hand hygiene "after touching blood, body fluids, secretions, excretions, and contaminated items; immediately after removing gloves; between patient contacts." These findings were reviewed with the administrator and director of nursing during a meeting on 3/14/2018 at 3:38 p.m.	F 880		