PRINTED: 09/14/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			ONIB NO. 0938-038
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	()	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMEN	ITS	F 000	F 000	
F 276	corrections are record to the census in this time of the survey of 11 current residuand Residents #11.	Medicare/Medicaid standard cted 9/6/17 through 9/8/17. Equired for compliance with 42 deral Long Term Care s 39 bed facility was 29 at the c. The survey sample consisted dents (Residents #1 through #10); and 1 closed record,	F 276	This Plan of Correction constitution written allegation of compliance deficiencies cited. Submission of Correction is not an admission deficiency exists or that one was correctly. This Plan of Correctis submitted to meet requirements by state and federal law. Cover is committed to sustaining comply with regulations.	e for the of this Plan on that a s cited on is established nant Woods
SS=D	(c) Quarterly Revi assess a resident instrument specifi by CMS not less f	MONTHS The was a second of the control of the cont			
	by: Based on staff in review, and clinic determined that the a quarterly MDS (terview, facility document al record review it was he facility staff failed to complete (minimum data set) assessment dents in the survey sample;	;	-acce, general general for the first transfer	
	The facility staff of (Minimum Data State was due in M	lid not complete a quarterly MDS set) assessment for Resident #, flarch, 2017.	5		-VOLC
	The findings inclu	ude:			
	Resident #1 was	admitted to the facility on mitted on 5/26/17 with the			

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.

		AND HUMAN SERVICES & MEDICAID SERVICES		F(TED: 09/14/20 DRM APPROVE NO: 0938-03!	
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	failure, atrial fibrillat	of limited to congestive heart ion, dementia, sleep apnea. pertrophy, high blood abosis.		Resident #1 was not found to be adversely affected.		
	coded as being severability to make daily			2. 100% audit of the most recent comprehensive and quarterly MDS assessment dates for each current resident to ensure assessments have be scheduled and completed per RAI.	9/29/17 een	
	Mental Status) exam requiring total care f transfers, dressing, for eating, and as us	n. Resident #1was coded as or bathing: extensive care for and hygiene; as independent sually continent of bowel and ing catheter for bladder.		3. Will audit the MDS assessment sched for three residents a week for four weeks.	ule 10/20/17	

A review of the clinical record revealed Resident #1 had a comprehensive MDS assessment completed with an ARD of 11/18/16; and the next assessment completed was an admission (readmission) with an ARD of 5/22/17. There were no quarterly or comprehensive assessments completed between these dates. At the minimum, a quarterly assessment was due approximately March 2017.

On 9/7/17 at approximately 1:00 p.m., an interview was conducted with RN #3 (Registered Nurse) who was doing MDS assessments at the time of the missed assessment. RN #3 stated the facility had changed computer systems around that time (March) and in the changeover, Resident #1's quarterly assessment was missed. She stated the old system reflected that the MDS pathway had been opened to begin the assessment, but did not carry over when the old MDS system was merged into the new MDS system. When asked what policy the facility uses

- 4. Will provide documentation of weekly 10/20/17 audits to the DON for review.

FORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID VA0416

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F 276	Continued From p	age 2	F 2	276			
to complete the MDS assessments, RN #4, the current MDS nurse, stated the RAI manual.							
	Administrator (adm #1) was made awa	eximately 5:30 p.m., the ninistrative staff member [ASM] are of the findings. No further ovided by the end of the					

According to the RAI manual (Resident Assessment Instrument), "The Quarterly assessment is an OBRA non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the Quarterly assessment. The ARD (A2300) must be not more than 92 days after the ARD of the most recent OBRA assessment of any type."

F 279 483.20(d);483.21(b)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21 (b) Comprehensive Care Plans F 279

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Event ID I6EN11

Facility ID VA0416

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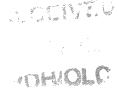
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- (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet 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

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F 279 Continued From page 4

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 staff interview, facility document review and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for two of 12 residents in the survey sample, Resident #2 and Resident #6.

- 1. The facility staff failed to develop a behavior care plan based on the CAA (care area assessment) trigger in section V. of Resident #2's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/2/17.
- 2. The facility staff failed to develop a vision care plan based on the CAA trigger in section V. of Resident #6's significant change MDS assessment with an ARD of 8/24/17.

The findings include:

1. The facility staff failed to develop a behavior care plan based on the CAA (care area assessment) trigger in section V. of Resident #2's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 5/2/17.

Resident #2 was admitted to the facility on 5/11/12 and readmitted on 4/25/17 with diagnoses that included but were not limited to: high blood

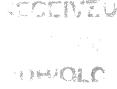
F 279

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I6EN11

Facility ID: VA0416

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F 279	Continued From pa	nge 5	F 27	79 F	279		- Annowed to the state of the s
	failure. The most recent Mi with an ARD of 8/2/	DS, a quarterly assessment, 17 coded the resident as		1	. Resident #2 was not found to be adversely affected. Plan of care for behavior has been updated to reflewhat was documented in the beha	ect	9/8/17
having scored a 15 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The resident was coded as requiring assistance from facility staff for all activities of daily living except for eating which the resident could do after the meal tray was prepared. The admission MDS assessment with an ARD of 5/2/17 coded the resident in Section E Behavior, E0800			2.	CAA. 100% audit will be performed for residents' behavior CAAs and cor to behavior care plans. Findings vereviewed at the interdisciplinary to morning meeting.	npared will be	9/29/17	
	Rejection of care - In the resident reject of bloodwork, taking me that is necessary to for health and well-blooded as a "1" indicative occurred 1 to 3 the CAA section of the documented, "09. B	Presence & Frequency. Did evaluation of care (e.g., nedications, ADL assistance) achieve the resident's goals being?" The resident was ating that "Behavior of this days." Review of section V. he MDS assessment ehavioral Symptoms. A. Care 'X" was in the box indicating		3.	After the complete audit has been performed, 3 behavior CAAs will chosen at random and reviewed w by the Social Worker. The behavior CAAs will be compared to the behavior care plans to ensure accuracy. Behavior CAAs will also be reviewed during comprehensive assessments.	eekly for navior havior	10/20/17
	the area was trigger Decision (a "1" was was to be care plant	ed). B. Care Planning in the box indicating the area ned)."		4.	An audit spreadsheet will be compweekly to document when behavior plans and CAAs are reviewed and findings. The findings will be rev	or care the	10/20/17
	plan created on 5/5/ "Psychosocial, Mood evidence documenta"	ent #2's comprehensive care 17 documented, d, and Behavior" did not ation or a plan of care with ess behaviors for Resident			weekly at the interdisciplinary team morning meeting ton include the E Administrator and MDS Coord.	ms	
	a.m. with LPN (licens	nducted on 9/8/17 at 11:10 sed practical nurse) #3.					

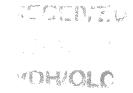
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#3 stated, "So we can know how to take care of

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Facility ID: VA0416

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/14/201 FORM APPROVE OMB NO 0938-039

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F 279 Continued From page 6

the resident in an efficient manner." When asked who developed the care plans, LPN #3 stated, "Up here (on the unit) I'm not sure but I think it's the unit manager. I usually work A.L. (assisted living)."

An interview was conducted on 9/8/17 at 11:15 a.m. with RN (registered nurse) #4, the MDS coordinator. When asked who completed the behavior sections of the MDS assessments, RN #4 stated, "Social services generates that one." When asked why a care plan was developed, RN #4 stated, "I develop the care plan so it gives the healthcare worker a guide to what preferences the resident has, what's their medical condition." When asked to review Resident #2's comprehensive care plan for a plan of care for behaviors, RN #4 stated, "I don't see it."

An interview was conducted on 9/8/17 at 11:30 a.m. with OSM (other staff member) #3, the social worker. When asked who developed the care plan for behavior, OSM #3 stated, "I do." When asked why a care plan is developed, OSM #3 stated, "To make sure that the care is tailored to the resident and there needs because everyone is different." OSM #3 was asked to review Resident #2's comprehensive care plan for a plan of care with interventions to address behaviors. OSM #3 stated, "It doesn't have one."

On 9/8/17 at 12:15 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

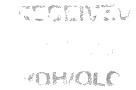
Review of the facility's policy titled "CARE PLANNING" documented, "Policy: A preliminary plan of care to meet the resident's immediate F 279

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Facility ID: VA0416

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needs shall be developed for each resident within twenty-four (24) hours of admission. An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Procedures: 2) A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident's comprehensive assessment (MDS). 6) Each resident's comprehensive care plan is designed to: a) incorporate identified problem areas; b) Incorporate risk factors associated with identified problems. 7) Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan."

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..." (1)

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

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				1.	Resident #6 was not found to be adversely affected. Plan of care vision has been updated to reflect was documented in the vision Care	for et what	9/8/17
	and readmitted on 8 included but were no difficulty urinating, d degeneration (2). The significant change a 8/24/17 coded the re-	mitted to the facility on 7/1/11 b/31/17 with diagnoses that of limited to: kidney stones, iverticulitis (1) and macular ne most recent MDS, a sesesment, with an ARD of esident as being understood others. Resident #6 was		2.	100% audit will be performed for residents' vision CAAs and compto vision care plans. 100% audit care plans to ensure inclusion of current diagnosis. Findings will reviewed at the interdisciplinary morning meeting.	pared of be	9/29/17
	short-term memory. requiring assistance daily living. In section triggered for 3. visual that this was a trigger plan would be developed. Review of the physical 2017 documented, "I	The resident was coded as from staff for all activities of N. CAA the resident was all function. It was documented ered care area and that a care oped for visual function. Jan's orders dated August PreserVison AREDS (3)		3.	After the complete audit has been performed, 3 vision CAAs will be chosen at random and reviewed with the MDS Coord. The vision Cay will be compared to the vision caplans to ensure accuracy. Also, of the comprehensive assessment, einclusion of current diagnosis on plan.	eweekly CAAs are during	10/20/17
	2Notes: Instruction Unspecified MACUL, Date: 8/25/2016." Review of the care padocumented, "COGN AND VISION" did not regarding the resider An interview was con a.m. with LPN (licens	s: Therapeutic Range: AR DEGENERATION. Order lan created on 5/23/17 IITION, COMMUNICATION, t evidence documentation it's macular degeneration. ducted on 9/8/17 at 11:10 ed practical nurse) #3. idents had care plans, LPN		4.	An audit spreadsheet will be com weekly to document when care p are reviewed and the findings. T findings will be reviewed weekly interdisciplinary teams morning meeting ton include the DON, Administrator and MDS Coord.	lans he	10/20/17

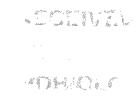
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#3 stated. "So we can know how to take care of the resident in an efficient manner." When asked

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F 279 Continued From page 9

who developed the care plans, LPN #3 stated. "Up here (on the unit) I'm not sure but I think it's the unit manager. I usually work A.L. (assisted living)."

An interview was conducted on 9/8/17 at 11:15 a.m. with RN (registered nurse) #4 MDS coordinator. When asked who completed the vision section of the MDS assessments, RN #4 stated, "Social services generates that one." When asked why a care plan was developed, RN #4 stated, "I develop the care plan so it gives the healthcare worker a guide to what preferences resident has, what's their medical condition." When asked to review Resident #6's care plan for a plan of care to address Resident #6's visual impairment, RN #4 stated, "I don't see it."

An interview was conducted on 9/8/17 at 11:30 a.m. with OSM (other staff member) #3, the social worker. When asked who developed the care plan for vision, OSM #3 stated, "I do." When asked why a care plan is developed, OSM #4 stated, "To make sure that the care is tailored to the resident and their needs because everyone is different." OSM #4 was asked to review Resident #6's care plan for a plan of care to address Resident #6's visual impairment. OSM #4 stated, "It doesn't have one. I think it was an oversight."

On 9/8/17 at 11:45 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

(1) Diverticulitis: Diverticular disease of the colon is among the most prevalent conditions in

F 279

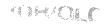
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:16EN11

Facility ID: VA0416

If continuation sheet Page 10 of 38





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		TH AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 09/14/2 FORM APPROV OMB NO. 0938-0
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	PROVIDER OR SUPPLIE			STREET ADDRESS. CITY. STATE. ZIP CODE 7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111	
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F 279	reasons for outpathospitalization. Was disease primari increasing incider than 40 years of a frequently presendiverticulitis, and its antibiotic therapinformation was on https://www.ncbi.r74080/ (2) Macular Degelor age-related maleading cause of variation.	nd is among the leading tient visits and causes of thile previously considered to be ly affecting the elderly, there is not among individuals younger age. Diverticular disease most as uncomplicated the cornerstone of management by and bowel rest. This	F 27	9	

older. It is a disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from: https://medlineplus.gov/maculardegeneration.htm (3) PreserVison AREDS: The Age-Related Eye

Disease Study (AREDS) - sponsored by the Federal Government's National Eye Institute - has found that taking high levels of antioxidants and zinc can reduce the risk of developing advanced age-related macular degeneration (AMD) by about 25 percent. This information was obtained from: https://nei.nih.gov/amd/summary

F 328 483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE SS=D FOR SPECIAL NEEDS

> (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

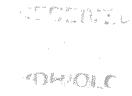
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I6EN11

Facility ID VA0416

If continuation sheet Page 11 of 38



PRINTED: 09/14/201 FORM APPROVEI OMB NO. 0938-039

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F 328 Continued From page 11

- (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and
- (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments
- (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.
- (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.
- (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.
- (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the

F 328





DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/14/201 FORM APPROVEI OMB NO. 0938-039

DEFICIENCY

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING ____ 495419 B WING 09/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE, ZIP CODE 7090 COVENANT WOODS DRIVE **COVENANT WOODS NURSING HOME** MECHANICSVILLE, VA 23111 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE

F 328 Continued From page 12

comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.

(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer oxygen as ordered by the physician for one of 12 residents in the survey sample, Resident #6.

The facility staff failed to administer Resident #6's oxygen at two liters per minute as per the physician's order.

The findings include:

Resident #6 was admitted to the facility on 7/1/11 and readmitted on 8/31/17 with diagnoses that included but were not limited to: kidney stones, difficulty urinating, diverticulitis (1) and macular degeneration (2). The most recent MDS, a significant change assessment, with an ARD of 8/24/17 coded the resident as being understood and understanding others. The resident was coded as having an intact long-term and short-term memory. The resident was coded as requiring assistance from staff for all activities of daily living. In Section O. Special Treatment, Procedures, and Programs. Section O0100 the

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F 328	Review of the physic September 2017 do (liters)/m (minute) p 9/6/2017.	as receiving oxygen therapy.	F 3.	 Resident #6 was not found to adversely affected. Liter flow adjusted to deliver oxygen at MD order. Liter flow for all receiving oxygen therapy we for accuracy per MD order. 	w was rate per residents	9/8/17	
	not evidence documentation regarding the oxygen order. Review of the care plan created on 5/23/17 and revised on 8/23/17 titled, "Cardiovascular Compromise" documented, "Administer oxygen per order."		2. 100% audit was performed of all resident files for accuracy of MD orders who receive oxygen therapy.3. Review of nursing procedures for			9/11/17 9/27/17	
	An observation was of Resident #6. The wheelchair. The res via a nasal cannula nose to deliver oxyg	made on 9/6/17 at 4:05 p.m. resident was sitting up in a ident was receiving oxygen (soft prongs that fit in the en) connected to an oxygen xygen concentrator flow rate 1/4 liters/minute.		 oxygen therapy with nursing In-service nursing staff or procedures for oxygen the Unit manager or designee to weekly audits on residents re oxygen therapy (weekly for t 	n policy and erapy. conduct ceiving	10/20/17	
	Resident #6 was lyir The resident had a r	made on 9/7/17 at 9:02 a.m. ng in bed with eyes closed. nasal cannula on and the flow rate was set at three		then every month).			
	Resident #6. The res	made at 11:30 a.m. of sident was up in a wheelchair on. The oxygen concentrator three liters/minute.					
	9/8/17 at 7:51 a.m. T	made of Resident #6 on The resident was in bed with connected to an oxygen					



concentrator. The oxygen concentrator flow rate



Facility ID VA0416

If continuation sheet Page 14 of 38



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/14/201 FORM APPROVE OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 495419 B WING 09/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE, ZIP CODE 7090 COVENANT WOODS DRIVE COVENANT WOODS NURSING HOME

MECHANICSVILLE, VA 23111

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

(X5) COMPLETION DATE

F 328 Continued From page 14 was set at three liters/minute.

> An observation was made of Resident #6 on 9/8/17 at 10:58 a.m. with RN (registered nurse) #3. the evening shift unit manager. The resident was in bed with the nasal cannula on connected to an oxygen concentrator. RN #3 was asked to check the oxygen flow rate on the oxygen concentrator, RN #3 stated, "It's (the oxygen flow rate) at three and 1/2 liters." When asked what the oxygen flow rate was supposed to be set at. RN #3 stated, "I think it's three liters but I have to check the EMAR (electronic medication administration record)." RN #3 checked Resident #6's EMAR and stated, "It's supposed to be at

two liters." RN #3 then returned to the resident's room and adjusted the oxygen flow rate on the oxygen concentrator to the correct rate.

An interview was conducted on 9/8/17 at 11:12 a.m. with LPN (licensed practical nurse) #3, the resident's nurse. When asked the process staff followed to check the resident's oxygen rate, LPN #3 stated, "We're supposed to check it when we go in and give them their meds (medications)." When asked why it was important that the oxygen be set at the physician ordered rate, LPN #3 stated, "It's a med. If you don't get the correct amount you're supposed to get, it could do as much harm as good." When asked what flow rate Resident #6's oxygen should be set at, LPN #3 stated, "I just looked at the MAR (medication administration record) and it's supposed to be at two liters." When asked if she had checked Resident #6's oxygen that morning, LPN #3 stated, "I hadn't checked her oxygen yet. I just checked on her to make sure she was breathing."

An interview was conducted on 9/8/17 at 12:00

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Facility ID: VA0416

If continuation sheet Page 15 of 38



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F 328 Continued From page 15

p.m. with RN #3. When asked the process staff followed when a resident was on oxygen, RN #3 stated, "The process is to check it (the oxygen flow rate) when you first come on and then throughout the shift." When asked why it was important that the resident received the oxygen as ordered by the physician, RN #3 stated, "It's a medication."

An interview was conducted on 9/8/17 at 12:10 p.m. with LPN #1, the day shift unit manager. When asked why the oxygen order for two liters/minute for Resident #6 was not on the treatment administration record, LPN #1 stated. "It's the way they entered the oxygen order into the treatment administration record in the software. Since the oxygen is continuous the nurse must sign it the oxygen off at the end of the shift on the treatment administration record. The only way you can see it is to pull up the nurse's sign off section (of the treatment administration record). I know it's confusing." A request was made to see the sign off sheet from the treatment administration record and the sign off sheet was provided. Review of the sign off sheet from the treatment administration record revealed the following was documented. "OXYGEN (O2) AT 2 L/MIN PER NASAL CANNULA. Continuous beginning 9/6/2017."

On 9/8/17 at 12:15 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's policy titled, "Oxygen Administration" documented, "Purpose. The purpose of the procedure is to provide guidelines for safe oxygen administration. Preparation. 1.

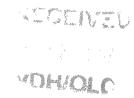
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I6EN11

Facility ID VA0416

If continuation sheet Page 16 of 38



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A BUILDING 495419 B WING 09/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE ZIP CODE 7090 COVENANT WOODS DRIVE COVENANT WOODS NURSING HOME MECHANICSVILLE, VA 23111

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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F 328 Continued From page 16

Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration."

No further information was provided prior to exit.

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects. such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

- (1) Diverticulitis: Diverticular disease of the colon is among the most prevalent conditions in western society and is among the leading reasons for outpatient visits and causes of hospitalization. While previously considered to be a disease primarily affecting the elderly, there is increasing incidence among individuals younger than 40 years of age. Diverticular disease most frequently presents as uncomplicated diverticulitis, and the cornerstone of management is antibiotic therapy and bowel rest. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC31 74080/
- (2) Macular Degeneration: Macular degeneration, or age-related macular degeneration (AMD), is a leading cause of vision loss in Americans 60 and older. It is a disease that destroys your sharp. central vision. You need central vision to see objects clearly and to do tasks such as reading

F 328

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Event ID: I6EN11

Facility ID VA0416

If continuation sheet Page 17 of 38



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https://medlineplus.g	ormation was obtained from: gov/maculardegeneration.htm	F 328		
 (i)(1) - Procure food considered satisfact authorities. (i) This may include from local producers and local laws or regardless from using pardens, subject to case growing and food from consuming food from consuming food (iii) This provision do from consuming food from consuming food from consuming food from consuming food (i)(2) - Store, prepare accordance with profeservice safety. (i)(3) Have a policy refoods brought to resivisitors to ensure safe handling, and consuming food safe provided from the safe provided from	from sources approved or ory by federal, state or local food items obtained directly s, subject to applicable State gulations. es not prohibit or prevent produce grown in facility compliance with applicable od-handling practices. bes not preclude residents ds not procured by the facility. e, distribute and serve food in fessional standards for food egarding use and storage of dents by family and other fe and sanitary storage,	F 37		





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1. The facility staff failed to label an opened

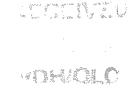
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F 371	gallon container of 2. During the 9/6/1 facility staff failed to cover and failed to wiping their nose or The findings include	sesame salad dressing. 7 dinner preparation, the wear a beard hair protective change their gloves after a the back of their glove.	F 37	 F 371 (1) Open container was disposed of at time observed. No residents were found to be dire affected. 	ectly
	on 9/6/17 at 3:40 p.member) #6, the die refrigerator on the to container of sesame approximately 3/4's remaining in the cor- date on the container manufacturer's use the date it was bottle An interview was co- time. When asked wopen date, OSM #6	of the kitchen was conducted m. with OSM (other staff etary manager. In the walk-in op shelf was a gallon e salad dressing. There was of the salad dressing ntainer. There was no open er. There was no by date on the container only ed which was March 2017. Inducted with OSM #6 at that thy food was marked with the stated so they would know and when it would be		 3. New labels have been ordered with highlighted area for the discard dat that it is easier to identify. All staff will be in-serviced on labeling and dating. 4. Management will do random week audits over the next 4 weeks. 	proper 10/18/17
	LABELING AND DA is Dining Service Po	o's policy titled, "FOOD TING" documented, "Policy: It licy that all food, whether raw erly covered, labeled and			
	,	ninistrative staff member) #1, d ASM #2, the director of aware of the findings.			
	made of OSM (other	p.m., an observation was staff member) #5, the cook,			



resident's dinner service. OSM #5 had a mustache and goatee. OSM #5 was not wearing





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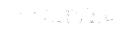
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F 371		age 19 over his beard. OSM #5 was s nose on the back of his glove	F 37	71 F 371 (2)		
	and then returned to stirred food. OSM #	the food steam table and to the food steam table and the food steam table and the food steam table and		1. OSM #5 met with managem review policy and procedure infection control, including and hair protection.	es regarding	9/6/17
	p.m. with OSM #6 t	onducted on 9/7/17 at 1:12 he dietary manager and OSM manager. When asked what		2. No residents were found to laffected.	oe adversely	
	preparing food show "They should have asked when staff shows "The OSM #7 stated, "The	member with a beard who was ald take, OSM #6 stated, a beard guard on." When hould change their gloves, ney change their gloves after		3. All staff will be in-serviced hair restraints and infection including hand washing and glove use.	control	10/18/17
	serving." When ask practices, OSM #7 infection. They can spread disease." Of	else than what they're ed why staff followed these stated, "Because of possible cross-contaminate and SM #6 and OSM #7 were observations and findings.		4. Management will do random audits over the next 4 weeks		10/20/17
	p.m. with OSM #5, t protection staff shot serving food, OSM a (the staff was wearing some kind of hat an asked why staff wor stated, "For protection #5 was made aware 9/6/17 dinner prepar	he cook. When asked what all wear when preparing and #5 stated, "This face guarding a face guard at this time), diprotective gloves." When e these items, OSM #5 on of the client." When OSM of the observation during the ration, OSM #5 stated, "I ad my gloves, washed my ew ones (gloves)."				
		m. ASM (administrative staff ministrator and ASM #2, the				

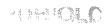


findings.

director of nursing were made aware of the







PRINTED: 09/14/201 FORM APPROVE OMB NO. 0938-039

DEFICIENCY)

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		ON	MB NO. 0938-03
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F 371

Review of the facility's policy titled, "EMPLOYEE -- HAIR/BEARD" documented, "Policy: Dietary staff must wear hair restrains (e.g. hairnet, hat. and/or beard restraint) to prevent their hair from contacting exposed food, clean equipment, utensils, and lines...Beard guards must be worn if the beard or mustache exceeds a "5 o'clock shadow."

Review of the facility's policy titled, "EMPLOYEE -- GLOVE USE" documented, "Policy: Single use gloves will be used to provide a food safe barrier between hands and food and to prevent cross-contamination. Gloves should never be used in the place of hand washing, and hands must be washed before putting on gloves and when changing to a new pair. Procedure: Food handlers must change gloves: Any time they become contaminated."

Review of the facility's policy titled, "EMPLOYEE -- HANDWASHING" documented, "Policy: Hand washing is the most important part of personal hygiene. Employees are required to use correct hand washing procedures in order to maintain sanitary conditions and prevent the spread of infections. When to wash hands: Dining service employees must wash their hands before they start work. Hands must be washed before putting on gloves, after removing gloves, and after the following activities, 3. Touching the hair, face, or body."

No further information was provided prior to exit. F 441 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, SS=F PREVENT SPREAD, LINENS

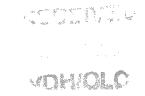
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PROVIDER'S PLAN OF CORRECTION.

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DEFICIENCY)

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495419 B. WING 09/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE COVENANT WOODS NURSING HOME MECHANICSVILLE, VA 23111 SUMMARY STATEMENT OF DEFICIENCIES

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(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:

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

- (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 (facility assessment implementation is Phase 2);
- (2) Written standards, policies, and procedures for the program, which must include, 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

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CHA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING 495419 8 WING 09/08/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY, STATE, ZIP CODE 7090 COVENANT WOODS DRIVE COVENANT WOODS NURSING HOME MECHANICSVILLE, VA 23111

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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.
- (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.
- (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.
- (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain an infection control program as evidenced by incomplete infection control tracking, trending, and surveillance logs for November 2016, December 2016, and May 2017; and failed to failed to follow infection control practices for 2 of 4 residents in the medication administration observation task; Residents #7 and #8, and; facility staff failed to change gloves or sanitize their hands prior to serving or feeding

F 441 F 441 (1)

- 1. No residents were found to be adversely affected during review of alternative data available.
- There is a dedicated staff person assigned to maintain infection control information.
 - There will be a redundancy in the process for saving infection control documentation.
- 3. DON or designee will audit 10/20/17 documentation for completion monthly.

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residents during the lunch service on 9/7/17.

- 1. The facility staff failed to maintain infection control tracking, trending, and surveillance logs for 3 of the last 12 months (November 2016, December 2016, and May 2017.)
- 2. During medication administration observation, RN (registered nurse) #1 was observed inserting her fingers into the medication cups used to prepare and administer medications to Residents #7 and #8.
- 3. On 9/7/17 at 12:30 p.m. the lunch service was observed in the dining room. Multiple facility staff were observed serving or feeding residents without changing gloves or sanitizing their hands, after having touching residents, themselves or various items.

The findings include:

1. The facility staff failed to maintain infection control tracking, trending, and surveillance logs for 3 of the last 12 months (November 2016, December 2016, and May 2017.)

A review of the infection control tracking, trending, and surveillance logs was conducted. The months of November 2016, December 2016, and May 2017 were missing.

On 9/7/17 at approximately 3:00 p.m., in an interview with the Director of Nursing (ASM #2 -- Administrative Staff Member), she stated during those time periods, there were individuals assigned to maintain the logs that did not do it. ASM #2 stated neither individual was still employed at the facility. She was unable to

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COVENANT WOODS NURSING HOME

MECHANICSVILLE, VA 23111

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

COMPLETION DATE

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provide any evidence the tracking, trending, and surveillance occurred during November 2016, December 2016, and May 2017.

A review of the facility policy, "Infection Control" documented, "2. The objectives of our infection control policies and procedures are to: Identify, investigate, control, and prevent infections in the facility Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public Establish guidelines for the implementation of Isolation precautions Maintain records of incidents and corrective actions related to infections Establish guidelines to follow implementing Standard Precautions for the handling of blood, body fluids, secretions, excretions, mucous membranes and nonintact skin."

No further information was provided by the end of the survey.

2. The facility staff failed to follow infection control practices for 2 of 4 residents in the medication administration observation task; Residents #7 and #8.

Resident #7 was admitted to the facility on 6/1/16 with the diagnoses of but not limited to dementia, high blood pressure, hypothyroidism, chronic pain, macular degeneration, depression, and spinal disc disorder. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 6/8/17. The resident was coded as being cognitively intact in ability to make daily life

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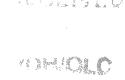
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F 441	decisions, scoring	age 25 a 15 out of a possible 15 on erview for Mental Status)	F 4	41 F 441 (2)1. Residents #7 and #8 were not a affected.	dversely	9/7/17
	4/26/17 with the dia anxiety, heart failur kidney disease, as hypothyroidism, an	dmitted to the facility on agnoses of but not limited to re, right hand fracture, chronic thma, high blood pressure, id high cholesterol. The most quarterly assessment with an		 Nurses immediately disposed o medication cups that were stack improperly with open side up o med cart. 	ked	9/7/17
r Æ r c	ARD of 8/9/17. Th	e resident was coded as being ed in ability to make daily life		 Education conducted with all no staff reviewing proper storage of cups with open side down on m 	of med	9/25/17
	Nurse) was observ administering medi	a.m., RN #1 (Registered ed preparing and ications to Resident #7. She ving medications for Resident		Education conducted on pol procedures for infection con the importance of hand wash	trol and	10/18/17
	Loratadine [1] 10 m Miralax [2] 17 gm (Aspirin [3] 81 mg Norvasc [4] 2.5 mg Senna [5] 8.6 mg			 Unit Manager or designee will a audits of med carts 3x weekly for weeks and then once weekly for weeks. 	or 4	10/20/17
	ml (milliliter) soufflé soufflé cups that we While obtaining a c RN #1's fingers wer the medication cup preparing each med	dications, RN #1 obtained a 30 cup from the top of a stack of ere stored open-side up. up from the top of the stack, re observed inserted down into RN #1 was then observed dication into the cup, and then he medications to Resident #7				
		.m., after administering ident #7, RN #1 was observed				



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F 441		ge 26 ons for Resident #8. She ing medications for Resident	F 441		
	Xanax [6] 0.5 mg Neurontin [7] 100 m Senna 8.6 mg Bupropion [8] 150 m Norvasc 5 mg Lasix [9] 20 mg				
	DN #1 obtained a 20	O mol doutflé our from the tou			

RN #1 obtained a 30 ml soufflé cup from the top of a stack of soufflé cups that were stored open-side up. When obtaining a cup from the top of the stack, RN #1's fingers were observed inserted down into the medication cup. RN #1 then prepared Resident #'s medications placing the medicines into this cup and was observed administering the medications to Resident #8 from this cup.

On 9/7/17 at approximately 2:00 p.m., in an interview with RN #1, she stated that she should not put her fingers into the cup, and she did not realize she had done that.

A review of the facility policy, "General Guidelines for Medication Administration" did not specifically document that staff should not touch or contaminate the inside of the medication cups. However, it did document, "6. c. Never touch any of the medication with fingers."

On 9/7/17 at approximately 5:30 p.m., the Administrator was made aware of the findings. No further information was provided by the end of the survey.

According to Potter and Perry's, Fundamentals of

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Nursing, 6th edition, page 847, "For safe administration, the nurse uses aseptic technique when handling and giving medications."

In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 655. "The nurse follows certain principles and procedures, including standard precautions, to prevent and control infection and its spread. During daily routine care the nurse uses basic medical aseptic techniques to break the infection chain. A major component of client and worker protection is hand hygiene. Contaminated hands of health care workers are a primary source of infection transmission in health care settings."

References:

- [1] Loratadine 10 mg (milligrams) is used to treat allergies. Information obtained from https://medlineplus.gov/druginfo/meds/a697038.html
- [2] Miralax 17 gm (grams) is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a603032.html
- [3] Aspirin 81 mg is used to treat pain, fever, and to help prevent clots in people at risk for strokes and heart attacks. Information obtained from https://medlineplus.gov/druginfo/meds/a682878.html
- [4] Norvasc 2.5 mg is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a692044.h tml
- [5] Senna 8.6 mg is used to treat constipation. Information obtained from https://medlineplus.gov/druginfo/meds/a601112.ht

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ml

[6] Xanax 0.5 mg is used to treat anxiety. Information obtained from https://medlineplus.gov/druginfo/meds/a684001.h tml

[7] Neurontin 100 mg is used to treat seizures, neuropathic pain, and restless leg syndrome. Information obtained from https://medlineplus.gov/druginfo/meds/a694007.html

[8] Bupropion 150 mg is used to treat depression, seasonal affective disorder, and to assist in smoking cessation. Information obtained from https://medlineplus.gov/druginfo/meds/a695033.html

[9] Lasix 20 mg is used to treat high blood pressure. Information obtained from https://medlineplus.gov/druginfo/meds/a682858.html

3. On 9/7/17 at 12:30 p.m. the lunch service was observed in the dining room. Multiple facility staff were observed serving or feeding residents without changing gloves or sanitizing their hands, after having touching residents, themselves or various items.

CNA (certified nursing assistant) #3 obtained two clothing protectors from a cabinet at the back of the room. CNA #3 put one of the protectors on a resident and then moved to another table and put the clothing protector on another resident. CNA #3 then sat down and started feeding the resident. CNA #3 did not sanitize her hands between touching the first resident and the second resident.

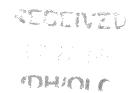
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F 441	Continued From pa	ige 29	F 44	⁴¹ F 441 (3)		
	and took it to a resi to another resident, the resident's chair, and put her gloved top. OSM #4 took to the food steam tabl by putting her forefi	y aide prepared a plate of food dent. OSM #4 then went over , put her hand on the back of , placed the menu on the table hand on the menu and table he resident's order, returned to e and picked up a soup bowl nger into the bowl and her the delivered the soup to the		 OSM #4 met with manageme review policy and procedures infection control. All nursing handwashing procedures and control reviewed at change o residents were found to be ac affected. 	s regarding g staff had l infection f shift. No	9/7/17
	resident and was the room manager to reher hands. OSM #4 wash her hands priesteam table; OSM #	ten told by OSM #7, the dining emove her gloves and wash did not change her gloves or or to returning to the food #4 then picked up a soup bowled fingers inside the bowl.		2. In-services on infection control concentrating on hand washing proper glove use will be held dining and nursing staff.3. Additional dining staff will be	ng and for all	10/18/17 9/11/17
	table. There were the table. CNA (certified sitting at the left con	ining room there was a square nree residents seated at the dinursing assistant) #2 was mer of the table between two was sitting with his chin in his		during meal times for hot foo well as cold food and beverag eliminate need for nursing sta into the kitchen.	od service as ges to	
	to the right of CNA # CNA #2 picked up to and cut up the food	byer his mouth. The resident #2 had her food served and he resident's knife and fork on the plate and began		Containers of alcohol base sanitizers were made avai dining room for staff use.		9/11/17
		nt with eating. CNA #2 did not rior to feeding the resident, ce with his hands.		A second wall mount unit installed as well.	was	9/21/17
	two residents. CNA moved it to the other	at the same table between #4 picked up her chair and r side of the resident sitting		Better definitions of dinin staff duties were put in pla	_	9/21/17
	CNA #4 pulled up he feeding the resident sanitizing her hands	the table. Prior to sitting down, er pants. CNA #4 then began to the right of her without and Another resident was placed CNA #4. CNA #4 started		4. Unit Manager or designee w dining room meal service for control issues 3x a week for and then once weekly for two	or infection 4 weeks	10/20/17

feeding the resident and then turned and fed the

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resident to her right. CNA #4 did not sanitize her hands after picking up her chair, pulling up her pants or prior to feeding one resident and then another.

An interview was conducted 9/7/17 at 1:12 p.m. with OSM #6, the dietary manager and OSM #7. the dining room manager. When asked when staff should change their gloves, OSM #7 stated, "They should change their gloves after they touch anything else then what they're serving. If they touch a resident or touch a table, they should wash their hands and put gloves back on."

An interview was conducted on 9/7/17 at 1:50 p.m. with OSM #4, the dietary aide. OSM #4 was asked the process staff followed when wearing gloves, OSM #4 stated, "Wash my hands before I put gloves on." When asked when she would remove her gloves and wash her hands, OSM #4 stated, "Whenever I touch anything but the food." OSM #4 was made aware of the above observation, OSM #4 stated, "I should have changed gloves and washed my hands."

An interview was conducted on 9/7/17 at 2:05 p.m. with CNA #2. When asked when staff wash their hands, CNA #2 stated, "Before and after care of course. Before and after bringing the meal into the room. Anytime you do any kind of care for anybody." When asked if staff sanitized their hands after touching their face and before feeding a resident, CNA #2 stated, yes. CNA #2 was made aware of the above observation. CNA #2 stated, "I should have washed my hands." When asked why staff wash their hands. "It's to stop the spreading of germs with the resident."

An interview was conducted on 9/7/17 at 2:10

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NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP O	CODE	
COVENAN	T WOODS NURSI	NG HOME		7090 COVENANT WOODS DRIVE MECHANICSVILLE, VA 23111		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC (DENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	,X5) COMPLETIO DATE	

F 441 Continued From page 31

p.m. with CNA #4. When asked when staff wash their hands, CNA #4 stated, "Before you go into a room. Before you feed them. When you go into the dining room. The whole day is washing your hands." CNA #4 was made aware of the above observation. CNA #4 stated, "Yes. I should have washed my hands between the patients and after I picked up my chair."

An interview was conducted on 9/7/17 at 2:15 p.m. with CNA #3. When asked when staff wash their hands, CNA #3 stated, "When we get them up for the bathroom. Before we go in the room and after we work with the resident. Even if I put my hand on a door knob." CNA #3 was asked if she touched the resident when a clothing protector was put on, CNA #3 stated, "Yes." When made aware of the above observation, CNA #3 stated, "I should have washed my hands." When asked why, "Germs, to sanitize them (hands)."

An interview was conducted on 9/7/17 at 2:17 p.m. with RN (registered nurse) #3, the evening unit manager. When asked when staff should wash their hands, RN #3 stated, "Any patient care, before and after. Before serve food." When asked if staff were feeding one resident and then began feeding another resident should they sanitize their hands, RN #3 stated, "Yes, they should sanitize their hands."

On 9/7/17 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's policy titled, "HANDWASHING / HAND HYGIENE"

F 441

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		ATE SURVEY OMPLETED
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F 441 F 514 SS=D	documented, "Pol hand hygiene the spread of infectior Implementation: 1 transmission of he 2. All personnel shandwashing/hand prevent the spread personnel, residen must wash hands using antimicrobia water under the fo and after direct resafter assisting a re No further informa 483.70(i)(1)(5) RECORDS-COMPLE (i) Medical records (1) In accordance washandards and practical resident processions of the spread of the sprea	icy: (Name of facility) considers primary means to prevent the ins. Policy Interpretation and it. Hygiene in preventing the ealthcare-associated infections it. Hygiene procedures to help it of infections to other its, and visitors. 5. Employees for at least fifteen (15) seconds for an infections: c. Before sident contact; g. Before and sident with meals."	F 441			
	(i) Complete;					
	(ii) Accurately docu	mented;				
	(iii) Readily accessi	ble: and				
	(iv) Systematically	organized				
	(5) The medical rec	cord must contain-				
	(i) Sufficient informa	ation to identify the resident;				



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- (ii) A record of the resident's assessments:
- (iii) The comprehensive plan of care and services provided:
- (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State:
- (v) Physician's, nurse's, and other licensed professional's progress notes; and
- (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. 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 maintain a complete and accurate clinical record for one of 12 residents in the survey sample, Resident #6.

The facility staff failed to document Resident #6 requested pain medication be given instead of being offered non-pharmacological interventions for pain relief.

The findings include:

Resident #6 was admitted to the facility on 7/1/11 and readmitted on 8/31/17 with diagnoses that included but were not limited to: kidney stones, difficulty urinating, diverticulitis (1) and macular degeneration (2). The most recent MDS, a significant change assessment, with an ARD of 8/24/17 coded the resident as being understood and understanding others. The resident was coded as having an intact long-term and short-term memory. The resident was coded as

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Event ID: I6EN11

Facility ID: VA0416

If continuation sheet Page 34 of 38



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requiring assistance from staff for all activities of daily living. In section J Health Conditions. Section JO300. Pain Assessment Interview. The resident was coded as having pain on a frequent basis. The resident was coded as having a ten out of ten on the pain rating scale, ten being the most severe pain.

Review of the care plan created on 5/23/17 documented "Pain Management. Resident has expressed/demonstration pain/discomfort related to: It (left) shoulder pain, low back pain. APPROACH: Encourage resident to tell nurse when pain interventions are not being effective. Assist the resident as needed to position in a manner that is most comfortable; use pillows or other devises as needed."

Review of the physician's orders dated September 2017 documented, "Norco (3) 5 mg (milligrams) - 325 mg tablet...Give one tab (tablet) every 4hrs prn (as needed)."

Review of the medication administration record documented, "Norco 5 mg-325 mg tablet Give one tab every 4hrs prn." The medication was documented as being administered on 9/1/17, 9/2/17, 9/417 and 9/5/17.

Review of the nurse's notes dated 9/2/17 at 9:27 p.m. documented "prn lortab (another name for Norco) given for c/o pain left (no location) 5/10 with good results no pain at this time."

An interview was conducted on 9/7/17 at 3:22 p.m. with LPN (licensed practical nurse) #1, the day shift unit manager. When asked the process staff followed when a resident complained of pain, LPN #1 stated, "We do an assessment, find

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F 514	medicate if it does would be document the nurse's notes." 9/2/17 nurse's notes should document value pain med (medicate) An interview was coper. With LPN # 2, the pain medication asked what process resident complained ask what the pain I asked if he had prointerventions prior LPN #2 stated, "Not gave it to her. I just On 9/8/17 at 12:15 member) #1 and A were made aware Review of the facility Assessment and Medicate in the pain I and A were made aware. The purpose intervention in the pain I and A were made aware. The purpose intervention in the pain I and A were made aware. The purpose intervention in the pain I and I assessment and I me purpose. The purpose intervention in the pain I and I assess of pain. De Interventions: 1. The part of the pain I are the p	is. We reposition first and then n't work." When asked if this ted, LPN #1 stated, "Yes, in When asked to review the ses, LPN #1 stated, "They what they did prior to giving the ion)." onducted on 9/7/17 at 3:25 the nurse who administered in on 9/2/17 at 9:27 p.m. When is staff followed when a did of pain, LPN #2 stated, "We evel is and document it." When ovided non-pharmacological to medicating the resident, it. She asks for the pill and I is didn't document it." p.m. ASM (administrative staff SM #2, the director of nursing	F 5	14 F 514 1. LPN #2 was counselled on the importance of non-pharmalogic interventions prior to administe medication as well as the import documenting pain related informatile. Resident #6 was not found adversely affected. 2. Pharmacy consultant will condustervice pertaining to the import non-pharmalogical intervention administering PRN medications 3. Nursing staff will review policy procedures for pain management including non-pharmalogical interventions. 4. Unit Manager or designee will prandom audits on all residents we receive PRN medication.	ering PRN retance of mation in to be uct an in- ance of as before s. y and nt	9/22/17 9/27/17 9/27/17
	resident's goals for specifically defined No further informat	treatment. Such goals will be and documented." ion was provided prior to exit.				
	Perry's Fundament	ation is found in Potter and als of Nursing 6th edition				

(2005, p. 477): "Documentation is anything

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written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner."

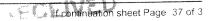
- (1) Diverticulitis: Diverticular disease of the colon is among the most prevalent conditions in western society and is among the leading reasons for outpatient visits and causes of hospitalization. While previously considered to be a disease primarily affecting the elderly, there is increasing incidence among individuals younger than 40 years of age. Diverticular disease most frequently presents as uncomplicated diverticulitis, and the cornerstone of management is antibiotic therapy and bowel rest. This information was obtained from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC31 74080/
- (2) Macular Degeneration: Macular degeneration, or age-related macular degeneration (AMD), is a leading cause of vision loss in Americans 60 and older. It is a disease that destroys your sharp, central vision. You need central vision to see objects clearly and to do tasks such as reading and driving. This information was obtained from: https://medlineplus.gov/maculardegeneration.htm

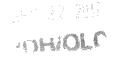
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Event ID I6EN11

Facility ID VA0416





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