STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495319	A. BUILDING _____ B. WING _____	02/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIAN	9229 ARLINGTON BLVD FAIRFAX, VA 22031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/13/2017 through 2/15/2017. No complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Survey/Report will follow. The census in this 100 certified bed facility was 69 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #13) and 3 closed records (Residents # 14 through #16).	F 000		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with	F 323		4/1/17

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

Electronically Signed | 03/02/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a safe environment on 1 of 3 units and for 1 resident (Resident #12) of 16 residents in the survey sample. During the medication pour and pass observation, (A) Licensed Practical Nurse C (LPN C) left medications on the top of the medication cart unattended and out of eye sight and (B) Licensed Practical Nurse A (LPN A) left medication on Resident #12's over bed table unattended, out of eye sight and within reach of the resident. The findings included: (A) On 2/14/17 at 8:30 a.m., a medication pour and pass observation was conducted with LPN C. At this time, LPN C prepared medications for Resident #11. Resident #11 sat next to the medication cart in the hallway while the medications were prepared. LPN C told Resident #11 she needed to take her into the room to administer the medications. LPN C covered the small medication cup with a larger plastic cup and left the medications on the top of the medication cart. LPN C asked this surveyor if it was ok if she left the medications on top of the cart. This surveyor did not respond. LPN C proceeded to push Resident #11 into her room. While in the room, LPN C had her back to the medication cart. The medications were not	F 323	It is the policy of The Virginian to ensure that our residents'□ environment remains as free from accident hazards as possible and each resident receives adequate supervision to prevent accidents. During the annual survey, two nurses were observed leaving medication out of sight during the medication pass observation. Nurse A left medication on Resident # 12□'s over bed table out of sight and within reach of the resident while washing her hands and LPN C left medications on top of the medication cart prepared for administration to Resident #11 out of sight while taking the resident to her room. Nurses A and C received in-service education regarding medication administration provided by the Omnicare Pharmacy Nurse. Resident #11 and #12 had no adverse effects from the medications being left out of sight of Nurses A and C. During the annual survey Unit Managers made rounds on each unit with no medications noted to be out of the line of sight of nurses.	

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F 323	Continued From page 2 within her line of sight. Around 10:30 a.m., the medication pour and pass observation was reviewed with LPN C. When asked if it was normal process to leave medications unattended on the top of the medication cart, LPN C stated no. She stated that she left them on the cart because this surveyor was standing with the medications after she had asked if it was ok. She stated that she would have put them in the cart if the surveyor was not there. It was reviewed with LPN C that surveyors are in the facility to observe and do not perform any type of nursing duties or patient care. (B) During the medication pour and pass observation on 2/14/17 at 9:13 a.m., LPN A left medication on Resident #12's over bed table unattended while in the bathroom washing her hands. The medication was out of LPN A's eye sight and within Resident #12's reach. Resident #12 was admitted to the facility on 2/9/17. Her diagnoses included respiratory disease, recurrent urinary tract infection, anemia, hypertension, constipation, anxiety, iron deficiency anemia, atrial fibrillation, weakness, chronic kidney disease stage 3, and cardiac pacemaker. Resident #12's most recent minimum data set assessment with an assessment reference date of 2/9/17 was coded as an admission tracking record, and did not include assessments. The Resident was a recent admission, and had been in the facility for only 6 days at the time of survey. Upon observation on 2/15/17, Resident #12 was found to be confused and lying in bed. Resident	F 323	No other residents were affected by this deficiency. Director of Nursing or designee will provide re-education to licensed nurses on resident safety during medication administration with medications being in the nurses line of sight at all times. Director of Nursing or designee will complete random audits of medication administration weekly on each shift for four weeks then monthly for two months. Results of these audits will be reviewed with the Quality Assurance Performance Improvement(QAPI)committee to ensure compliance.	

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F 323	Continued From page 3 #12 needed extensive to total assistance for all activities of daily living according to staff interview. LPN A prepared 10 milliliters (ml) of acetylaysteine (breathing treatment) in a 30 ml cup to be administered via nebulizer. LPN A entered Resident #12's room. Resident #12 was sitting in bed with the over bed table across her lap. LPN A set the medication cup on the over bed table. LPN A removed Resident #12's clothing protector. LPN A left the bedside to wash her hands in the resident bathroom. The medication was out of LPN A's sight while she was in the bathroom. After washing her hands, LPN A administered the breathing treatment. At the end of day meeting on 2/14/17, the Administrator, Director of Nursing and Clinical Manager were notified that two different nursed left medications unattended during the medication pour and pass observation. No further information was provided.	F 323		
F 327 SS=D	SUFFICIENT FLUID TO MAINTAIN HYDRATION CFR(s): 483.25(g)(2) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (2) Is offered sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced	F 327		4/1/17

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F 327	Continued From page 4 by: Based on observation, staff interview, and clinical record review, the facility staff failed for 1 resident (Resident #4) in the survey sample of 16 residents, to ensure that adequate hydration was available at the bedside. The facility staff failed to ensure that water was at Resident #4's bedside at all times. The Findings included: Resident #4 was a 77 year old who was admitted to the facility on 10/20/11. Resident #4's diagnoses included History of Fecal Impaction, History of Urinary Tract infection, Legal Blindness, and Parkinson's Disease. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 1/19/17 coded Resident #4 as having a Brief Interview of Mental Status Score of 3, indicating severe cognitive impairment. He was also coded as requiring staff assistance to set up his food and drinks in order to enable him to consume them. On 2/14/17 a review was conducted of Resident #4's clinical record. According to hospital documentation, he was sent to the hospital emergency room on 10/29/16. The hospital report read, "Diagnoses: Fecal Impaction in Rectum, Urinary Tract Infection." According to the Bowel Management Record, Resident #4 had daily bowel movements for each of the three days prior to the fecal impaction on 10/29/16.	F 327	It is the policy of The Virginian based on the comprehensive care plan to ensure our residents are offered sufficient fluid intake to maintain proper hydration and health. During the annual survey, based on observation, staff interview, and clinical record review, the facility staff failed to ensure that adequate hydration was available at the bedside for Resident #4. On 2/14/17 Unit Managers made immediate rounds to ensure residents had adequate hydration at the bedside. No other residents were affected by this deficiency. Director of Nursing or designee will identify residents who require assistance with hydration needs to ensure hydration needs are meet. Director of Nursing or designee will provide re-education to clinical staff on ensuring residents have fluids at the bedside, reporting bowel movements, signs and symptoms of fluid volume deficit and a urinary tract infection. Director of Nursing or designee will review alerts during daily clinical review meetings on Monday through Friday to ensure implementation of the bowel regimen per physician orders. Interdisciplinary Team members will	

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F 327	Continued From page 5 Resident#4's Care Plan read, "9/30/16. Potential for fluid volume deficit. Assess for dehydration. Diet - Thin liquids. Consistent Carbohydrate Diet; No added salt, Regular Consistency." On 2/14/16 at 9:30 A.M. an observation was made of Resident #4 in his room. There was no drinking water in his room. On 2/14/16 at 10:00 A.M. a second observation was made of Resident #4 in his room. There was no drinking water in his room. On 2/14/16 at 10:30 A.M. an observation was made of Resident #4 in his room. There was no drinking water in his room. Certified Nursing Assistant CNA A) was present in the room. When asked why Resident #4 did not have any drinking water, CNA A stated, "Water is supposed to be there each shift. It's supposed to be in a white styrofoam container. The night shift was supposed to put it there." The charge nurse (Registered Nurse B) was also present in the room. She stated, "I don't know where his water is. He's supposed to have it by his bedside. He doesn't have any swallowing problems. Not having water can cause dehydration and make him confused." On 2/14/16 at 5:00 P.M. the facility Administrator (Employee A) was informed of the findings. No further information was received.	F 327	review residents with changes in condition during the weekly Interdisciplinary Team meeting to ensure the plan of care is revised as indicated. Director of Nursing or designee will conduct random audits on each shift to ensure fluids are available at the bedside weekly for four weeks than monthly for two months. Director of Nursing or designee will review audit results with the QAPI committee to ensure compliance.	
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		4/1/17

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F 371	Continued From page 6 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to store, prepare, and serve food in a sanitary manner. The findings included; Five issues were identified as deficient in the kitchen on initial tour 2-13-17 at 2:30 p.m., and on the following day during tray line observation on 2-14-17 at 11:00 a.m. The tour was completed with the Dining Services Director on 2-13-17, and with the Chef on 2-14-17. Those issues included; 1) Upon entering the kitchen, a shelving unit for storage of dried foods, drink boxes, supplement drinks, and puddings was observed. The	F 371	It is the policy of The Virginian to store and prepare food in a sanitary manner. During the survey five issues were identified within the kitchen. Dining staff immediately removed pallets away from food shelving and placed them on the loading dock. The full trash bin was immediately taken out of the kitchen and taken to the loading dock area for emptying. Metal plate covers were immediately washed, dried and restacked. Expired syrups were discarded. Pots and containers in the sink were immediately re-sanitized per state regulation. Temperatures of food in hotboxes were immediately taken in the presence of the	

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F 371	Continued From page 7 shelving unit had (2) dirty, black substance encrusted, wooden truck delivery pallets leaning up on their sides against the front of the shelving unit, touching the stored food. Also, a large, gray trash bin measuring approximately 3 feet wide by 4 feet long by 3 feet deep, was observed full of boxes, and bags of garbage sitting against the pallets and food storage shelving unit. 2) On the clean cookware shelving unit, where clean cooking pans and metal plate covers were stacked after washing until needed for food preparation, approximately 30 metal plate covers were found stacked on top of one another wet (wet nested), and unable to air dry. They were stacked as clean for reuse. 3) Seven boxes of expired concentrated drink syrup was found connected by hoses to the soda machine for self service of Residents and visitors to the facility, and were in use during survey. The boxes originally contained between 2.5 and 5 gallons of syrup each, and had expired on different dates. Those dates were; 8-3-16, 9-3-16, 9-10-16, 11-7-16, (2) on 1-17-17, and 1-27-17. 4) At the 3 compartment sink, used for food defrosting, cook ware washing, rinsing, and sanitizing, and air drying, large cook ware pots were found sanitizing in a liquid quaternary chemical bath. One metal soup container was only half submerged, and not fully sanitizing. The dining services director was asked to check the dilution of the chemical bath with a chemical measuring paper strip to test the liquid for a proper level of chemical sanitizing. The strip revealed only 100 parts per million (PPM) solution, and the test was repeated with a second	F 371	surveyor and found to be in compliance. No individual Resident or any other Resident was affected by this deficient practice. Dining staff will be formally retrained on proper sanitation policies and procedures utilized for the three compartment pot sink, and policies regarding drying techniques, checking expiration dates on food items, and taking temperatures prior to food being placed in hot boxes. Attendance will be kept in the weekly training log. The Director of Dining Services and the Executive Chef will be responsible for training. Dining Operations Manager and the Executive Chef, or designee, will conduct random audits weekly to include all working shifts for four weeks, then monthly for two months.	

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F 371	Continued From page 8 strip which revealed the same result. The proper dilution of chemical Quaternary is 150 to 200 PPM. 5) During tray line observation at 11:00 a.m. on 2-14-17, hot box carts were observed being loaded, and destined for the kitchen service areas on each of the long term care units. Temperatures were being taken by one staff member for the items he was responsible for, as they were placed in the hot box carts. It was noted that the hot box carts already had food in them, and the temperature records were reviewed to reveal that the items previously placed in the boxes had not been temperature checked for proper safe holding and serving temperatures. The Staff member responsible for those items was interviewed in the presence of the chef, and she stated the temperatures had not been checked, and that she would remove the items and check them now. The Administrator, and Dining Services Director were notified of the kitchen issues on 2-14-17 during and after tour, and again at end of day debrief on 2-14-17, and on 2-15-17. The both stated the issues had been resolved by the end of survey on 2-15-17.	F 371		
F 386 SS=E	PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS CFR(s): 483.30(b)(1)-(3) (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;	F 386		4/1/17

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F 386	Continued From page 9 (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical documentation review, the facility staff failed for 9 residents (Resident #10, 4, 7, 2, 8, 14, 1, 9, 13) of 16 residents in the survey sample to ensure the physician signed and dated orders at each visit. 1. For Resident #10, the most current signed physician order sheet in the clinical record was dated 3/13/16. 2. For Resident #4, the facility staff failed to ensure that a recapitulation of care was done every 60 days. 3. For Resident #7, the facility staff failed to ensure that a recapitulation of care was done every 60 days. 4. For Resident #2, the facility staff failed to ensure physician orders were signed timely. 5. For Resident #8, the facility staff failed to ensure physician orders were signed timely. 6. For Resident #14, the facility staff failed to ensure physician orders were signed timely. 7. For Resident #1, the facility staff failed to ensure physician orders were signed timely.	F 386	It is the goal of The Virginian to ensure physicians review the residents total program of care as well as write, sign, and date progress notes at each visit. During the annual survey, based on staff interview and clinical documentation review, the facility staff failed for 9 of 16 residents to ensure the physician signed and dated orders timely and failed to ensure recapitulation of care was done every 30 days during the first 90 days after admission and then every 60 days thereafter. All residents have the potential to be affected by this deficiency. Nursing Management Team or designee will conduct an initial review and reconcile of physician orders with appropriate follow-up as indicated. Nursing Management Team or designee will conduct a physician order reconciliation and recapitulation of care audit for currently admitted residents with follow-up as indicated.	

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F 386	Continued From page 10 8. For Resident #9, the facility staff failed to ensure physician orders were signed timely. The findings included: 1. For Resident #10, the most current signed physician order sheet in the clinical record was dated 3/13/16. Resident #10, an 80 year old, was admitted to the facility on 12/20/12. Her diagnoses included end stage renal disease, diabetes, depression, dementia, insomnia and reflux. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/23/16. Resident #10 was coded with a Brief Interview of Mental Status score of 10 indicating moderate cognitive impairment. She required extensive assistance with her activities of daily living. A physician order sheet titled "Physician's Order Reconciliation for 1/30/16" was included in the clinical record. This form was signed by the physician on 3/13/16. At the end of day meeting on 2/14/17, it was reviewed with the Administrator, Director of Nursing and Clinical Manager that it appeared that the physicians were not signing physician orders with each physician visit for any of the residents in the facility. The facility staff were asked to provide any current signed physician order sheets for Resident #10. On 2/15/17 at 11:20 a.m., the Clinical Manager	F 386	Clinical Specialist or designee will develop and implement a recapitulation process for physicians. Nursing Home Administrator or designee will re-educate physicians on the policy and procedure for recapitulation of care. Director of Nursing or designee will provide re-education training on physician order review and reconciliation to licensed nurses. Director of Nursing or designee will conduct random audits of the recapitulation of care weekly for four weeks and monthly for three months. Results of these audits will be reviewed with the QAPI committee to ensure compliance.	

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F 386	Continued From page 11	F 386		

stated that the facility referred to the physician order sheets as a medication "reconciliation". He stated that the medication reconciliation forms were not consistently being reviewed and signed by the physicians. No additional medication reconciliation forms were provided for Resident #10.

2. For Resident #4, the facility failed to ensure that a recapitulation of care was done by the physician every 60 days.

Resident #4 was a 77 year old who was admitted to the facility on 10/20/11. Resident #4's diagnoses included History of Fecal Impaction, History of Urinary Tract infection, Legal Blindness, and Parkinson's Disease.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 1/19/17 coded Resident #4 as having a Brief Interview of Mental Status Score of 3, indicating severe cognitive impairment.

On 2/14/16 a review was conducted of Resident #4's clinical record. Resident #4's clinical record did not contain a recent recapitulation of care by Resident #4" physician. According to the most recent Physician's Note, Resident #4 was last examined on 10/23/16.

On 2/14/17 at 5:00 P.M. the facility Administrator (Employee A) was informed of the findings. No further information was received.

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3. For Resident #7, the facility failed to ensure that a recapitulation of care was done by the physician every 60 days.

Resident #7 was a 92 year old who was admitted to the facility on 4/22/15. Resident #7's diagnoses included Hypertension, Muscle weakness, Generalized, and Major Depressive Disorder.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 11/28/16 coded Resident #7 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment.

On 2/14/16 a review was conducted of Resident #7's clinical record. Resident #7's clinical record did not contain a recent recapitulation of care by Resident #4" physician. According to the most recent Physician's Note, Resident #7 was last examined on 10/23/16.

On 2/14/17 at 5:00 P.M. the facility Administrator (Employee A) was informed of the findings. She stated the she expected the recapitulations of care to be done every 60 days, and that it was not done. No further information was received.

4. For Resident #2, the facility staff failed to ensure physician orders were signed timely.

Resident #2 was originally admitted to the facility on 12-8-16. Diagnoses included; vertebral fracture, dementia, depression, glaucoma, anemia, hypertension, hypothyroid, anxiety, high cholesterol, fail to thrive, confusion, and left lung mass.

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The most recent Minimum Data Set (MDS) was a 30 day assessment with an Assessment Reference Date (ARD) of 1-7-17. The MDS coded Resident #2 with moderate cognitive impairment, and requiring extensive assistance with most activities of daily living. The Resident was coded as frequently incontinent of bowel and occasionally incontinent of bladder.

On 2-14-17 Resident #2's clinical record was reviewed. The review revealed the physician had not signed any of the recapitulation of orders titled "Physician's Orders" for the months of November and December of 2016, and January and February of 2017. The physician had seen and documented visits between the months in question, but failed to recapitulate and reinstitute the Resident's medication, and treatment orders.

On 2-14-17, and 2-15-17, the Administrator, clinical coordinator, and Director of Nursing were informed of the findings.

On 2-15-17 at 10:00 a.m. the Administrator, and Clinical Coordinator stated the orders had not been signed, and it was an oversight by the physicians. They stated they were working with the physician's to train them on the software program used for the order entry, and would be correcting the problem, and the orders had not been consistently recertified. No further information was provided by the facility staff.

5. For Resident #8, the facility staff failed to ensure physician orders were signed timely.

Resident #8, was admitted to the facility on 7-5-16. Diagnoses included; pubic fracture,

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dementia, high cholesterol, gastro-esophageal reflux disease, hypertension, Parkinson's disease, right hip pain, and overactive bladder.

Resident #8's most recent MDS with an ARD of 1-21-17 was coded as a quarterly assessment. The Resident was coded with a score of 6 in a possible 15 points, on a brief interview for mental status (BIMS), revealing moderate cognitive impairment. Resident #8 was coded as needing extensive assistance of one to two staff members for all of activities of daily living with the exception of eating, for which the Resident only needed supervision.

On 2-13-17, and 2-14-17, Resident #8's clinical record was reviewed. The review revealed the physician had not signed any of the recapitulation of orders titled "Physician's Orders" for the months of November and December of 2016, and January and February of 2017. The physician had seen and documented visits between the months in question, but failed to recapitulate and reinstitute the Resident's medication, and treatment orders.

On 2-14-17, and 2-15-17, the Administrator, clinical coordinator, and Director of Nursing were informed of the findings.

On 2-15-17 at 10:00 a.m. the Administrator, and Clinical Coordinator stated the orders had not been signed, and it was an oversight by the physicians. They stated they were working with the physician's to train them on the software program used for the order entry, and would be correcting the problem, and the orders had not been consistently recertified. No further information was provided by the facility staff.

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6. For Resident #14, the facility staff failed to ensure physician orders were signed timely.

Resident #14 was originally admitted to the facility on 11-22-16, and discharged home on 1-21-17. This record was a closed record review. Diagnoses included; Vitamin D deficiency, constipation, femur fracture, hypothyroidism, hypertension, overactive bladder, polyneuropathy, duodenal ulcer, and deep vein thrombosis.

The most recent Minimum Data Set (MDS) was a 30 day assessment with an Assessment Reference Date (ARD) of 11-22-16. The MDS coded Resident #14 with moderate cognitive impairment, and requiring limited to extensive assistance with most activities of daily living.

On 2-15-17 Resident #14's clinical record was reviewed. The review revealed the physician had not signed any of the recapitulation of orders titled "Physician's Orders" for the months of November and December of 2016, and January of 2017. The physician had seen and documented visits between the months in question, but failed to recapitulate and reinstitute the Resident's medication, and treatment orders.

On 2-15-17, at approximately 10:00 a.m., the Administrator, clinical coordinator, and Director of Nursing were informed of the findings.

On 2-15-17 at 10:00 a.m. the Administrator, and Clinical Coordinator stated the orders had not been signed, and it was an oversight by the physicians. They stated they were working with the physician's to train them on the software

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program used for the order entry, and would be correcting the problem, and the orders had not been consistently recertified. No further information was provided by the facility staff.

7. For Resident #1, the facility staff failed to ensure physician orders were signed timely.

Resident #1 was admitted to the facility on 12/31/2015 with the diagnoses of, but not limited to, Peripheral Vascular Disease, Blindness in Right Eye, Hypertension, Pressure Ulcer Right Buttock, Acute Cardiovascular Accident, Atrial Fibrillation, Chronic Urinary Retention and History of Transient Ischemic Attack.

The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/31/16. The MDS coded Resident # 1 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 1 was coded as requiring extensive assistance of one to two staff persons for bed mobility, dressing, toileting and hygiene; required total assistance of one staff person for bathing and supervision for eating; and always incontinent of bowel and a catheter for bladder.

On 2/14/17 at 9 a.m., Resident #1's clinical record was reviewed. Review of the Physicians orders revealed no signed recapitulation of orders in the paper clinical record from July 2016 to January 2017. Review of the Progress Notes revealed documentation of regular visits by the physician during that period but no recapitulation of orders.

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F 386	Continued From page 17 On 2/14/2017 at 11:20 a.m., an interview was conducted with the Assistant Director of Nursing (Admin D) who stated she was employed had been working as the Unit Manager on the unit and had not seen monthly Physician Order Summary Forms on the records. Admin D stated the Physicians should sign orders at least every 60 days. On 2/14/2017 at 11:30 a.m., an interview was conducted with Registered Nurse C (RN C) who stated that after admission, the facility physicians did not do monthly Physician Order Summary Forms. RN C stated the physicians sign telephone orders after nurses write them and also physicians write their own orders on the records. RN C stated the physicians should sign the Physician Order Summary Forms for recapitulation of orders every 60 days. On 2/14/2017 at 5:00 p.m. during the end of day debriefing, the Administrator, Director of Nursing and Clinical Manager were informed that there was no documentation of signed Physicians orders every 60 days for recertification in the clinical record. The facility staff were asked to provide copies of the signed Physicians orders for recertification. On 2/15/17 at 10:00 a.m., an interview was conducted with the Administrator, and Clinical Coordinator who both stated the orders had not been signed consistently for recertification and that it was an oversight by the physicians. They stated they were working with the physicians to train them on the software program used for the entry of orders, and would be correcting the problem.	F 386		

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On 2/15/2017 at 11:20 a.m. during the end of day debriefing, the Administrator, Director of Nursing and Clinical Coordinator were informed of the findings. The Clinical Coordinator stated the physicians were not signing the Physicians Orders for recapitulation of orders consistently. The Administrator stated the expectation was that physicians would recertify the residents every 30 days for the first 90 days, then every 60 days.

No further information was provided by the facility staff.

8. For Resident #9, the facility staff failed to ensure physician orders were signed timely.

Resident #9 was admitted to the facility on 1/14/2016 with the diagnoses of, but not limited to, Dementia, Diabetes , Hypertension, Major Depressive Disorder, Gastroesophageal Reflux Disease and History of Breast Cancer.

The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 11/30/16. The MDS coded Resident # 9 with a BIMS (Brief Interview for Mental Status) of 3/15 indicating severe cognitive impairment; Resident # 9 was coded as requiring extensive assistance of one to two staff persons for Activities of Daily Living; and always incontinent of bowel and bladder.

On 2/13/17 at 9:40 a.m., Resident #9's clinical record was reviewed. Review of the Progress Notes revealed Resident # 9 was seen by her physician on 3/31/2016, 6/30/2016 and 9/25/2016. Review of the Physicians orders

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F 386	Continued From page 19 revealed no signed recapitulation of Physicians orders during the time frames resulting in 91 days between 3/31/2016 and 6/30/2016 visits and 87 days between the 6/30/2016 and 9/25/2016 visits. On 2/14/2017 at 5:00 p.m. during the end of day debriefing, the Administrator, Director of Nursing and Clinical Manager were informed of no documentation of signed Physicians orders every 60 days in the clinical record. The facility staff were asked to provide copies of the signed Physicians orders for recertification. On 2/15/17 at 10:00 a.m., an interview was conducted with the Administrator, and Clinical Coordinator who both stated the orders had not been signed consistently for recertification and that it was an oversight by the physicians. They stated they were working with the physicians to train them on the software program used for the entry of orders, and would be correcting the problem. On 2/15/2017 at 11:20 a.m. during the end of day debriefing, the Administrator, Director of Nursing and Clinical Coordinator were informed of the findings. The Clinical Coordinator stated the physicians were not signing the Physicians Orders for recapitulation of orders consistently. The Administrator stated the expectation was that physicians would recertify the residents every 30 days for the first 90 days, then every 60 days. No further information was provided by the facility staff.	F 386		
F 387 SS=D	FREQUENCY & TIMELINESS OF PHYSICIAN VISIT CFR(s): 483.30(c)(1)(2)	F 387		4/1/17

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F 387	Continued From page 20 (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure one Resident (Resident # 9) in a survey sample of 16 Residents, was seen and evaluated by her clinician in a timely manner. For Resident # 9, the facility staff failed to ensure physicians visits were timely. Resident # 9 was not seen by the physician between 3/31/2016 and 6/30/2016 resulting in 91 days between visits and next seen on 9/25/2016 resulting in 87 days between visits 6/30/16 and 9/25/16. The findings included: Resident #9 was admitted to the facility on 1/14/2016 with the diagnoses of, but not limited to, Dementia, Diabetes , Hypertension, Major Depressive Disorder, Gastroesophageal Reflux Disease and History of Breast Cancer. The most recent Minimum Data Set (MDS) was an Annual Assessment with an Assessment Reference Date (ARD) of 11/30/16. The MDS coded Resident # 9 with a BIMS (Brief Interview for Mental Status) of 3/15 indicating severe	F 387	It is the policy of The Virginian to ensure residents are seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. During the annual survey, based on staff interview and clinical record review, the staff failed to ensure one resident (Resident #9) in a sample of 16 Residents, was seen and evaluated by her clinician in a timely manner. No other residents were affected by this deficiency. To identify other residents potentially affected by this deficient practice, the Medical Records clerk/designee will conduct an initial audit to record dates of the last physician visits for all residents in the Healthcare Center. Nursing Home Administrator or designee will provide re-education in-service to physicians, licensed nurses, medical records clerk, unit secretary regarding	

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F 387	Continued From page 21 cognitive impairment; Resident # 9 was coded as requiring extensive assistance of one to two staff persons for Activities of Daily Living; and always incontinent of bowel and bladder. On 2/13/17 at 9:40 a.m., Resident #9's clinical record was reviewed. Review of the Progress Notes revealed Resident # 9 was seen by her physician on 3/31/2016, 6/30/2016 and 9/25/2016. A thorough review of her clinical record revealed no other documentation of visits by the physician between 3/31/2016 and 6/30/2016 and 6/30/2016 and 9/25/2016. Resident # 9 was not seen by the physician between 3/31/2016 and 6/30/2016 resulting in 91 days between visits and next seen on 9/25/2016 resulting in 87 days between visits 6/30/16-9/25/16. On 2/14/2017 at 9:50 AM, an interview was conducted with the Unit Manager, Registered Nurse A (RN-A), who stated she would check to see if any other visits were documented. RN A stated the expectation was that the physician should have timely visits at least every 60 days. On 2/14/2017 at approximately 2 PM, the DON (Director of Nursing) stated the expectation was that the physicians should have timely visits at least every 60 days. During the end of day debriefing on 2/14/2017 at approximately 5:10 PM., the administrator, Clinical Manager (Admin E) and DON were informed of the failure of the staff to ensure Resident # 9 was seen by her clinician at least every 60 days. No further information was provided.	F 387	policy and procedure of frequency and timeliness of physician visits. Nursing Home Administrator or designee will notify physician of residents under their care who are in need of a documented physician visit. Medical Records clerk or designee will complete monthly audits to review Resident records for occurrence of physician visits with notification to the physician as indicated. Director of Nursing or designee will conduct random audits weekly for four weeks then monthly for two months with findings reviewed at the QAPI committee meeting.	

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For Resident #8, no clinician visit was made between 11-30-16 and 2-15-17, for a lapse of 78 days.

The findings included:

Resident #8, was admitted to the facility on 7-5-16. Diagnoses included; pubic fracture, dementia, high cholesterol, gastro-esophageal reflux disease, hypertension, Parkinson's disease, right hip pain, and overactive bladder.

Resident #8's most recent MDS with an ARD of 1-21-17 was coded as a quarterly assessment. The Resident was coded with a score of 6 in a possible 15 points, on a brief interview for mental status (BIMS), revealing moderate cognitive impairment. Resident #8 was coded as needing extensive assistance of one to two staff members for all of activities of daily living with the exception of eating, for which the Resident only needed supervision.

Review of Resident #8's clinical record revealed no clinician's visit or progress notes between 11-30-16, and 2-15-16 during survey, which was a lapse of (78 days). A thorough review of the clinical record indicated Resident #8 was a continuing Resident at the facility during the period of time in question.

The administrator and DON (director of nursing) were informed of the lack of any clinician visit for

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F 387	Continued From page 23 the 78 days, and they stated the Resident had not been seen during that time, and it was an oversight. As of the end of the survey, no further information was provided.	F 387		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure medication was available for one resident (Resident #1) in a survey sample of 16 residents. For Resident # 1, the facility staff did not administer the medication, Vitamin D 2 50,000 unit capsule on 2/5/2017. Vitamin D 2, a medication used for the treatment of Vitamin D deficiency, was circled as not administered and unavailable for administration on 2/5/17. The findings included: Resident #1 was originally admitted to the facility	F 425	It is the policy of The Virginian to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. It was identified during the annual survey, the facility staff failed to ensure medication (Vitamin D) was available for Resident #1. Resident received the medication (Vitamin D) as ordered. Residents medication supplies were checked by the Unit Managers to ensure medications were available with no other	4/1/17

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F 425	Continued From page 24 on 12/31/2015 with the diagnoses of, but not limited to, Peripheral Vascular Disease, Blindness in Right Eye, Hypertension, Pressure Ulcer Right Buttock, Acute Cardiovascular Accident, Atrial Fibrillation, Chronic Urinary Retention and History of Transient Ischemic Attack. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 12/31/16. The MDS coded Resident # 1 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 1 was coded as requiring extensive assistance of one to two staff persons for bed mobility, dressing, toileting and hygiene; required total assistance of one staff person for bathing and supervision for eating; and always incontinent of bowel and a catheter for bladder. On 2/14/17 at 9 a.m., Resident #1's clinical record was reviewed. The review revealed a physician's order dated 9/30/2016 which read: Vitamin D 2 50,000 unit capsule one capsule by mouth every week. The order was transcribed on the February 2017 Medication Administration Record (MAR) as ordered to be administered at 9 a.m. Review of the February 2017 MAR, on page 2, revealed circle around the initial "N" for 2/5/17. On page 5 of the MAR under the "order text" section was observed to have the following documentation for 2/5/17 at 9:00 a.m.: "Med (medication) Not Administered" Under the "notes" section was written "Not available, call made to pharmacy and will send vit. (vitamin) D 50,000 units." Review of the Interdisciplinary Notes revealed documentation on 2/5/2017 at 4:05 PM of	F 425	residents affected by this deficiency. Director of Nursing or designee will provide re-education to licensed nurses on the policy and procedure to ensure medications are available and steps to take when medications are needed. Director of Nursing or designee will complete random audits of medication availability on each shift for four weeks then monthly for two months. Results of these audits will be reviewed with the QAPI committee.	

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F 425	Continued From page 25 "Resident Vit (vitamin) was not given today was not available pharmacy notified will sent (sic) dose as soon as possible was reordered." An interview and MAR review were conducted with the Clinical Manager (Admin D) on 2/15/17 at 9:15 a.m. When asked about the procedure regarding administration of medications, Admin D stated the nurse should call the pharmacy immediately to request a medication that is not available at the scheduled time of administration. Admin D stated the facility has a staff member available to pick up any medication. A request for the emergency (stat) box medication list was requested. On 2/15/17 at 10:50 a.m. an interview was conducted with Admin D who stated he had checked the documentation in the computer and with Pharmacy and determined that the medication was not administered on 2/5/2017. Admin D stated the expectation was that medications should be administered as ordered by the physician. A list of the contents of the stat box was not presented to the surveyor. It was undetermined if the Vitamin D 2 50,000 units was available in the stat box at the time it was circled on the MAR as "unavailable." During the end of day debriefing on 2/15/2017 at 11:10 a.m., the facility Administrator and Director of Nursing were informed of the findings. The facility staff did not present any further information regarding the findings.	F 425		
F 428	DRUG REGIMEN REVIEW, REPORT	F 428		4/1/17

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F 428 SS=E	Continued From page 26	F 428		

IRREGULAR, ACT ON
CFR(s): 483.45(c)(1)(3)-(5)

c) Drug Regimen Review

(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic.

(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.

(iii) The attending physician must document in the resident's medical record that the identified

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F 428	Continued From page 27 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure irregularities identified during the monthly pharmacy drug regimen reviews were reported to the facility's medical director. During the time period of 11/28/16- 2/15/17, the facility's medical director had not reviewed irregularities identified during the monthly pharmacy drug regimen reviews. The findings included: At the end of day meeting on 2/14/17, it was reviewed with the Administrator, Director of Nursing, and Clinical Manager that the survey team was having difficulty locating pharmacy drug regimen reviews and recommendations in the clinical records. It was also reviewed that for the pharmacy reviews which were located in the clinical record, it did not appear that the medical director was involved in the review of irregularities. It was reviewed that the	F 428	It is the policy of The Virginian that residents□ drug regimen is reviewed monthly by a licensed pharmacist with irregularities reported an acted on. During the annual survey, based on staff interview and clinical record review, from 11/28/16-2/15/17, the facility□'s Medical Director had not reviewed irregularities identified during the monthly pharmacy drug regimen reviews. All residents had the potential to be affected by this deficiency. During the annual survey, a monthly pharmacy drug regimen review was completed by the Omnicare Pharmacy Consultant. The results of the monthly pharmacy drug regimen review were submitted to the Medical Director, Attending Physician, and Director of Nursing for review and follow-up.	

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F 428	Continued From page 28 requirement for the medical director to review pharmacy drug regimen review irregularities was included in the federal regulation changes effective 11/28/16. The facility staff were asked to look into the issue and get back with the survey team the next day. At this time, the Administrator stated that the medical director had not been involved in the review of irregularities reported by the pharmacist. On 2/15/17 at 11:25 a.m., the Administrator stated that she had located a pile of pharmacy drug regimen review information on the desk of the former Director of Nursing. She stated that the medical director had come to the facility earlier in the morning to review the pile of pharmacy drug regimen review information. The Administrator provided the policy "Drug Regimen Review" with a revision dated of 2/17. The policy read "Findings and recommendations will be reported to the Director of Nursing, the attending physician and Medical Director." When asked when the policy became effective, the Administrator stated yesterday (2/14/17).	F 428	Nursing Home Administrator will review the policy and procedure of follow-up on the recommendations of the monthly drug regimen review results with the Medical Director, Director of Nursing or designee, and the Pharmacy Consultant. Director of Nursing or designee will revise guidelines to follow when monthly pharmacy drug regimen review results are received from the Pharmacy Consultant. Director of Nursing or designee will re-educate Nursing Supervisors on the actions to take when the monthly pharmacy drug review results are received. Director of Nursing or designee will conduct random audits of the monthly pharmacy drug regimen review recommendations weekly for four weeks then monthly for two months. Omnicare Pharmacy Consultant will monitor follow-up on the previous month□s pharmacy drug regimen results during the review of the current months pharmacy drug regimen review. Results of these audits will be reviewed during the QAPI committee meeting to ensure compliance.	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 441		4/1/17

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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:

(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 involved, and

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F 441	Continued From page 30 (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 and staff interview, the facility staff failed to implement an effective infection control program. During the medication pour and pass observation, three of the four nurses observed did not use a paper towel to turn off the faucet after washing their hands. The findings included: The medication pour and pass observation began	F 441	It is the policy of The Virginian to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. During the annual survey, based on observation and staff interview, the facility staff failed to implement an effective infection control program in the area of hand hygiene procedures. Three licensed	

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F 441	Continued From page 31 on 2/14/17 at 7:55 a.m. with Licensed Practical Nurse B (LPN B). LPN B entered Resident #10's room and checked Resident #10's blood sugar. Resident #10, an 80 year old, was admitted to the facility on 12/20/12. Her diagnoses included end stage renal disease, diabetes, depression, dementia, insomnia and reflux. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/23/16. Resident #10 was coded with a Brief Interview of Mental Status score of 10 indicating moderate cognitive impairment. She required extensive assistance with her activities of daily living. After checking Resident #10's blood sugar, LPN B entered the bathroom and washed her hands. LPN B did not use a paper towel to turn off the faucet. LPN B prepared and administered Resident #10's medications. Afterwards, LPN B washed her hands again without using a paper towel to turn off the faucet. On 2/14/17 at 8:30 a.m., the medication pour and pass observation continued with LPN C. LPN C prepared and administered Resident #11's medications. Resident #11, a 91 year old, was admitted to the facility on 6/24/15. Her diagnoses included dementia, depression, chronic kidney disease and heart failure. The most recent Minimum Data Set assessment was an annual assessment with an assessment reference date of 2/6/17. Resident #11 was coded with a Brief Interview of	F 441	nurses failed to use a paper towel to turn off the faucet after washing their hands during the medication pass observation to Residents #10, 11, and 12. Residents assigned to licensed nurses A, B, and C had the potential to be effected by this deficient practice. During the survey, in-service education on hand washing policy and procedure was initiated by Nursing Supervisors to the clinical staff. Director of Nursing or designee will re-educate clinical staff on proper hand washing/hand hygiene policy and procedures. Director of Nursing or designee will complete random audits on hand washing three times a week for four weeks then monthly for two months. Director of Nursing or designee will complete random audits of hand washing/hand hygiene practices during the medication pass weekly on each shift for four weeks then monthly for two months. Audit results will be reviewed with the QAPI Committee to ensure compliance.	

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Mental Status score of 12 indicating mild cognitive impairment. She required extensive assistance with her activities of daily living.

LPN C first administered Resident #11's inhaler. Afterwards, LPN C proceeded to the bathroom. LPN C was observed to wash her hands for approximately 10 seconds. She turned the faucet off with her bare hands.

On 2/14/17 at 9:13 a.m., the medication pour and pass observation continued with LPN A. LPN A prepared a breathing treatment for Resident #12.

Resident #12 was admitted to the facility on 2/9/17. Her diagnoses included respiratory disease, recurrent urinary tract infection, anemia, hypertension, constipation, anxiety, iron deficiency anemia, atrial fibrillation, weakness, chronic kidney disease stage 3, and cardiac pacemaker.

Resident #12's most recent minimum data set assessment with an assessment reference date of 2/9/17 was coded as an admission tracking record, and did not include assessments. The Resident was a recent admission, and had been in the facility for only 6 days at the time of survey. Upon observation on 2/15/17, Resident #12 was found to be confused and lying in bed. Resident #12 needed extensive to total assistance for all activities of daily living according to staff interview.

LPN A removed Resident #12's clothing protector. LPN A then entered the bathroom to wash her hands. LPN A was observed to turn the faucet off with her bare hands. After washing her hands, LPN A turned to exit the bathroom and realized

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this surveyor was observing. She turned back to the sink and washed her hands with proper handwashing technique.

At 10:40 a.m., LPN B was asked to explain proper handwashing technique. LPN B stated that hands should be washed for 20 seconds and a paper towel should be used to turn off the faucet. It was reviewed with LPN B that she was observed to turn the faucet off with her bare hands during the medication pour and pass observation.

At 10:55 a.m., LPN C was asked to explain proper handwashing technique. LPN C stated that hands should be washed for 2 minutes and a paper towels should be used to turn the faucet off. It was reviewed with LPN C that she was observed to wash her hands for approximately 10 seconds and did not use a paper towel to turn off the faucet.

On 2/14/17 at the end of day meeting, handwashing issues observed during the medication pour and pass observation were reviewed with the Administrator, Director of Nursing and Clinical Manager.

The Clinical Manager, who functions as the facility's infection control nurse, was interviewed on 2/15/17 at 9:00 a.m. The Clinical Manager stated that all nursing staff receive handwashing training. He stated that on the spot training is performed if an issue is identified by the management team when they are out on the units.

The facility policy titled "Hand Washing/ Hand Hygiene" was reviewed. The "Procedure for

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F 441	Continued From page 34 Washing Hands" read "2. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for at least twenty (20) seconds under a moderate stream of running water, at a comfortable temperature." The policy also read "Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel."	F 441		