STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495002	A. BUILDING _____ B. WING _____	03/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

(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	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 03/01/16 through 03/03/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 98 certified bed facility was 83 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents 1 through 14 and 20) and 5 closed record reviews (Residents 15 through 19).

F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226	

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review the facility staff failed to implement abuse protocol for screening of new staff for 1 of 25 new hires.
Findings included:
For new hire #18 the facility staff failed to obtain a criminal record background check within 30 days of hire date per their abuse policy for screening of new hires.
The facility staff provided the survey team with a facility document that listed 25 new hires. All of

The criminal background check for new hire #18 was late being sent to the VA State Police Dept. and was consequently not returned within the 30 day window. When returned it showed no criminal convictions. During this time there were no disciplinary issues with the employee and no resident was affected.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Administrator 03/18/16

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 226 Continued From page 1

these employee records were chosen for review the team leader.
A review of the employee records was completed on 03/02/16.
New hire #18 was a CNA (certified nurse's assistant) with a hire date of 10/05/15. The facility staff did not complete a Virginia State Police criminal record check until 11/11/15. No problems were noted when this background check was completed.
The facility policy and procedure on screening of new hires was reviewed and read as follows "Procedure
2. After hire. the employee will submit to a criminal background check as required by State and Federal regulation. This request is sent within one week of employment to the Virginia Department of State Police."
The surveyor spoke with facility human resources manager on 03/03/16 at approximately 0825 regarding the criminal background check for new hire #18. Human resources manager confirmed that she had sent the background check in late. The concern of the late criminal background check was brought to the attention of the administrative staff during a meeting on 03/03/16 at approximately 1100.
No further information was provided prior to exit

F 226

All residents have the potential to be affected if the facility fails to timely conduct criminal backgrounds of employees.

On or before April 8, 2016 all employees involved in the hiring process will receive additional training on the regulations, procedures, and policies regarding F 226. In addition, the facility is reviewing its procedure to make sure background checks are sent on time and will add additional oversight to this process to ensure compliance.

For the next 90 days, the Administrator or Assistant Administrator will review each new employee to make sure the criminal background check has been submitted timely. After this period, the Administrator or Assistant Administrator will sample 50% of completed applications to make sure all policies and procedures are being correctly followed and background checks are being returned as required. These samplings will be reviewed quarterly at QA meeting.

All issues regarding F 226 will be complete by 4/8/16.

F 278 SS=D 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

F 278

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

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F 278	Continued From page 2 A registered nurse must sign and certify that the Assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1 , 000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by Based on staff interview and clinical record, the facility staff failed to ensure an accurate Minimum Data Set(MDS) for 1 of 20 residents (Resident #9). The findings include The facility staff failed to ensure an accurate Minimum Data Set (MOS) assessment for Resident #9. Resident #9 was admitted to the facility on 5/29/15 with diagnoses of Alzheimer's disease, Myasthenia Gravis, hypertension, depression, arthritis, gastro-esophageal reflux disease, and	F 278	A significant correction of the 11-24-15 MDS, section V, CAA summary to denote dates/locations of CAA information for Resident #9 was conducted on 3-15-16. The MDS department will conduct a review of 20% of Comprehensive Assessments, Section V, CAA summary to determine compliance with identifying date and location of CAA information by April 8, 2016. Beginning March 7, 2016, the MDS coordinator will review all Comprehensive Assessments, Section V to monitor for compliance with the date and location of the CAA information each week for 12 weeks. A weekly report will be forwarded to the Administrator or Designee for review and compliance will be reviewed quarterly at QA. All issues regarding F 278 will be completed by 4-8-16.	

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F 278 Continued From page 3 F 278

bipolar disease.

The significant change Minimum Data Set (MOS) with a reference date of 11/24/15 was reviewed. The resident was assessed with long and short term memory deficit The resident was assessed requiring total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene.

Section V for Care Area Assessment (CAA) Summary was also reviewed. The facility staff failed to identify the date and location of the CAA information used to determine the care plan. The only documentation was the "CAA WS (work sheet) dated 12/8/2015".

The MDS coordinator (RN#1) was interviewed on 3/2/16 at 9 25 a.m. regarding the CAA summary. RN#1 stated computer reports were used to determine care planning, but stated she did not document where the information was obtained.

The administrator, director of nursing, and assistant administrator were informed of the findings during a meeting with the survey team on 3/2/16 at 4:00 p.m.

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN — F 282

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by

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NAME PROVIDER OR SUPPLIER	STREET ADDRESS. CITY STATE, ZIP CODE
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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 282 Continued From page 4

Based on observation, staff interview and clinical document review it was determined the facility failed to provide care by qualified people in accordance with the plan of care for 1 of 20 residents (Resident #20.)

Findings:

Resident #20 was admitted to the facility on 10/25/13. The diagnoses included : GERO (Gastro esophageal reflux disease,) constipation and pressure ulcers.

The latest MOS (minimum data set) assessment coded the resident with mild cognitive impairment. She required the assistance of at least one staff member for the accomplishment of the ADLs (activities of daily living) with set-up only to eat The resident required staff assistance to The MOS coded Resident #20 at risk for actual pressure ulcers.

The CCP (comprehensive care plan) revised on 1/26/16 noted the problem of GERO. The interventions to staff was to "Keep head of bed up at 90 degrees or sitting in chair at least 30 minutes after eating."

The CCP included the resident had a self-care performance deficiLshe was independent in eating after set-up, limited to extra assist with other ADLs. The intervention to staff was provide and serve diet as ordered.

The CCP acknowledged a potential for pressure sores development. The intervention to staff was to float heels when she is in bed.

F 282

When informed of the issues, staff members promptly implemented the appropriate plan of care for resident #20. Additionally, she was seen by her physician the following morning.

To ensure appropriate care plan adherence for other residents on or before 4-8-16, facility staff will review 100% of residents having physician orders requiring feeding assistance, positioning, and pressure ulcer prevention in order to make sure all physician orders are being followed.

Prior to 4-8-16, all nursing employees will receive inservicing as it relates to F 282.

A sampling of 50% of residents with the identified physician orders will be reviewed for compliance. The facility will appoint specific staff members who will be responsible for ensuring that the physician orders related to feeding assistance, proper positioning, and pressure ulcer prevention are being followed X 90 days. These staff members will report directly to the DON or Administration who will review the reports, take appropriate action where necessary, and report the findings to the QA committee.

All issues regarding F 282 will be complete by 4-8-16.

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F 282	Continued From page 5	F 282		

On 3/3/16 at 8:05 AM the resident was observed to have her tray set up in her bed so she could eat breakfast The resident had a bowl of grits on the tray. The CNA removed the lid from the grits, but did not offer to assist the resident with the condiments (Butter, sugar, salt, pepper) left unopened on the tray.

The surveyor asked Resident #20 if she required any of the condiments on her grits or other food items. The resident picked up the sugar and asked the surveyor to put it in her grits.

The surveyor went out to find CNA I to assist the resident. CNA I said the staff member setting up the tray should ask the resident if she wanted sugar and butter on her grits during the tray set-up.

The surveyor left the room and returned at 8 15 AM to find the resident finished with her meal tray and lying flat down in the bed with a big brown blanket over her. Her feet were not observed to be floated.

CNA II came into the room to assist the resident to the toilet She was asked about floating Resident #20's feet. She said the resident moves around so much by her self, they don't try to float them.

RN Iwas asked about floating the resident's feet and the manner in which they were floated. RN I said she was floated using a heel's up wedge. She said she checked the wedge off the treatment sheet as there every day. The surveyor accompanied RN I to the resident's room to find the heel-up pillow. None was found in the room.

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F 282 Continued From page 6

The resident was still lying flat in the bed after her breakfast.

The treatment sheets for February and March 2016 were observed to be checked of for heels floated at all times--may use heel's up cushion.

The surveyor's observations were reported to the DON and administrator prior to exit. The surveyor said the staff were not following the plan of care to address Resident #20's requirements for feeding assistance, positioning, or pressure ulcer prevention.

No additional information was provided. The DON told the survey team she would expect the CNA's to provide the careplaned interventions for residents in all these areas.

F 282

F 312 SS=D 483.25(a)(3) AOL CARE PROVIDED FOR DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by Based on observation, staff interview and clinical document review it was determined the facility staff failed to provide necessary AOL (actvities of daily living) feeding tray assistance for 1 of 20 residents (Resident #20.)

Findings:

F 312

When informed by the surveyor that the residents tray was not satisfactorily set-up, a C.N.A. went in to the room and assisted the resident.

All residents have the potential to be affected by staff members who do not set up the meal tray for residents as needed.

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F 31 Continued From page 7

Resident #20 was admitted to the facility on 10/25/13. The diagnoses included : GERO /Gastro esophageal reflux disease,) constipation and pressure ulcers.

The latest MOS (minimum data set) assessment coded the resident with mild cognitive impairment. She required the assistance of at least one staff member for the accomplishment of the ADLs (activities of daily living) with set-up only to eat. The resident required staff assistance to position her in bed.

The CCP included the resident had a self-care performance deficit...she was independent in eating after set-up, limited to extra assist with other ADLs. The intervention to staff was provide and serve diet as ordered.

On 3/3/16 at 8:05 AM the resident was observed to have her tray set up in her bed so she could eat breakfast. The resident had a bowl of grits on the tray. The CNA removed the lid from the grits, but did not offer to assist the resident with the condiments (Butter, sugar, salt, pepper) left unopened on the tray. The CNA then left the room.

The surveyor asked Resident #20 if she required any assistance to place any of the condiments on her grits or other food items. The resident picked up the sugar and asked the surveyor to put it in her grits.

The surveyor went out to find CNA I to assist the resident. CNA I said the staff member setting up the tray should ask the resident if she wanted sugar and butter on her grits during the tray set-up. She assisted the resident with the

F 312

Prior to 4-8-16, all C.N.A.'s will receive additional training on the importance of assisting residents in tray set-up. Specific employees will be designated to check that resident trays are properly set up depending on the residents specific need.

Facility will develop an audit tool for staff to use for monitoring and compliance. For the next 3 months, 50% of residents unable to perform ADL for meal set-up independently will have their trays reviewed with results forwarded to the DON. The DON will bring findings to the QA meetings for any additional follow up and/or inservicing needs until the issue is resolved.

All issues regarding F 312 will be resolved by 4-8-16.

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(X41 ID PREFIX	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)	COMPIE TiON

F 31 Continued From page 8
condiments.

On 3/3/16 at 10:00 AM the OM (dietary manager) was asked about the tray set-up and condiments placed on the trays. The OM said they only put butter in the grits in the kitchen, but place sugar and extra butter on the trays for resident who wish to use it. The CNAs then set up the tray to the resident's preferences

At 11:00 AM the surveyor's observations were reported to the DON and administrator prior to exit. The surveyor said the staff were to assist residents with their tray set-up as necessary.

No additional information was provided.

F 312

F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES
SS=D

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by
Based on observation, staff interview and clinical document review it was determined the facility staff failed to follow physician's orders for the prevention of pressure ulcers for 1 of 20 residents (Resident #20.) interventions.

F 314

The C.N.A. caring for resident #20 had taken the heels up cushion to the laundry for cleaning. When notified by the surveyor the heels were not floated as care planned, a staff member obtained another device and promptly floated the residents heels.

On or before 4-8-16, all residents with physician ordered interventions as it relates to pressure ulcer prevention will be reviewed for compliance. 100% of TAR's as they relate to pressure ulcer prevention will be reviewed.

All Licensed Nurses will be inserviced on the proper protocol for signing interventions as they relate to pressure ulcer prevention. C.N.A.'s will be inserviced on proper adherence and importance of implementing pressure reduction devices.

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F 314 Continued From page 9

Findings:

Resident #20 was admitted to the facility on 10/25/13. The diagnoses included : GERO (Gastro esophageal reflux disease,) constipation and pressure ulcers.

The latest MOS (minimum data set) assessment coded the resident with mild cognitive impairment. She required the assistance of at least one staff member for the accomplishment of the ADLs (activities of daily living) with set-up only to eat. The resident required staff assistance to position her in bed.

The MOS coded Resident #20 at risk for actual pressure ulcers.

The CCP acknowledged a potential for pressure sores development. The intervention to staff was to float heels when she is in bed.

Resident #20's physician's orders , signed and dated on 3/1/16, included the order, "Float heels at all times, may use heels up cushion."

On 3/3/16 at 8:05 AM the resident was observed to have her tray set up at her bed side so she could eat breakfast. The surveyor left the room and returned at 8: 15 AM to find the resident finished with her meal tray and lying flat down in the bed with a big brown blanket over her. Her feet were not observed to be floated.

CNA II came into the room to assist the resident to the toilet. She was asked about floating Resident #20's feet. She said the resident moves around so much by her self, they don't try to float them.

F314

Prior to 4-8-16 the facility will develop an audit tool to ensure interventions for pressure ulcer prevention are being followed. Specific staff will be selected to complete these audits which will then be provided to the DON and Administration. The DON or designee will visually observe 50% of residents with ordered pressure relieving devices 3X a week for 90 days. Audit results will be reviewed by Administration monthly and reviewed quarterly at QA.

All issues regarding F 314 will be resolved by 4-8-16.

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F 314 Continued From page 10 F 314

At 10:10 AM, RN I was asked about floating the resident's feet and the manner in which they were floated. RN I said she was floated using a heel's up wedge. She said she checked the wedge *off* the treatment sheet as it was used every day. The surveyor accompanied RN I to the resident's room to find the heel-up pillow. None was found in the room. The resident was still lying flat in the bed after her breakfast and toileting break.

RN I checked the resident's skin integrity on both feet. The resident's left great toe and left heel were reddened, but blanchable. The skin on the left foot was intact The resident did not exhibit any signs or symptoms of distress during the exam.

The treatment sheets for February and March 2016 were observed to be checked of for heels floated at all times--may use heel's up cushion.

The surveyor's observations were reported to the DON and administrator prior to exit. No additional information was provided.

F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY F 371
SS=F

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and
(2) Store, prepare, distribute and serve food under sanitary conditions

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F 371 Continued From page 11

This REQUIREMENT is not met as evidenced

Based on observations, staff interviews, and a facility document review, the facility's staff failed to store, prepare and serve food in a safe and sanitary manner.

The findings include:

The initial tour of the kitchen was conducted on 3/1/16 at 3:00 pm. The dietary manager *gave* a tour of the kitchen. The hood over the stove was observed to have significant amount of dust. The dietary manager said it was last cleaned in January, 2016.

The dietary manager took the surveyor to the dry storage area. There were no dates listed on the gourmet coating crumbs. The surveyor asked how the rotation of the dry food was done without a date. He said as the supplies came in they were rotated back to front. However, there were no dates to determine if this process was being followed by the staff The surveyor noted a box of approximately 70 individual size Special K cereals with an expiration date of August, 2015. The dietary manager said "I didn't know it had expired" he also said he would check if any of the residents were requesting the cereal. After checking he informed the surveyor none of the residents had requested that brand of cereal.

On 3/3/16 at 11:25 am, the surveyor returned to the kitchen and asked the cook to check the tray line temperatures. The temperatures on the tray line were maintained at 140 degrees and greater. However, the cook leaned the food thermometer against the wall of the pan that contained the

F 371

The box of Special K and breadcrumbs were thrown out the day of the survey. All other food items were reviewed and found to be within acceptable dates. The hood over the stove was cleaned during survey.

All residents have the potential to be affected if proper procedure is not followed as it relates to rotation of food stock.

On or before 4-8-16, all individuals working in the dietary dept. will receive inservicing on proper food storage and rotation procedures as well as serving food under sanitary conditions. A system of dating food procured will be implemented. This will enable employees to safely track "best if used by" and actual "expired" food items.

To ensure there is not a recurrence, for the next 3 months the dietary manager will make a weekly inspection of the food storage area. A written report will be presented to the Administrator outlining that all food items were within acceptable dates and that for any item found to be outside acceptable storage parameters corrective action was taken. The food storage policy as it relates to F 371 will be reviewed and revised as necessary. All results will be forwarded to the QA committee for review and necessary follow-up.

All corrective action for F 371 will be completed by 4-8-16.

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	495002	A BUILDING_____ B. WING_____	03/03/2016

NAME PROV! DER OR SUPPLIER	STREET ADDRESS, CITY. STATE. ZIP CODE
SOUTH ROANOKE NURSING HOME INC	3823 FRANKLIN RD, SW ROANOKE, VA 24014

ID 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)
F 371	Continued From page 12 chopped chicken. As he moved on he placed the thermometer in the pan of greens allowing the plastic top to touch the food. On 3/4/16 at 11:00 am, the administrator, assistant administrator and director of nurse were informed of the tray line issues, the dusty hood, and the dry food storage.	F 371	
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by Based on observation and staff interview, the facility failed to ensure the dumpster lid was Closed. The findings include: The dumpster area was observed on 3/1/16 at 3 15 p.m., by the surveyor and the dietary director. The dumpster had a side slide door and a top lid. Both were observed to be open. The dietary director stated the dumpster had been emptied that day and someone had put a more trash in leaving it open. On 3/2/16 the assistant administrator was informed of the open lid on the dumpster; she said "it needs to be kept closed." The administrator assistant administrator and director of nursing were informed of the findings	F 372	The dumpster sits approximately 150 feed from the closest point of the building. Both the lid and door were closed the day of survey. All residents have the potential to be affected if proper infection control procedures are not followed when disposing of garbage or refuse. On or before 4-8-16, all individuals in the dietary and house-keeping departments will receive inservicing on the regulation to keep the dumpster doors closed at all times. On 3-18-16, the facility ordered signage to affix to the dumpster that the door and lid is to be closed at all times. Beginning 3-21-16 and continuing for 3 months, the Housekeeping and Dietary managers will inspect the dumpster twice each day to make sure the lids are closed. If lids are found open, the manager will determine which employee was involved and take appropriate action. Administration will be informed of non-compliance and who was responsible. After 6-21-16, random inspections will occur with any negative results reported to Administration. All issues related to F 372 will be resolved by 4-8-16.

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F 372	Continued From page 13 during a meeting with the survey team on 3/3/16 at 11:00 a.m.	F 372		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

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.

The facility must employ or obtain the services of a licensed pharmacist who 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 document review, and clinical record review, the facility staff failed to ensure medications were available for administration for 2 of 20 residents (Residents #7 and #8).

The findings include:

1. The facility staff failed to ensure the

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F 425 Continued From page 14

medication , Tobradex eye drops (an antibiotic) were available for administration to Resident #7.

Resident #7 was admitted to the facility on 8/19/15 with diagnoses of dementia, depression, anxiety, psychosis, hypertension, and a wound infection.

The current quarterly Minimum Data Set (MOS) with a reference date of 1/27/16 assessed the resident with a cognitive score of "6" of "15'. The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, toileting, bathing, and hygiene.

The clinical record was reviewed. The physician had responded to a communication from the facility on 1/18/16 the resident had not responded to treatment for an eye infection for conjunctivitis. The physician ordered the medication, Tobradex, two eye drops to each eye four times a day for 7 days.

The January 2016 medication administration record (MAR) was reviewed. The nurses had circled their initials on 1/19/16 and 1/20/16 indicating the medication was not administered those days. The nurses documented on the back of the MAR that the Tobradex eye drops were not available to administer on 1/19/16 and 1/20/16.

The nurse (RN#4) administering the medication on 1/21/16 at 9 00 a.m. was asked how medications were provided from the pharmacy. RN#4 stated she had called the pharmacy and it was still not available, so she called the back up pharmacy and had the medication delivered.

F 425

When the facility determined the resident had not received the medication when scheduled, it was promptly obtained from the pharmacy and administered. This incident had been corrected prior to the surveyor bringing it to our attention.

In order to determine no other residents are being affected, the DON will review all current MARS by 3-25-16 to ensure compliance.

On 3-16-16, the Administrator, Assistant Administrator, and DON met with a pharmacy representative to review this issue. It was determined that the facility pharmacist will conduct a comprehensive inservice for all licensed Nurses as it relates to ordering and re-ordering medications and appropriate use of back-up pharmacy. On or before 4-8-16, facility Administrator in conjunction with pharmacy will review and revise as necessary the current procedures in place to make sure medications are received in a timely fashion.

In order to ensure compliance, the facility will develop a medication tracking log that will show when a medication was not available and what was done to obtain the medication. For 3 months this log will be monitored at least 5 days a week by the DON or Administration. This will provide additional oversight to make sure the medication is attained and given in a timely fashion. A summary of the med tracking log will be reviewed quarterly by the QA committee and on an ongoing basis.

All issues related to F 425 will be resolved by 4-8-16.

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(X4\ ID PREFIX	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)	DATE
F 425	Continued From page 16	F 425		

record (MAR) was reviewed. The nurse had circled her initials on 1/22/16 indicating the Lantus was not administered .. The nurse documented on the back of the MAR that the Lantus was not available to administer on 1/22/16 at 8:00 p.m.

The director of nursing (DON) was asked for the policy for obtaining medications from the pharmacy. The policy stated the pharmacy was called for any medications not available and of unable to deliver on the next pharmacy run, then the back up pharmacy would be utilized.

The administrator, director of nursing, and assistant administrator were informed of the findings during a meeting with the survey team on 3/2/16 at 4 00 p.m.

State of Virainia

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F ooo	Initial Comments	F 000		

An unannounced Medicare/Medicaid standard survey and biennial State Ucensure Inspection was conducted 03/01/16 through 03/03/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 98 certified bed facility was 83 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents 1 through 14 and 20) and 5 closed record reviews (Residents 15 through 19).

F 001 Non Compliance — F 001

The facility was out of compliance with the following state licensure requirements

This RULE is not met as evidenced by
The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities

Policies and Procedures
12 VAC 5-371-140-E3b)-Cross reference to F226

Based on staff interview, facility document review, employee record review, and the Code of Virginia the facility staff failed to complete employee criminal background checks within 30 days of employment through the Virginia State Police for 1 of 25 new hires.
Findings included
For new hire #18 the facility staff failed to obtain a criminal record background check within 30 days of hire date per the facility policy for screening of new employees and the Code of Virginia.

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

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F Continued From Page 1	F001		

facility staff provided the survey team with a document that listed 25 new hires, All of these employee records were chosen for review the team leader,
A review of the employee records was completed on 03/02/16
New hire #18 was a CNA (certified nurse's assistant) with a hire date of 10/05/15, The facility did not complete a Virginia State Police criminal record check until 11/11/15. No problems were noted when this background check was completed.
The facility policy and procedure on screening of new hires was reviewed and read as follows:
"Procedure
2. After hire, the employee will submit to a criminal background check as required by State and Federal regulation. This request is sent within one week of employment to the Virginia Department of Police. "
The Code of Virginia (updated September 2014) reads as follows-
"Criminal Records-Employment Barrier Crimes-State law (§32,1-126,01 and 32.1-162,9:1 of the Code of Virginia) requires that each...nursing home ..obtain a criminal record background check on new hires within 30 days of employment The law requires that these background checks be obtained using the Central Criminal Records Exchange from the Virginia State Police"
The surveyor spoke with facility human resources manager on 03/03/16 at approximately 0825 regarding the criminal background check for new hire #18, Human resources manager confirmed that she had sent the background check in late.
The concern of the late criminal background check was brought to the attention of the administrative staff during a meeting on 03/03/16 at approximately 1100,
No further information was provided prior to exit

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F 001	Continued From Page 2	F001		

Resident Assessment and care planning
12 VAC 5-371-250 (D)- Cross reference to F278

Nurse Staffing
12 VAC 5-371-210 (A.3)-Cross reference to F282

Nursing Services
12 VAC 5-371-220 (A, C1)-Cross reference to F312 and F314

Infection Control
12 VAC 5-371-180 (A, B,C7 AND 9)- Cross reference to F371 and F372

Pharmaceutical Services
12 VAC 5-371-300 (A)-Cross reference to F425.