STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E131	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SW VA M H INST GERI TRT CTR	340 BAGLEY CIRCLE MARION, VA 24354

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F 000	INITIAL COMMENTS An unannounced Medicaid standard survey was conducted 4/12/16 through 4/14/16. Corrections are required for complaince with the Federal Long Term Care requirements of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this certified 25 bed facility was 17 at the time of the survey. The survey sample consisted of 8 current Resident reviews (Residents 1 through 8) and 1 closed record review (Resident 9).	F 000		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to submit the Minimum Data Set (MDS) for 2 of 9 residents in the survey sample (Residents # 1 and #7). 1. The facility staff failed to submit the MDS for Resident #1. 2. The facility staff failed to submit the MDS for Resident #7. The findings included: 1. The facility staff failed to submit the MDS for Resident #1. Resident #1 was readmitted to the facility on 12/10/15 with the following diagnoses of, but not limited to major depressive disorder with	F 276	**F 276** MDS Assessments for residents #1 and #7 were completed and submitted during day 2 of the Survey. — 04/13/16 All other resident MDS Assessments were reviewed to identify other completion/submission issues. Identified assessments not completed/submitted. — 04/28/16 Monthly Recovery Services Plan Review Conference schedule is posted in each Treatment Team Room the end of each month for the upcoming month. This schedule reflects the MDS Assessments dates for the upcoming month. These scheduled monthly MDS Assessments are to be opened by the MDS Nurse by 0830 hours on the day of the Team review. — 04/28/16 & Ongoing MDS Nurse will send an email to the Treatment Team Distribution List upon opening each MDS, including admission and special assessments such as Discharge, Readmission, and Significant Change, reflecting the date in which — 04/18/16 & Ongoing	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
R Michael Jones Ph.D./LNHA	Director Geriatric Services	4/29/16

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ıer safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ɔgram participation.

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F 276	Continued From page 1 psychotic features, dementia, coronary artery disease and hearing loss. The quarterly MDS (an assessment protocol) with an ARD (Assessment Reference Date) of 3/22/16 coded the resident as having a BIMS (Brief interview for Mental Status) score of 5 out of 15. Under Section D, the resident was scored at 16 for mood. The resident was also coded as only needing one person assist with bathing, dressing and personal hygiene. During the clinical record review of Resident #1 ' s chart, it was noted by the surveyor that the above documented MDS with an ARD of 3/22/16 had not be submitted electronically for approval. The MDS nurse was interviewed on 4/13/16 at approximately 1:30 pm in the MDS office by the surveyor. The MDS nurse stated " This MDS that you are looking at has not been submitted or exported but I will do it right now. I know it is late by looking over this now with you. " At 2:10 pm, the MDS nurse gave the surveyor a copy of the submission of the above documented MDS. The copy stated " MDS 3.0 File Submission ...Your submission has been received .Submission Date: 4/13/2016 at 14:00:02 (2:00 pm) ... " On 4/13/16 at 3:15pm, the Geriatrics Program Director and the RN (Registered Nurse) Coordinator was notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/14/16. 2. The facility staff failed to submit the MDS for Resident #7. Resident #7 was admitted to the facility on 3/1/16 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, end stage renal disease, diabetes, arthritis, dementia	F 276	the MDS assessment opened and date in which each Department required to have their respective sections completed - maximum time for completion being 7 calendar days from date of respective MDS being opened. MDS Nurse to review completion status of the respective MDS within one business day after the identified due date. Any sections noted to be incomplete at this review will result in a second email to the Team Distribution List, copied to the Facility Dir., Medical Dir., Chief Nurse Executive (CNE), Clinical Dir., Asst. Dir. for Administrative Services, and Facility Department Directors, identifying the specific sections noted to be incomplete. Members of the Executive Team will be responsible to ensure completion of the identified sections by their respective staff by close of the next business day. MDS Nurses will review the completed MDS assessments, certify their completeness, and electronically export them no later than 14 calendar days from the Assessment Reference date. Any barriers associated with delay in opening the MDS Assessments by 0830 hours on the designated Team Review date/Assessment Reference date or	04/30/16 & Ongoing 05/05/16 & Ongoing 05/06/16 & Ongoing

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F 276	Continued From page 2 and manic depression. The comprehensive assessment MDS with an ARD (Assessment Reference Date) of 3/17/16 coded the resident as having a BIMS (Brief Interview Mental Status) score of 0 out of a possible score of 15. Under Section D for Mood, the resident received a score of 4. Resident #7 was coded as needing limited assistance of one staff member for bathing, personal hygiene and toileting. During the clinical record review of Resident #7 ' s chart, it was noted by the surveyor that the above documented MDS with an ARD of 3/17/16 had not be submitted electronically for approval. The MDS nurse was interviewed on 4/13/16 at approximately 2:45 pm in the MDS office by the surveyor. The MDS nurse stated " This MDS that you are looking at has not been submitted or exported but I will do it right now. I know it is late by looking over this now with you. " At 2:55 pm, the MDS nurse gave the surveyor a copy of the submission of the above documented MDS. The copy stated " MDS 3.0 File Submission ...Your submission has been received .Submission Date: 4/13/2016 at 15:46:16 ... " On 4/13/16 at 3:15pm, the Geriatrics Program Director and the RN (Registered Nurse) Coordinator was notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 4/14/16.	F 276	with the electronic exporting of the respective MDS by the 14th calendar date from the assessment reference date will be immediately reported by email to the Dir. of Geriatric Services and the Unit Nurse Coordinator (UNC) with a copy to the Facility Dir. and CNE. Barriers associated with jRAVEN operations to be immediately reported to the SWVMHI I.T. Services for resolution. Barriers associated with staffing dynamics to be reported to the CNE for immediate resolution. CNE to ensure leadership/schedulers prioritize MDS role in daily assignments of MDS/Team Nurse. The jRAVEN assessment status tracking report reflecting the assessment date and status will be printed/checked by UNC each week to determine/confirm all assessments completed/submitted within the required time frames.	04/28/16 & Ongoing
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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	F 371	Pasteurized shell eggs immediately purchased by the SWVMHI food Service Dir. from Food City Grocery Store No. 848, Marion, VA during the first day of Survey to maintain scheduled menus pending delivery of supply from vendor on 04/15/16.	04/12/16

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F 371	Continued From page 3 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure items in the kitchen were stored, labeled, and stored in the kitchen in a sanitary manner. The kitchen also was using unpasteurized hard shell eggs. The findings include: A tour of the kitchen was conducted on 4/12/16 at 11:50 a.m. with the food director and food manager. The large thaw cooler refrigerator was observed. There was observed a tray of mixed vegetables sitting on a food storage rack. The tray was uncovered and not labeled. There also was a small foam container of cooked mixed vegetables sitting on a food cart along with another small foam container of cooked potatoes. These items were covered, but not labeled. The food manager stated the items should be covered and labeled. The refrigerator lower food storage shelf was observed to have three large boxes of "fresh eggs" sitting on the shelf. The food director was asked if the eggs were pasteurized and stated the vendors they bought the eggs from did not supply pasteurized eggs and was unaware that the eggs were required to be pasteurized for use. The geriatric program director and Registered	F 371	Pasteurized shell eggs procured from and delivered by Sysco vendor. Resident menu system updated by RD to reflect pasteurized egg (fried, boiled, poached, etc.) on resident tray tickets when shell egg item on menu for Geriatric residents. Will also allow for an accurate daily tally for cooks in meal preparations and managers for ordering. Food Service Supervisors to complete daily monitoring of tray line temperature logs and tally sheets which include pasteurized shell eggs for Geriatric residents. Recently prepared mixed vegetables for cooking at evening meal were immediately covered and labeled. Recently cooked mixed vegetables and potatoes that were covered were immediately labeled. All other coolers checked to identify any other food trays uncovered/unlabeled. None found. Cooks to receive updated training in proper covering and labeling of all food items in coolers, including these pulled for preparation for next meal service. Attendance rosters with staff signatures to be completed after each in-service to confirm completion.	04/15/16 &ongoing 05/06/16 & Ongoing 05/06/16 & Ongoing 04/12/16 04/12/16 05/06/16 & Ongoing

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F 371	Continued From page 4 Nurse Coordinator were informed of the findings during a meeting with the survey team on 4/13/16 at 3:00 p.m. They stated the food director had purchased pasteurized eggs for use from the local grocery store.	F 371	Dietary Supervisors to complete daily monitoring of all coolers for covering/labeling of all food items utilizing a daily checklist to confirm proper covering/labeling observations.	04/29/16 & Ongoing
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	Food Service Manager to monitor completion of temperature log and tally sheets regarding pasteurized shell eggs along with the daily food covering/labeling observation checklist on a weekly basis to verify sustained compliance. **F 441** Infection Control/Hand Hygiene requirements and associated performance expectations addressed with RN#1 by the Unit Nurse Coordinator with corresponding documentation in her supervisory file A laminated sign alerting staff of hand hygiene/glove usage is being prepared and to be placed above bed of resident #2. Similar signs are also being utilized in all resident bedrooms for staff alerts for every resident. Unit Nurse Coordinator/Shift Head Nurse will provide updated education to all Geriatric Nursing staff regarding SWVMHI Policy 12007 – *Hand Hygiene*; SWVMHI Infection Prevention and control education (2016); two diagrams	05/13/16 & Ongoing 04/13/16 05/06/16 05/16/16 & Ongoing

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F 441	Continued From page 5 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to observe proper hand hygiene while performing a dressing change on 1 of 9 residents in the survey sample (Resident #2). The findings included: Resident #2 was readmitted to the facility on 5/4/15 with the following diagnoses of, but not limited to anxiety, paraplegia, vascular dementia, Bipolar Disorder, diabetes, high blood pressure, heart disease and renal failure. On the resident ' s quarterly MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 2/11/16 scored the resident as having a BIMS (Brief Interview for Mental Status) a 2 out of a possible score of 15. Resident #2 is totally dependent on staff members for all activities of daily living. A review of Resident #2 ' s clinical record was performed. A Stage II intergluteal pressure area was noted in the treatment notes. On 4/12/16 at 2:40 pm, Registered Nurse (RN) #1 came into the conference room with gloves on her hands and stated the resident had soiled himself and they had to change his dressing. The surveyor went with RN #1 into the resident ' s room. The resident had already been cleaned up and the dressing had already been removed. RN #1, using the same gloves that were worn into the conference room was also used to redress the	F 441	regarding hand hygiene/glove utilization (copies posted in Ward Treatment Room). A competency test to confirm learning to be completed by all staff upon completion of the education. Attendance rosters with staff signatures acknowledge completion of the education/competencies to be maintained by the UNC. Each shift Head Nurse to complete 10 staff audits/observations each month with the Hand Hygiene/Glove use observation tool. Results to be noted in respective staff supervisory file. Monthly audits/observations to continue each shift each month pending 6 consecutive months of compliance, per respective shift.	05/27/16 & Ongoing Ongoing

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F 441	Continued From page 6	F 441		

resident ' s pressure area. RN #1 removed her gloves after the dressing change, put the gloves in the trash can and exited the resident ' s room. There was no handwashing performed by RN #1 observed by the surveyor.

At 3:30 pm in the conference room, the Infection Control Coordinator was notified of the above documented findings. The Infection Control Coordinator stated, " The nurse should always wash her hands after the soiled dressing is removed, then after cleaning the wound as ordered. Then anytime she removes her gloves for any reason, she should wash her hands. "

The Infection Control Coordinator provided the surveyor with a copy of the policy and procedure titled " Hand Hygiene " at 4 pm. Under the section of Hand Hygiene Indications #10 states " Perform hand hygiene after removing gloves. "

The Infection Control Coordinator also provided a copy of what the facility uses as a standard of practice from the text book of Perry and Potter, 8th edition, Clinical Nursing Skills & Techniques, page 957 under section Implementation #14 states " Remove gloves and perform hand hygiene. "

On 4/13 16 at approximately 3:15 pm, the Geriatrics Program Director and the director of nursing was notified of the above documented findings. The director of nursing stated " This is will be addressed with this nurse. "

No further information was provided to the surveyor prior to the exit conference on 4/14/16.