STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 10/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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	RECEIVED NOV 08 2016 VDH/OLC	

An unannounced Medicare/Medicaid standard survey was conducted 10/18/16 through 10/20/16. The facility was not in compliance with the Federal Long-Term Care regulations. One complaint was investigated during the survey.

The census in this 120 certified bed facility was 104 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #20) and 3 closed record reviews (Residents #21-23).

F 281 SS=D 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of nursing practice in regards to diabetic management for 1 of 23 Residents, Resident #17.

The findings included.

The facility nursing staff failed to document they had obtained an order from the physician for 10 units of insulin and failed to document they had administered the insulin.

The record review revealed that Resident #17 was admitted to the facility 10/14/16. Diagnoses included, but were not limited to, diabetes, diastolic congestive heart failure, history of

F281	1. Resident #17's current medication administration record accurately reflects physician order for insulin and current doses given are accurately documented. 2. Current residents receiving insulin injections were reviewed to determine documentation of MD notification for any recent significant change in condition and to ensure accuracy of insulin orders. Corrections were made immediately as indicated.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Phillip Mabe — TITLE: Administrator — (X6) DATE: 11/3/16

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 281	Continued From page 1 myocardial infarction (heart attack), orthostatic hypotension, and muscle weakness. There was no completed MDS (minimum data set) assessment on this Resident. However, the Resident was alert and orientated and had shared with the surveyor that she had been a diabetic since she was very young. On 10/19/16 at approximately 3:55 p.m. the surveyor interviewed LPN (licensed practical nurse) #1 regarding Resident #17's insulin and elevated (BS) blood sugars. LPN #1 reviewed the eMAR (electronic medication administration record) with the surveyor and stated that on 10/17/16 the Residents BS was elevated (413) and she had spoken with the doctor and received an order for 10 units of insulin. When asked about the documentation regarding the insulin LPN #1 verbalized to the surveyor that she had not written an order for the insulin and did not document in the Residents clinical record anything about the insulin. LPN #1 then stated "I should have put an order in but I didn't." The administrative staff were notified of the missing documentation in an end of the day meeting with the survey team on 10/19/16 at approximately 4:00 p.m. The surveyor requested a copy of what the facility would use as a standard of practice regarding documentation in regards to diabetic management. On 10/20/16 the nurse consultant provided the surveyor with a copy of a standard of practice from the nursing reference "Textbook of Medical-Surgical Nursing" eleventh edition. "RECORDING THE DATA...This record provides a means of communication among members of	F 281	3. Licensed nursing staff were educated regarding documentation of MD notification and documenting new orders when received. Nursing leadership will review shift reports and order listing reports daily 5X weekly X6 weeks to ensure significant changes in condition have been reported to the physician and documented and that insulin orders are accurate. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 11-10-2016	

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F 281	Continued From page 2 the health care team and facilitates coordinated planning and continuity of care. The record fulfills other function as well: It serves as the legal and business record for a health care agency and for the professional staff members who are responsible for the patients care... It serves as a basis for evaluating the quality and appropriateness of care and for reviewing the effective use of patient care services..." The nurse consultant also provided the surveyor with a copy of their policy and procedure titled "Nursing Documentation." "Licensed Nurses...will document all pertinent nursing assessments, care interventions, and follow up actions in the medical record...Document all of the facts and pertinent information related to an event, course of treatment, patient condition, response to care, and deviations from standard treatment along with the reason for the deviation...Every change in the patient's condition or significant patient care issues will be noted and charted until the condition is resolved or stabilized. Documentation that provides evidence of follow-through is critical. Use summary statements to describe changes of condition stating objective facts." The nurse consultant verbalized to the surveyor that their policies were based on nursing standards. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 3	F 323		

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a hazard free environment for 1 of 23 residents (Resident #14). The facility staff failed to ensure Resident #14's seatbelt was fastened when the resident was up and in the wheelchair.

The findings included:

The facility staff failed to ensure the physician ordered seatbelt for Resident #14 was fastened when the resident was up and in the wheelchair.

The clinical record of Resident #14 was reviewed 10/19/16. Resident #14 was admitted to the facility 7/9/15 and readmitted 3/14/16 with diagnoses that included but not limited to osteoarthritis, gastrointestinal hemorrhage, hypothyroidism, hypertension, iron deficiency anemia, dementia with behavioral disturbances, depressive disorder, atrial fibrillation, and muscle weakness.

Resident #14's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/20/16 assessed the resident with a cognitive summary score of 11 out of 15 in Section C Summary

F323

1. Resident #14's seatbelt is currently fastened according to physician order.
2. Current residents with seatbelts in use were reviewed to ensure in use per physician order. Corrections will be made immediately as indicated.
3. Current facility staff were educated regarding following physician order when using seatbelts. Leadership staff will round daily 5X weekly X6 weeks to ensure seatbelts are in use per physician order. Any issues will be addressed immediately at the time of identification.
4. Process will be reviewed in QA committee for two quarters.
5. 11-10-2016

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Score. Section P Restraints assessed Resident #14 with use of a trunk restraint that was used less than daily. Section G assessed the resident with functional impairment of the upper extremity on one side. Section J Health Conditions and J1700 Fall History coded Resident #14 without any falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Resident #14's current comprehensive care plan created 12/1/15 and reviewed 9/28/16 identified the use of physical restraints-seatbelt r/t (related to) poor safety awareness. Interventions "discuss and record with the resident/family/caregivers the risk and benefits of the restraint, when the restraint should/will be applied, routines while restrained and any concerns or issues regarding restraint use. Apply seatbelt. Seatbelt in place while up in wheelchair. Release and reposition seat belt q (every) 2 hours while in w/c (wheelchair) with seat belt on. Toilet prn (whenever necessary). Resident has poor safety awareness with history of falls. Monitor q 30 mins (minutes) while in chair."

Resident #14's October 2016 physician order sheet had an order that read "Seat belt in place while up in wheelchair. Release and reposition seat belt every 2 hours while in w/c with seat belt prn. Toilet prn. Resident has poor safety awareness with hx (history) of falls. Monitor q 30 mins while in chair every shift."

The most recent physical restraint assessment had been completed 9/14/16. Information on the device assessment for the continued use of the physical restraint read "Resident #14 was unaware of safety boundaries when in wheelchair, hx (history) of leaning forward.

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During restraint reduction trial, resident attempted to lean forward in the chair, 1:1 intervention to ensure safety and prevention of falls."

The surveyor observed Resident #14 on 10/19/16 at 3:00 p.m. Resident #14 was observed sitting in a wheelchair and participating in bingo. Upon completion of the group activity, Resident #14 returned to the resident's room. The surveyor observed Resident #14 sitting in the wheelchair at 3:55 p.m. The surveyor was unable to observe the physician ordered seat belt and asked the resident if she had a seat belt. The resident stated yes and showed the surveyor the left side of the unfastened belt which had been tucked in to the left side of the wheelchair. The seatbelt was not fastened. Resident #14 stated "They don't want me to fall." Upon request, Resident #14 was able to show the surveyor the right side of the seat belt where the buckle was located. Resident #14 was asked if she could connect the two straps. After two attempts, Resident #14 was unable to fasten the belt.

The surveyor requested the assistance of licensed practical nurse #1 on 10/19/16 at 4:00 p.m. L.P.N. #1 stated Resident #14 had a history of falls and was unable to fasten the seat belt. She verified that the seatbelt was not fastened and stated the resident was unable to unfasten or fasten the seatbelt herself.

The surveyor interviewed the activity director on 10/19/16 at 4:01 p.m. The surveyor asked if the activity staff unfastened Resident #14's seatbelt prior to bingo at 3:00 p.m. The activity director stated the seat belt was not unfastened by activities prior to the activity that started at 3:00 p.m.

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The surveyor informed the administrative staff of the above concern on 10/19/16 at 4:00 p.m.

No further information was provided prior to the exit conference on 10/20/16.

F 333 SS=E 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS

The facility must ensure that residents are free of any significant medication errors.

This REQUIREMENT is not met as evidenced by:
Based on Resident interview, staff interview, and clinical record review the facility staff failed to ensure 1 of 23 Residents was free of significant medication errors in regards to insulin, Resident #17.

The findings included.

The facility nursing staff had (a) transcribed an order for the wrong type of sliding scale insulin the Resident had received this insulin once and (b) failed to transcribe an order for sliding scale insulin which resulted in the Resident not receiving any sliding scale insulin coverage.

The record review revealed that Resident #17 was admitted to the facility 10/14/16. Diagnoses included, but were not limited to, diabetes, diastolic congestive heart failure, history of myocardial infarction (heart attack), orthostatic hypotension, and muscle weakness.

There was no completed MDS (minimum data

F	F333		
		1. Resident #17 is currently receiving accurate type of insulin at the right dose per physician order. 2. Current residents receiving insulin injections were reviewed to determine accuracy of physician orders. Corrections were made immediately as indicated. 3. Licensed nursing staff were educated regarding order transcription for sliding scale insulin. Nursing leadership will review order listing reports daily 5X weekly X6 weeks to ensure insulin orders are accurate. Any issues will be addressed immediately at the time of identification.	

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F 333	Continued From page 7	F 333	4. Process will be reviewed in QA committee for two quarters. 5. 11-10-2016	

set) assessment on this Resident. However, the Resident was alert and orientated.

On 10/19/16 when reviewing the Residents clinical record it was noted that the Residents eMAR (electronic medication administration record) included orders for novolin N insulin inject as per sliding scale. This order had been transcribed on 10/14/16 at 1243 (12:43 p.m.) and been discontinued on 10/14/16 at 2249 (10:49 p.m.). Per the documentation on the Residents eMAR Resident # 17 had received 4 units of this insulin on 10/14/16 for a BS (blood sugar) of 265 at 2100 (9:00 p.m.). The surveyor was unable to locate an order for the novolin N to be used as sliding scale insulin on the Residents discharge paperwork from the hospital.

On 10/19/16 at approximately 4:25 p.m. the surveyor interviewed LPN (licensed practical nurse) #2 regarding the Residents elevated BS's and sliding scale insulin order. After reviewing the Residents eMAR and insulin orders LPN #2 verbalized to the surveyor that he was the staff person that had placed the sliding scale insulin order into the computer. LPN #2 then stated that novolin N wouldn't be used as sliding scale and he did not know who had discontinued the order.

The DON (director of nursing) was made aware of the surveyors concerns regarding the insulin order on 10/19/16 at approximately 4:40 p.m.

On 10/20/16 at approximately 8:10 a.m. RN (registered nurse) #1 (house supervisor) verbalized to the surveyor that when Resident #17 had been admitted to the facility the admission paperwork had been completed by LPN #2 and that when LPN #2 had added the

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F 333	Continued From page 8	F 333		

sliding scale insulin he may have gotten confused and put in the incorrect insulin. RN #1 then stated that LPN #3 had noticed that the sliding scale insulin order was incorrect and had the order discontinued. RN #1 stated that LPN #3 had thought she had added an order for humulin R insulin on Friday (10/14/16) prior to leaving for the weekend. But discovered when she returned to work on Monday (10/17/16) that she had failed to transcribe the order and she then added the insulin order. Indicating that Resident #17 had went the entire weekend (10/15-10/16/16) and part of the day on Monday (10/17/16) without any sliding scale insulin coverage. The Residents BS's were documented as follows.
Saturday 10/15/16-187, 168, 166, and 276
Sunday 10/16/16-183, 283, 222, and 321.
Monday 10/17/16-191, 413, 498, and 471.

The sliding scale insulin order transcribed by LPN #3 on 10/17/16 included the following administration instructions.
Humulin R subcutaneously before meals and at bedtime
If below 60 call MD
200-250=2 units
251-300=4 units
301-350=6 units
351-400=8 units
Above 400 call MD

RN #1 verbalized to the surveyor that medication errors would be completed. When asked how many errors RN #1 stated two.

On 10/20/16 the surveyor spoke with Resident #17 regarding her elevated BS's. Resident #17 verbalized to the surveyor that she had been a diabetic since she was a child and was use to the

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fluctuations in her BS's. When asked if she was aware her BS's had been elevated at the facility she stated yes and when asked if she had felt bad during this time she stated she had not.

The Resident had been treated for a UTI (urinary tract infection) from 10/14-10/18/16 and did have other insulin orders in place during this timeframe.

The administrative staff were notified of the significant medication errors involving insulin during a meeting with the survey team on 10/20/16 at approximately 9:55 a.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 371 SS=D 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 under sanitary conditions

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, and a facility document review, the facility's staff failed to prepare and serve food in a safe and sanitary manner.

F F371

1. Meal trays are currently being served covered through the use of an enclosed car per policy. The fly is no longer present in room 309.
2. Current residents' meal trays were observed during delivery to ensure all food items in separate bowls were covered in an enclosed cart prior to serving. Occupied resident rooms were inspected for presence of flies. Corrections were made immediately as applicable.

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F 371	Continued From page 10 The findings include: On 10/19/16 at 8:20 am, during breakfast tray delivery the surveyor observed trays served to room 605, room 608 and 609 that had bowls of strawberries that did not have a lid or plastic wrap covering. The surveyor also observed a large fly in room 309. A second surveyor observed an uncovered bowl of strawberries served to room 404. CNA #1 was asked if the residents were severed food that was not covered. She stated " no it is usually covered. " On 10/19/16 at 4:00 pm, the administrative staff was notified of the uncovered strawberries. At 7:50 am, on 10/20/16 the dietary manager was asked if it was the normal practice for the strawberries or other food to be served to the units without a covering. He said, " Usually we cover it. We have bowls with lids or use plastic wrap. " Review of the policy and procedure titled Dining Services Policies and Procedures revealed the following: Under procedures 4. All meals will be delivered to the nursing units timely and efficiently. All foods served to patients dining in their rooms will be delivered covered through the use of an enclosed cart or an open cart using lids or plastic wrap. Prior to exit on 10/20/16 no further information was received from the facility related to food service.	F 371	3. Dietary personnel and nursing staff were educated regarding policy for food preparation regarding covering food items prior to serving. Dietary manager will observe tray line operation 3X weekly X6 weeks to ensure food items in separate bowls are covered per policy prior to serving. Maintenance staff will inspect 10% of resident rooms weekly X6 weeks to ensure free from flies. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 11-10-2016	

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F 502 SS=D	Continued From page 11 483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered laboratory test for 1 of 23 residents (Resident #3). The findings included: The facility staff failed to obtain a hemoglobin A1C for Resident #3 on 1/4/16. The clinical record of Resident #3 was reviewed 10/19/16. Resident #3 was admitted to the facility 7/23/11 and readmitted 1/14/16 with diagnoses that included but not limited to diabetes mellitus, chronic obstructive pulmonary disease, pneumonia, hypothyroidism, hypertension, gastroesophageal reflux disease, dementia without behavioral disturbances, hyperlipidemia, pain, lymphedema, overactive bladder, and major depression. Resident #3's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 8/17/16 assessed the resident with a cognitive summary score of 9 out of 15 in Section C Summary Score. The clinical record revealed a physician order dated 12/31/15 that read "A1C on 1/4/16." The	F	F502 1. Resident #3's A1C laboratory test has been completed as ordered. 2. Current residents with active laboratory test orders were reviewed to ensure complete per MD order. Corrections were made immediately as applicable. 3. Licensed nursing staff were educated regarding laboratory process to include accurate order transcription and completion of lab requisition form. Nursing leadership will review order listing report daily 5X weekly X6 weeks to ensure test orders have transcribed accurately for completion. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 11-10-2016	

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F 502	Continued From page 12	F 502		

surveyor reviewed the laboratory section in both the paper and electronic clinical records and was unable to locate the results of the A1C ordered to be obtained 1/4/16.

The surveyor requested the assistance of the assistant director of nursing and the corporate registered nurse on 10/19/16 at 11:30 a.m. Both reviewed the physician order and the laboratory section of the clinical record and stated they would call the contracting laboratory.

On 10/19/16 at 1:35 p.m., the assistant director of nursing stated the laboratory had no record that the laboratory test (A1C) was obtained on 1/4/16.

The surveyor informed the administrative staff of the above finding on 10/19/16 at 4:00 p.m.

No further information was provided prior to the exit conference on 10/20/16.

F 514 SS=D 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

F	F514	1. Resident #14's restraint assessment was corrected to reflect accurate date of responsible party notification. Resident #16's current dialysis communication forms are complete	

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	495378	A. BUILDING _____ B. WING _____	C 10/20/2016

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 2 of 23 residents. (Resident #16 and Resident #14)

The findings included:

1. The facility staff failed to maintain a complete and accurate clinical record for dialysis communication for Resident #16.

Resident #16 was admitted to the facility on 8/15/15 with the following diagnoses of, but not limited to anemia, high blood pressure, aphasia, dementia, psychotic disorder and end stage renal disease. The quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/15/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 0 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

The surveyor conducted a review of Resident #16 ' s clinical record on 10/19/16. It was noted by the surveyor that the following dialysis communication sheets did not contain documentation of either post dialysis vital signs and/or post dialysis weights for the dates of: 10/4/16, 9/29/16, 9/27/16, 9/24/16, 9/20/16, 9/8/16, 9/6/16 and 9/1/16.

The corporate nurse was notified of the above documented findings by the surveyor on 10/19/16 at 5 pm. The corporate nurse stated " We

to include weight and vital sign documentation.
2. Current residents with restraints were reviewed to ensure accuracy of assessment documentation for date of RP notification. Current residents receiving dialysis were reviewed to ensure communication forms are complete to include weight and vital signs.
Corrections were made immediately as applicable.

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F 514	Continued From page 14	F 5	3. Licensed nursing staff were educated regarding accurate completion of restraint assessments and dialysis communication forms. Nursing leadership will review restraint assessments for accuracy during scheduled quarterly review and will review dialysis communication forms weekly X6 weeks to ensure accuracy of documentation. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 11-10-2016	

should be calling the dialysis center back to see if these were taken. This information is important for us to know. " The corporate nurse came back to the surveyor at 5:40 pm and stated, " I called the dialysis center and they faxed these weights to me. I am going to follow up with our staff here and talk with the dialysis staff to let them know that this is important information that we need. " The corporate nurse gave the surveyor post dialysis weights for the following dates: 9/1/16, 9/6/16, 9/24/16, 9/27/16, 9/29/16 and 10/6/16. The surveyor asked the corporate nurse if these weights were in the resident ' s clinical record here at the facility and the corporate nurse stated, " No, these were in the dialysis center ' s clinical record they have there. I called and they faxed these weights to me after we talked. "

On 10/20/16 at approximately 9:30 am, the administrative team was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference on 10/20/16.
2. The facility staff failed to ensure the quarterly physical restraint assessments were accurate for Resident #14.

The clinical record of Resident #14 was reviewed 10/19/16. Resident #14 was admitted to the facility 7/9/15 and readmitted 3/14/16 with diagnoses that included but not limited to osteoarthritis, gastrointestinal hemorrhage, hypothyroidism, hypertension, iron deficiency anemia, dementia with behavioral disturbances, depressive disorder, atrial fibrillation, and muscle weakness.

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Resident #14's significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/20/16 assessed the resident with a cognitive summary score of 11 out of 15 in Section C Summary Score. Section P Restraints assessed Resident #14 with use of a trunk restraint that was used less than daily. Section G assessed the resident with functional impairment of the upper extremity on one side. Section J Health Conditions and J1700 Fall History coded Resident #14 without any falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).

Resident #14's current comprehensive care plan created 12/1/15 and reviewed 9/28/16 identified the use of physical restraints-seatbelt r/t (related to) poor safety awareness. Interventions "discuss and record with the resident/family/caregivers the risk and benefits of the restraint, when the restraint should/will be applied, routines while restrained and any concerns or issues regarding restraint use. Apply seatbelt. Seatbelt in place while up in wheelchair. Release and reposition seat belt q (every) 2 hours while in w/c (wheelchair) with seat belt on. Toilet prn (whenever necessary). Resident has poor safety awareness with history of falls. Monitor q 30 mins (minutes) while in chair."

Resident #14's October 2016 physician order sheet had an order that read "Seat belt in place while up in wheelchair. Release and reposition seat belt every 2 hours while in w/c with seat belt prn. Toilet prn. Resident has poor safety awareness with hx (history) of falls. Monitor q 30 mins while in chair every shift."

The most recent physical restraint assessment

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F 514	Continued From page 16	F 514		

had been completed 9/14/16. Information on the device assessment for the continued use of the physical restraint read "Resident #14 was unaware of safety boundaries when in wheelchair, hx (history) of leaning forward. During restraint reduction trial, resident attempted to lean forward in the chair, 1:1 intervention to ensure safety and prevention of falls." Section F Communication documented in 1. that the family/POA (power of attorney)/Decision Maker Notified of Decision on the use of a seatbelt on 12/1/2016 and 4. that an LPN (licensed practical nurse) provided that information.

The date that the family was notified of the facility's decision/assessment to continue to use the seatbelt had not yet occurred (12/1/2016) and there was no specific L.P.N. documented who had informed the family of that decision. The surveyor reviewed the quarterly physical restraint assessments dated 3/17/16 and 6/29/16. The documentation on these assessments was identical to the quarterly assessment completed 9/29/16.

The surveyor informed the administrative staff of the above concern on 10/19/16 at 4:00 p.m. Upon completion of the meeting, the assistant director of nursing stated she was responsible for the inaccuracy of the assessments.

The surveyor reviewed the facility policy on device assessments on 10/20/16. The policy read in part "2. The Device Assessment is used to provide documentation that the patient/responsible party has been informed of the purpose, benefits, and potential complications associated with the use of a device(s). 5. A licensed nurse will ensure completion of the

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F 514	Continued From page 17 notification section of the form for any patient having been assessed as needing a device." No further information was provided prior to the exit conference on 10/20/16.	F 514		

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F 000	Initial Comments	F 000		

An unannounced biennial State Licensure Inspection was conducted 10/18/16 through 10/20/16. The facility was in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 120 bed facility was 104 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #20) and 3 closed records (Residents #21-23).

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.

12 VAC 5-371-370. Maintenance and Housekeeping
12 VAC 5-371-370 (A, D, H, J, M) Cross Reference to F Tag 323

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (B) Cross reference to F- 333.

12 VAC 5-371-350 Dietary Services
12VAC 5-371- 350- (E) Cross reference to F-371

12 VAC 5-371-310. Administration.
12 VAC 5-371-310 (A) Cross reference to F-502..

12 VAC 5-371-360. Clinical Records
12 VAC 5-371-360 (A,E,f,j) Cross Reference to F-514

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

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