STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 10/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST FRANCIS NURSING CTR	4 RIDGEWOOD PARKWAY NEWPORT NEWS, VA 23602

(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 10/25/16 through 10/27/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 115 certified bed facility was 93 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents #1 through #16) and 3 closed record reviews (Residents #17 through #19).	F 000		
F 156 SS=D	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(b)(5) - (10), 483.10(b)(1) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156		12/1/16

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

Electronically Signed | 11/17/2016

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 156	Continued From page 1	F 156		

other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a

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F 156	Continued From page 2 complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure the Resident and/or Responsible party (RP) was notified of changes in services for 1 of 19 residents (Resident #19), in the survey sample. The facility staff failed to notify Resident #19 and/or Responsible party that the ordered Occupational Therapy and Physical Therapy services would be discontinued on 4/18/16, giving them the opportunity to appeal the decision. The findings included: Resident #19 was originally admitted to the facility 3/30/16. The diagnoses included; malignant neoplasm of the right lower lobe, hypertension, epilepsy, atherosclerosis, GERD	F 156	Please Find the facility Plan of Correction following 42 CFR Part 483 Long Term Care Requirements: F 156 Facility staff to ensure all residents and/or responsible party (RP) is notified of changes in services provided. 1. Facility staff failed to notify Resident #19 and/or RP that the ordered Occupational and Physical Therapy services would be discontinued on 4/18/16, giving them the opportunity to appeal the decision. Facility Social Workers will ensure all	

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F 156	Continued From page 3 (gastroesophageal reflux disease), cerebral infarction, and dysphagia (difficulty swallowing). The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 4/6/16 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 12 out of a possible 15. This indicated Resident #19's cognitive abilities for daily decision making were intact. The MDS was also coded that Resident #19 started Speech Therapy (ST) services 3/30/10, Occupational Therapy (OT) 3/31/16 and Physical Therapy (PT) 3/31/16. The clinical record reveals Resident #19 had a physician's orders dated 3/30/16 to consult ST, PT and OT services. The PT discharge summary was viewed in Resident #19 clinical record. The document stated PT services were started on 3/31/16 and discontinued on 4/18/16. The PT discharge summary also read; " ambulation goal not met on 4/18/16. The patient will improve gait ability with front wheeled walker x (times) 200 feet on even surfaces to modified independence (assistive device or extra time needed) in order to move throughout home and community safely. The ambulation goal read; not met on 4/18/16, The Patient will complete all functional transfers safely with independence (0% assist, no assistive device or extra time needed) Explanation: patient unable, patient requires stand by assistance for safety due to decreased balance. Patient demonstrated a decline in functional mobility and activity tolerance due to medical condition. Patient plans to return home with family support". The OT discharged summary revealed OT	F 156	residents who are receiving services that are discontinued are provided with the Advanced Beneficiary Notice of Non-Coverage-CMS-R-131 for (ABN)/Notice of Medicare Non-Coverage-CMS-10123 form (NOMNC). Social Workers will provide the process for appeal, the contact number and discussion of the process in a manner the Resident and/or Responsible party understands. Education provided on November 10, 2016 to both facility's Social Workers on the regulatory standard and required compliance by the facility Administrator. Facility Social Workers will document in the residents permanent medical record that the process was performed. Facility Social Workers will up-date and document any ABN and/or NOMNC issued daily in the facility's Daily Morning Meeting and document on the Daily Moring Meeting report. Facility Social Workers will report weekly at the Facility's PPS meeting on any ABN and or NOMNC issued and will be documented on the Weekly PPS report. Facility Social Workers will report quarterly to the QAPI Committee on compliance.	

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services were started on 3/31/16 for 5 times per week for 4 weeks for therapeutic exercises, neuromuscular re-education, therapeutic activities and self- care training. The discharge summary also stated on 4/19/16 revealed all goals were not met. The analysis read; "patient has demonstrated a decline in functional status due to medical status". The discharge summary OT services were ended on 4/19/16.

An interview was conducted with the Physical Therapist on 10/26/16 at approximately 5:40 p.m. The Physical Therapist stated PT services for Resident #19 were discontinued on 4/18/16 because of a decline in condition/function and complaints of increased abdominal and back pain.

An interview was also conducted with the Occupational Therapist on 10/26/16 at approximately 5:45 p.m. The Occupational Therapist the resident began exhibiting a decline and fatigue on 4/13/16; therefore, bed level therapy was instituted.

The surveyors again viewed Resident #19's clinical record for the Advanced Beneficiary Notice of Non-coverage (ABN) but it was not a part of the clinical record. This information was shared with the Social Worker.

An interview was conducted with the Social Worker on 10/27/16 at approximately at 11:15 a.m. The social worker stated there was no ABN notice for discontinuation of OT/PT services for Resident #19 because she forgot it. The Social Worker stated the procedure is during the morning meeting residents due to be discharged would be discussed and an ABN notification

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F 156	Continued From page 5 would be explained and given to the Resident and or Responsible Party. The above findings were shared with the Administrator, Director of Nursing and Corporate Nurse on 10/27/16 at approximately 2:30 p.m. No additional information was presented.	F 156		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.25 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to provide the necessary care and services to promote and maintain the highest practicable physical well-being for 1 of 19 residents in the survey sample, Residents #7. The facility staff failed to follow the physicians order for application and removal of the TED hose compression stocking for Resident #7. The findings included: Resident #7 was admitted to the facility on 10/20/16 with diagnoses to include history of a right knee replacement and deep vein thrombosis of the right lower extremity.	F 309	F 309 The facility ensures each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. The facility failed to follow the physicians order for application and removal of the TED hose compression stocking for Resident #7. 2. The Interim Care Plan did not	12/1/16

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F 309	Continued From page 6 The resident's MDS (Minimum Data Set) had not been completed because of the short length of time in the facility. The nurses' admission assessment dated 10/20/16 revealed resident #7 was alert and oriented to person, place, time and situation. An interview with Resident #7 revealed the resident had intact long and short term memory, was oriented to person, place and time and he exhibited he was capable of making good decisions. Review of the Physician Order Summary revealed an order dated 10/25/16 which read, "measure and apply thigh-high TED hose to right lower extremity (on in a.m., off in p.m.) in the morning for deep vein thrombosis. Measure and apply thigh-high TED hose to right lower extremity, (on in a.m. and off in p.m.) remove per schedule". You wear compression stockings (TEDs) to improve blood flow in your legs. Compression stockings gently squeeze your legs to move blood up your legs. This helps prevent leg swelling and, to a lesser extent, blood clots. (https://medlineplus.gov/ency/patientinstructions/000597.htm) Review of the interim care plan did not include the use of the TED hose. Resident #7 was observed during the initial tour on 10/25/16 at approximately 12:40 p.m., in his room with blue non-skid socks on bilateral feet. He was observed again on 10/26/16 at approximately 11:15 a.m. seated in a chair at bedside with yellow non-skid socks on bilateral	F 309	include the use of the TED hose. Facility staff applied resident #7 TED hose on 10/27/16 at 2:45pm. Review of all residents with order of TED hose compression stockings was completed on 10/27/16 by the Director of Nursing to ensure all orders for TED Hose compression stockings are being followed. Review of all Interim Care Plans of those residents with TED Hose compression stockings was completed on 11/10/16 by the Director of Nursing to ensure Interim Care plan was initiated. Education provided to all Licensed Nursing staff by the Director of Nursing and MDS Coordinator regarding compliance of following facility policy/procedure on following physician orders and initiating interim care plans-completed on 11/16/16. Director of Nursing and/or designee will monitor for compliance of following physician's orders and initiation of Interim Care Plans Monthly. Director of Nursing and/or designee will report to the QAPI Committee compliance quarterly.	

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F 309	Continued From page 7 feet. The right knee and right lower extremity were with + two edema (assessment of pitting edema). Resident #7 was observed again in his room completing intravenous antibiotic therapy. Review of the electronic TAR (treatment administration record) revealed the facility staff had signed the TED hose order indicating it had been applied and removed as ordered. On 10/27/15 at 1:30 p.m., an interview was conducted with Resident #7. The Resident was asked what time are the TED hose applied and removed. The resident stated the TED hose had never been applied and his wife also asked him the same question. The above findings were shared with the Administrator, Director of Nursing and Corporate Nurse on 10/27/16 at approximately 2:30 p.m. The Director of Nursing stated at approximately 2:45 p.m., the staff was applying the TED hose when she arrived to the resident's room.	F 309		
F 494 SS=D	NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY CFR(s): 483.75(e)(2)-(3) A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b).	F 494		12/1/16

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F 494	Continued From page 8 A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility documentation review, the facility staff failed to ensure (1) individual working in the facility as a nurse aide did not work over 4 months (120 days) prior to becoming certified. The findings included: During the Task of checking employee records, it was determined that employee #52 had worked 127 days as a nursing assistant and had not become certified. The Administrative Director of Extended Care Services, stated that she felt employee #52, met the criteria of F494, as followed: That individual is competent to provide nursing and nursing related services: and That individual has completed a training and	F 494	Please find the facility Plan of Correction following 42 CFR Part 483 Long Term Care Requirements: Nurse Staffing 12 VAC 5-371-210 (G) Cross-Reference to F-494 F-494 The facility is compliant with Long Term Care requirements-Any person employed to perform the duties of a nurse aide on a permanent full-time, part-time, hourly, or contractual basis must be registered as a certified nurse aide within 120 days of employment. 1. Employee #52 had worked 127 days as a nursing assistant and had not become certified. Employee #52 will remain off the facility	

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F 494	Continued From page 9 competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of 483.151.154 of this part: or That individual has been deemed or determined competent as provided in 483.150 (a) and (b). The following information on Employee #52 was provided: 1. Copy of Employee #52's Commonwealth of Virginia Certification of completion of Nurse Aide, signed 7/15/2015 2. Certificate of completion for CPR/AED (Cardio-Pulmonary Resuscitation/Automated External Defibrillator) for Professional Rescuers with First Aid (completed 8/3/15) 3. Student and Group Transcript Report documenting areas of study, estimated time, and completion date. a. Recognizing Chest Pain: Estimated Time: 45 minutes Completion Date: 10/9/16 b. Obesity Awareness and Sensitivity: Estimated Time 1.30 hours Completion Date: 10/9/16 c. Protecting the Rights of Residents: Estimated Time: 55 minutes Completion Date: 9/1/16 d. Patient Restraint and Seclusion in the Acute-Care Setting: Estimated Time: 1.05 hours Completion Date 8/31/16 e. Life Net Health: Estimated Time: 40 minutes Completion Date 8/9/16 f. 2016 National Patient Safety Goals (with pre-test): Estimated Time 40 minutes Completion Date: 8/9/16 g. Long Term Care Resident Restraint:	F 494	nursing schedule/not working, until she successfully completes and obtains her Nursing Assistant Certification. Facility Administrator and Nursing Leadership will initiate "no hire" rule of any/all nursing assistants not certified prior to date of employment of the facility. Compliant 11/16/16. Director of Nursing and/or designee will ensure all nursing assistants are certified and current prior to hire. Facility Human Resource department will continue current practice of providing notification to the facility Administrator and/or Nursing Leadership of Certified Nursing Assistants certification renewal dates to ensure compliance with Long Term Care regulations. Director of Nursing and/or designee will report quarterly to the QAPI Committee on compliance	

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Estimated Time 52 minutes Completion Date: 7/29/16
h. Alzheimer's Disease: Estimated Time 55 minutes Completion Date: 7/26/16
i. New Employee Orientation Day 21: Estimated Time 8 hours Completion Date 7/26/16
j. Care of the Aging Adult: Estimated Time 1.45 hour Completion Date: 7/14/16
k. Congestive Heart Failure: Estimated Time 1:15 hour Completion Date: 7/11/16
l. Care of the Bariatric Surgical Patient: Estimated Time 1.15 minutes Completion Date: 7/11/16
m. Labeling of Laboratory Specimens: Estimated Time 40 minutes Completion Date 6/22/16
n. HIPAA (Health Insurance Portability and Accountability Act) Security Awareness: Estimated Time 40 minutes Completion date: 6/22/16
o. Hospice and Palliative Care: Estimated Time 1 hour Completion Date: 6/22/16
p. Hearing Impaired and Limited English Proficiency: Estimated Time 40 minutes Completion Date 6/22/16
q. Foley Catheter Indications and Use: Estimated Time 15 minutes Completion Date: 6/22/16
r. CDC (Centers Disease Control) Hand Hygiene: Estimated Time 30 minutes Completion Date: 6/22/16
s. BE FAST Scale Training: Estimated Time 35 minutes Completion Date: 6/22/16
t. Assessing Patients for Suicidal Intent: Estimated Time 10 minutes Completion Date 6/22/16
u. Advance Medical Directive: Estimated Time 35 minutes Completion Date: 6/22/16
v. New Employee Orientation: Estimated Time

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15 hours Completion Date: 6/20/16

4. Signed Statement of receipt of Resident Rights (7/12/16)

5. Quiz copies for: Resident Rights, Dignity,

6. Signed acknowledgement of Safe Resident Transfer Coding (6/4/16)

7. Signed acknowledgement of Gait Belt receipt and understanding of policy (not dated)

8. Signed acknowledgement of Employee Policy and Procedures Agreement (6/24/16)

9. Signed acknowledgement of Mandated Reporter Status (6/22/16)

10. 9/2/16 Skills Fair Test Completion

11. Copy of Orientation Scavenger Hunt

12. Skills Fair sign in sheet: 8/29/16-9/2/16

13. Copy of Job Description for Certified Nursing Assistant

14. Copy of: Commonwealth of Virginia Regulations Governing Certified Nurse Aides (revised date 2/27/14)
a. under 18VAC90-25-71 Certification by examination To be placed on the registry and certified by examination, the nurse aide must: 1. Have satisfactorily completed: a. A nurse aide education program approved by the board or: (the following was highlighted in yellow for the survey team) b. At least one clinical nursing course which included at least 40 hours of clinical

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(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 494	Continued From page 12	F 494		

experience involving direct client care within the past 12 months while enrolled in a nursing education program preparing for registered nurse or practical nurse licensure

15. Copy of 18VAC90-25-72 Certification by endorsement

16. Copy of 483.150 Statutory basis: Deemed meeting or waiver of requirements: section b (deemed meeting of requirements. A nurse aide is deemed to satisfy the requirement of completing a training and competency evaluation approved by the State.

17. Copy of 483.154 Nurse aide competency evaluation:

18. Copy of 483.151 State Review and approval of nurse aide training and competency evaluation programs and competency evaluation programs.

During an interview with the Administrative Director of Extended Care Services on 10/27/18 at approximately 2:30 p.m., she was asked if the facility had any type of waiver from the Department of Nursing for their orientation/training program for Nurse Aides. The Administrative Director of Extended Care Services stated that the facility had no waiver; however, she felt the Nurse Aide met any criteria to continue working as a Certified Nursing Assistant. The Administrative Director of Extended Care Services stated that employee #52 was a Registered Nurse in the Philippines prior to being employed by the facility as a Nurse Aide. The Administrative Director of Extended Care Services stated that the Philippines was considered part of the United States and should

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495204	A. BUILDING _____ B. WING _____	C 10/27/2016

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F 494	Continued From page 13 not be discriminated against. When asked why Employee #52 was taken off the schedule on 10/25/16, the Administrative Director of Extended Care Services stated that the employee was taken off the schedule until the facility received guidance from the surveyors if the employee would be allowed to continue to work. The facility employee records documented Employee #52's Date of Hire was 6/20/16 The Facility Staffing logs documented that Employee #52 was on the schedule: 10/24/16, 10/25/16, 10/21/16, 10/20/16, 10/18/16, 10/16/16, and 10/15/16 and was removed from the schedule on 10/26/16. The facility administration was informed of the findings during a briefing on 10/27/16 at approximately 2:30 p.m. The facility did not present any further information about the findings.	F 494		
F 520 SS=D	QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CFR(s): 483.75(o)(1) A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	F 520		12/1/16

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F 520	Continued From page 14 A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility documentation review, the facility staff failed to ensure the Quality Assessment and Assurance (QAA) committee had a physician present during the first quarter. (January, February, March, 2016) The findings included: On 10/26/16 at approximately 1:00 p.m. the facility's sign-in sheets were reviewed for their Quality Assessment and Assurance meetings. Sign-in logs reviewed for January, February, and March 2016 showed no documentation that a Physician was in attendance. The facility was not able to provide documentation from the Quality Assessment and Assurance meeting notes, that a Physician was in attendance. Review of the facility Policy and Procedure titled, "Quality Assessment and Performance Improvement Plan 2016" documented the following: "Everyone is responsible for the QAPI (Quality	F 520	F 520 A facility must maintain a quality assessment and assurance committee consisting of the Director of Nursing; a physician designated by the facility and at least 3 other members of the facility staff. 1. The facility failed to ensure Quality Assessment and Assurance Committee had a physician present during the first quarter (January, February, March 2016). Review of the deficient practice and education provided with the facility medical director was conducted on November 15, 2016 by the facility Administrator. Facility Administrator and/or designee will monitor to ensure compliance with the required attendance of a minimum of at least one meeting per quarter by a physician.	

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F 520	Continued From page 15 Assessment and Performance Improvement) Program, however, there exists a committee of individuals led by the Administrative Director, who will drive the process and ensure its success ... ." "The QAA (Quality Assessment and Assurance) committee must meet at least quarterly and identify quality deficiencies and develop and implement plans of action to correct the deficiencies... ." The facility administration was informed of the findings during a briefing on 10/27/16 at approximately 2:30 p.m. The facility did not present any further information about the findings.	F 520	Facility Administrator will report to the QAPI Committee on compliance quarterly.	