COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
Fax (804) 527-4502

March 9, 2017

Mr. Thomas Chesney, Administrator
Stratford Healthcare Center
508 Rison Street
Danville, VA 24541

RE: Stratford Healthcare Center
Provider Number 495166

Dear Mr. Chesney:

An unannounced standard survey, ending March 2, 2017, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Two complaints were investigated during the survey. The complaints were unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of F), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Rodney L. Miller, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).

- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date.

- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: "http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf". We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Rodney L. Miller, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joann Atkins, Dmas (Sent Electronically)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. BUILDING _____ B. WING _____	C 03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HEALTHCARE CENTER	508 RISON STREET DANVILLE, VA 24541

(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 03/01/17 through 03/02/17. Two complaints were investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 51 at the time of the survey. The survey sample consisted of 1 current Resident reviews (Residents #1 through #12 and#14) and 4 closed record reviews (Residents #13 and #15.#16, #17).	F 000	2017 Annual POC F155 Resident #5 now has a completed DDNR order form. All residents whom have a DNR order have been reviewed to ensure that their DDNR is completed accurately. SW and licensed nursing staff will be in-serviced by DON or designee on completing DDNR forms accurately. All new admissions will be reviewed by SW or designee to ensure a DDNR is filled out completely if applicable. SW will continue to complete monthly Advanced Directive Audits which will now include monitoring for completion accuracy of the DDNR form. Results of audits will be presented at the monthly QAPI meeting for review and recommendations for the duration of the monitoring period. Completion Date 4/5/17	
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE, FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 155		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	3/16/17

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 155	Continued From page 1 resident's option, formulate an advance directive (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to accurately complete a DDNR (Durable Do Not Resuscitate) order form for 1 of 17 Residents, Resident #5	F 155		

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F 155	Continued From page 2	F 155		

The findings included.

Section 1 and 2 of the Residents DDNR order form had not been completed.

The record review revealed that Resident #5 had been admitted to the facility 08/07/16. Diagnoses included, but were not limited to, chronic kidney disease, essential hypertension, peripheral vascular disease, hypothyroidism, and gastritis.

Section C (cognitive status) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/20/17 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points.

The clinical record included an original DDNR order form from the Virginia Department of Health dated 10/21/16 and a copy of the same form. Section 1 and 2 of these forms had been left blank.

Under section 1 the DDNR read in part, "I further certify [must check 1 or 2]:
1. The patient is CAPABLE of making an informed decision ..
2. The patient is INCAPABLE of making an informed decision..."
The boxes beside #1 and #2 had been left blank.

Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below had also been left blank.

The clinical record also included a comfort care order sheet indicating the Residents' code status

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F 155	Continued From page 3 was a DNR (do not resuscitate). When reviewing the most current physician signed (03/01/17) POS (physician order sheet) it was noted that someone had transcribed "DNR" onto the form. On 03/01/17 at approximately 2:30 p.m. the DON (director of nursing) was shown the DDNR's. The administrative staff of the facility was notified of the missing information on the DDNR during a meeting with the survey team on 03/02/17 at approximately 2:35 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 155	F328 Resident #2 is receiving the correct amount of oxygen per physician order. All residents who have orders for oxygen have been reviewed to ensure the oxygen administration rate is the same as the Physician orders. 100% licensed nurses will be in-serviced by DON or designee to follow physician orders for oxygen administration. Oxygen audits will be completed weekly x4, then monthly by DON or designee to ensure the administration rate is what the physician ordered Results of audits will be presented at the monthly QAPI meeting for review and recommendations for the duration of the monitoring period. Completion Date 4/5/17	
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy	F 328		

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F 328	Continued From page 4 services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical	F 328		

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F 328	Continued From page 5	F 328		

record review, the facility staff failed to ensure the correct level of oxygen ordered by the physician was administered to 1 of 17 residents (Resident #2).

The findings include:

The facility staff failed to follow the physician orders for administration of oxygen for Resident #2.

Resident #2 was admitted to the facility on 10/21/16 with diagnoses of dysphagia, hypertension, bipolar disease, hypothyroidism, malnutrition, seizure disorder, dementia with psychosis and bulbous phemphogoid disorder.

The current quarterly Minimum Data Set (MDS) with a reference date of 2/6/17 assessed the resident with a cognitive score of "5" of "15". The resident was assessed requiring total assistance of 2 persons for bed mobility, dressing,eating, toileting, bathing, and hygiene.

The resident was observed on 3/1/17 at 1:30 p.m. in bed with head of bed elevated. The resident had oxygen infusing via nasal cannula(NC) at 3 Liters/min. The resident was able to communicate her needs.

The clinical record was reviewed. The record contained a physician recertification order dated 3/1/17 for," O2(oxygen)cont(continuous) via NC 2L /min Q (every) shift".

The comprehensive care plan was reviewed. The care plan had a problem listed the resident was at risk for altered cardiac/resp status. The first intervention was listed for "O 2 as ordered".

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F 328	Continued From page 6 The director of nursing (DON) was asked to accompany the surveyor to observe the resident at 2:45 p.m. on 3/1/17. The DON noted the oxygen was set at the wrong rate and corrected the rate to 2 liters per minute. The administrator, DON, and assistant DON, were informed of the findings during a meeting with survey team on 3/1/17 at 4:00 p.m.	F 328		
F 372 SS=F	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to dispose of garbage and refuse properly. The findings included. The sides of the dumpster were observed by the surveyor to have holes and debris was observed to be scattered around the dumpster area. On 03/02/17 at approximately 7:35 a.m. the surveyor and maintenance employee #1 observed the dumpster on the outside of the facility. The surveyor observed 3 large oblong shaped holes on one side of the dumpster and birds were observed to be going in and out these holes. On the other side of the dumpster the surveyor observed 2 oblong shaped holes. Trash was observed sticking out of the holes and debris was scattered around on the ground. This debris	F 372	F372 The dumpster cited has been replaced. All residents are affected. A facility designee will inspect the dumpster and the surrounding area twice weekly for four weeks to verify it is functioning properly. An additional weekly inspection will be performed by a facility designee to assure appropriate function. Completion Date 4/5/17	

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F 372	Continued From page 7	F 372		

included, but was not limited to, gloves, paper, and empty juice containers.

Maintenance employee #1 verbalized to the surveyor that he had called the trash company recently and found out that the dumpster belonged to the facility.

The administrator was notified of the issues regarding the dumpster on 03/02/17.

On 03/02/17 at approximately 11:10 a.m. the administrator verbalized to the surveyor that a vendor would be bringing a new dumpster to the facility this afternoon.

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