STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495381	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH & REHABILITATION CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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 05/30/17 through 06/01/17. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow. The census in this 120 bed facility was 102 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents # 1 through #18, and # 22 and #23) and 3 closed record reviews (Residents # 19 through #21).	F 000		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:	F 309		7/14/17

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

Electronically Signed | 06/07/2017

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 309	Continued From page 1 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow physician's orders for one of 23 residents in the survey sample, Resident #11. Resident #11 was observed without physician ordered TED (compression stockings). Findings include: Resident #11 was admitted to the facility on 3/26/12 with readmission on 4/23/16 with diagnoses including, but not limited to: Congestive heart failure, and edema. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 5/8/17. Resident #11 was assessed as being severely cognitively impaired with a cognitive score of 3 out of 15. Review of Resident #11's medical chart on 5/31/17 evidenced via physician orders, that	F 309	1. TED hose were placed on Resident #11 at approximately 2:30p.m. on 05/31/2017. Education has been provided to C.N.A. #1 and LPN#2 regarding placement of TED hose per MD order and proper documentation of placement of TED hose. 2. A 100% audit of all residents with Physician's orders for TED hose will be completed to ensure staff follow Physician Orders for TED hose. This audit will be completed by the Director of Nursing or designee. Staff will verify placement of TED hose on the residents. 3. Education will be provided to Licensed Nurses and C.N.A.s by the Director of Nursing or designee regarding placement of TED hose on patients per MD order and proper documentation of same. 4. A 10% audit of all residents on each Neighborhood with orders for TED hose will be conducted by the Director of Nursing or designee monthly for 3	

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F 309	Continued From page 2 Resident #11 had an order for TED hose to be placed on legs in the morning and taken off in the evening due to edema . The original date of the order was 12/1/16 and was current at the time of the survey. On 5/31/17 at 1:20 p.m. Resident #11 was observed sitting in the Resident's room in a wheelchair without TED hose in place. This surveyor then reviewed Resident #11's treatment administration record (TAR) and indicated (via nurses initials) that Resident #11's TED hose were in place on 5/31/17. On 5/31/17 at 1:55 p.m., this surveyor then went back to where Resident #11 resided and interviewed the certified nurses assistant (CNA #1) assigned to Resident #11. CNA #1 was asked if she knew if Resident #11's TED hose were on. CNA #1 verbalized uncertainty if the TED hose were in place, verbalizing that the night shift gets Resident #11 up prior to the shift ending and puts the hose on, then the evening CNA takes them off prior to going to bed for the night. CNA #1 also verbalized that the TED hose could be dirty. This surveyor and CNA #1 then observed Resident #11 without TED hose in place. When asked, where the TED hose could be, CNA #1 verbalized the hose were probably in the bathroom. CNA #1 then went to the bathroom and located Resident #11's TED hose and verbalized that she (CNA #1) would put the hose on Resident #11. On 5/31/17 at 2:05 p.m. Resident #11's nurse (license practical nurse, LPN #2) was interviewed	F 309	months. Results of these audits will be reported to the monthly QAPI Committee for recommendations and to ensure ongoing compliance. 5. All corrective action will be complete by July 14, 2017.	

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F 309	Continued From page 3 concerning documentation of placement of Resident #11's TED hose. LPN #2 verbalized that she thought Resident #11's TED hose were in place, but must have been dirty. This surveyor asked if Resident #11 only had one pair of hose, what would happen if the TED hose were soiled. LPN #2 verbalized that she (LPN #2) would go to the supply room and obtain another pair of TED hose and get them placed on Resident #11. On 5/31/17 at 4:45 p.m. the above finding was brought to the attention of the director of nursing and administrator. No other information was provided prior to exit conference on 6/1/17.	F 309		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation.	F 323		7/14/17

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F 323	Continued From page 4 (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide safe ambulation assistance for one of 23 residents in the survey sample. Resident #17 was assisted with ambulation by a certified nurses' aide without use of a gait belt for safety as required in her plan of care. The findings include: Resident #17 was admitted to the facility on 4/28/17 with a re-admission on 5/16/17. Diagnoses for Resident #17 included post care for a femur fracture, osteoporosis, high blood pressure and hearing loss. The minimum data set (MDS) dated 5/17/17 assessed Resident #17 with severely impaired cognitive skills and requiring the extensive assistance of one person for ambulation. On 5/31/17 at 1:50 p.m. Resident #17 was observed walking in the hallway on her living unit assisted by certified nurses' aide (CNA) #3. The resident was ambulating using a walker with CNA #3 pulling a wheelchair behind the resident. CNA #3 was pulling the wheelchair with her right hand and was holding onto the back waistband of the resident's pants with her left hand. There was no gait belt in use with Resident #17. The resident walked in this manner with CNA #3 down the	F 323	1. A gait belt was applied to Resident # 17 by the COTA prior to seating her in her wheelchair following a walk by C.N.A. #3. Education was provided to C.N.A. # 3 by the COTA regarding use of a gait belt during ambulation for this resident. 2. A 100% audit will be conducted by the DON or designee of Residents' Care Plans who need gait belts for safe ambulation. The DON or designee will verify that these residents have a gait belt used during ambulation. 3. Education will be provided by the Rehab Manager or designee to Licensed Nurses and C.N.A's regarding use of gait belts for safety if indicated in a resident's Plan of Care. 4. A 10% audit of all residents on each neighborhood whose Care Plan indicate the use of a gait belt for safe ambulation will be conducted by the DON or designee monthly for 3 months. The results of theses audits will be reported monthly to the QAPI Committee for recommendations and to ensure ongoing compliance. 5. All corrective action will be complete by July 14, 2017.	

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F 323	Continued From page 5	F 323		

length of the hallway and back to the day area near the nursing station. When back in the day area a certified occupation therapy assistant (COTA) was waiting stating she was ready to take the resident to therapy. The COTA applied a gait belt to the resident prior to seating her in the wheelchair.

Resident #17's care plan (effective date 5/17/17) documented the resident was dependent on staff for assistance with walking. Interventions listed to safely increase the resident's independence with ambulation included proper footwear and use of a gait belt.

On 5/31/17 at 1:55 p.m. CNA #3 was interviewed about ambulating Resident #17 without use of a gait belt. CNA #3 stated she was supposed to use a gait belt when assisting the resident with walking. CNA #3 stated she usually put a gait belt on Resident #17 but did not today. CNA #3 stated Resident #17 was recovering from hip surgery and required assistance and a walker for ambulation.

On 5/31/17 at 3:25 p.m. the licensed practical nurse (LPN #3) caring for Resident #17 was interviewed about the use of a gait belt with Resident #17. LPN #3 stated a gait belt was supposed to be used when assisting Resident #17 with walking or transfers.

On 5/31/17 at 3:35 p.m. the COTA providing therapy for Resident #17 was interviewed. The COTA stated she saw CNA #3 walking the resident without the gait belt. The COTA stated the protocol for assisting residents with ambulation included use a gait belt for safety.

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F 323	Continued From page 6 These findings were reviewed with the administrator and director of nursing during a meeting on 5/31/17 at 4:45 p.m.	F 323		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure various pans used for cooking and serving food were not nested wet in the main kitchen.	F 371	1. All pans identified as "wet nesting" were immediately removed by the Dietary Services Supervisor and placed on a cart to be re-washed. 2. A daily Pan Check Schedule has been	7/14/17

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F 371	Continued From page 7 Findings include: On 5/30/17 beginning at 7:00 p.m. an inspection of the facility's main kitchen was conducted with the dietary services supervisor, identified as OS (other staff) # 1. Two metal shelves were identified as having clean,dried serving pans stacked on the wire racks. OS # 1 was asked if he would randomly lift the pans up for inspection. OS # 1 then lifted up the first of five deep sheet pans, which was nested wet. OS # 1 immediately removed the pan and placed in on a cart to be rewashed. This surveyor and OS # 1 continued inspecting the pans, and revealed the following: Two of six half-third pans was nested wet; five quarter pans were nested wet; six of seven half full pans were nested wet; and three of nine deep half pans were nested wet. OS # 1 removed all the wet nested pans to be rewashed. OS # 1 stated "These were from lunch. I'm going to have to get on the crew from lunch time!" On 5/31/17 at 4:45 during a meeting with facility staff, the administrator, DON (director of nursing), and the corporate services personnel were informed of the above findings. No further information was provided prior to the exit conference.	F 371	implemented by the Nutrition Services Manager to observe for wet nesting. All pans will be checked 3 times daily by a Dietary Supervisor or the Nutrition Manager. 3. Education will be provided for Dietary Staff by the Nutrition Manager or designee on Improved Methods of Drying and Storing of Pans. 4. The daily Pan Check Schedule/ audit will continue for 1 month; then weekly for 2 months. The results of these audits will be reported monthly to the QAPI Committee for recommendations and to ensure ongoing compliance. 5. All corrective action will be completed by July 14, 2017.	
F 406 SS=E	PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES CFR(s): 483.65(a)(1)(2) (a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology,	F 406		7/14/17

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F 406	Continued From page 8 occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a physician's ordered ST (Speech Therapy) consult was completed as ordered by the physician for one of 23 residents in the survey sample, Resident # 3. The facility staff failed to obtain a physician's order for a ST consult for Resident # 3 after it was identified by staff that the resident was having difficulty swallowing food on 04/05/17. A physician's order was obtained on 05/12/17 for a ST consult/evaluation, but was not completed until 05/31/17. Findings include: Resident # 3 was admitted to the facility on 11/24/14. Diagnoses for Resident # 3 included, but were not limited to: depression, Vitamin D deficiency, GERD (gastroesophageal reflux disease), dysphagia (difficulty swallowing),	F 406	1. A Speech Therapy Consult/ Evaluation for Resident #3 was completed by the Speech Therapist on May 31, 2017. 2. A 100% audit of all MD orders for Speech Therapy for the past 30 days will be completed by the DON or designee to ensure the Evaluations are competed as ordered. 3. Education will be provided to Licensed Nurses and the Rehab Department employees on the process to communicate MD orders for Speech Therapy Evaluations to the Therapy Department. 4. A 10% audit of MD orders for Speech Therapy on each neighborhood will be completed by the DON or designee for 3 months to ensure the evaluations are completed as ordered. 5. All corrective action will be completed by July 14, 2017,	

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oropharyngeal phase; cough (difficulty moving food or liquid into the throat, resulting in coughing during or right after eating or drinking).

The most current MDS (minimum data set) was a assessment dated 05/11/17. This MDS assessed the resident as having a cognitive score of 15, indicating the resident is cognitively intact for daily decision making skills. This MDS also assessed the resident as requiring limited assistance (resident highly involved) with one person physical assistance for consuming meals.

Resident # 3 was observed eating breakfast on 05/31/17 at approximately 8:10 a.m. The resident was seated at the dining area close the nurse's station on her unit, with the resident's husband sitting beside her. The resident was given a breakfast tray, consisting of oatmeal, scrambled eggs, yogurt, toast and bacon. The resident was given milk in a 'sippy' type of cup, along with coffee in a 'sippy cup' and a small glass of apple juice in a regular tumbler type, plastic cup. The resident was observed using the 'sippy cup' several times and drank all of the apple juice from the regular cup.

During clinical record review a nursing note dated 04/05/17 (evening shift) documented, "...CNA [certified nursing assistant] came to nurse with concerns resident is having difficulty swallowing her food at meals...nurse put in concern in book for MD [medical doctor] to follow up..."

The resident's clinical records were further reviewed and no ST consult or evaluation could be located, in reference to the nursing note dated 04/05/17.

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A physician's order dated 05/12/17 was reviewed, which documented: "...ST to evaluate and treat. Therapeutic Range: Continuous Starting 05/12/17..."

The resident's clinical records were again reviewed and no consult and/or evaluation was found.

On 05/31/17 at approximately 3:45 p.m., the facility's consultant was asked for assistance in locating the consult/evaluation for Resident # 3 and assistance in determining why the resident was not seen soon after the nursing note dated 04/05/17 identified the resident as having difficulty swallowing and additionally not seen after a physician's order was written on 05/12/17.

On 05/31/17 at approximately 4:30 p.m., the ST (Speech Therapist) was interviewed regarding Resident # 3. The ST stated that we (therapy) usually always get a "Hey" form (communication form) from the nurse's letting us know if someone needs to be seen. The ST was informed of the nursing note dated 04/05/17. The ST stated that she was unaware that the resident was having any difficulty at that time, but was seen in January 2017 and was ordered the provale (sippy) cup that was now in use. The ST was also made aware of the physician's order dated 05/12/17, which was over a month that the nursing note had been written and was asked if she (the ST) knew about the order. The ST stated, "No."

The ST was asked if an evaluation had been done on Resident # 3. The ST stated, "Yes" and when asked when that was completed the ST stated, "Today." The ST was asked who sent a "hey" or communication form to the therapy unit,

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the ST stated, "Nobody." The ST was then asked how did she know the resident needed to be seen, the ST stated that a CNA came down to therapy today and told her (the ST) that the resident was having difficulty."

On 05/31/17 at approximately 4:45 p.m., the facility consultant, administrator and DON (director of nursing) were made aware of concerns that concerns for Resident # 3 were reported to the nurse in April 2017 and then a physician's order was written on 05/12/17 and then the resident was not seen until today.

The facility staff were asked for assistance in determining why the resident was not seen sooner. The facility consultant stated that they (the facility staff) did not have anything different to contribute.

On 06/01/17 at approximately 8:15 a.m., the manager of the therapy department was asked for the evaluation for Resident # 3 dated 05/31/17.

The evaluation was presented and reviewed and documented, "...Start of Care: 05/31/17...resident was referred to therapy due to reports from nursing of coughing with sips of thin liquids...history of dysphagia. Coughing episodes are caused by delayed initiation of the pharyngeal swallow...would benefit from skilled dysphagia therapy intervention to address coughing episodes...and determine liquid consistency which patient is able to safely swallow with not overt signs/symptoms of penetration/aspiration...aspiration risk..."

No further information and or documentation was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495381	A. BUILDING _____ B. WING _____	06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT HEALTH & REHABILITATION CENTER	1300 ENTERPRISE DRIVE LYNCHBURG, VA 24502

(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 406	Continued From page 12 presented to evidence that the Resident # 3 was seen in a timely manner by Speech Therapy Services prior to the exit conference on 05/31/17 at 9:30 a.m.	F 406		
F 456 SS=E	ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION CFR(s): 483.90(d)(2)(e) (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on facility document review, and staff interview the facility failed to ensure proper temperatures for the hydrocollator in the therapy department. The hydrocollator was above the recommended temperature as indicated in the specifications of the hydrocollator hand book. Findings Include: On 5/31/17 at 3:30 p.m. general observations of the therapy department was conducted. The daily logs for the hydrocollator were reviewed and evidenced temperatures for the months of March, April , and May were consistently at 168 degrees Fahrenheit. At this time an occupational therapist (other staff, OS #3) was asked to provide the hydrocollator's	F 456	1. The temperature setting on the hydrocollator was adjusted by the Facilities Manager in May 31, 2017 to achieve a temperature range of 160-165 degrees Fahrenheit as per the hydrocollator specification sheet. 2. There are no additional hydrocollators within the facility, 3. A temperature log is in place to record daily temperatures of the hydrocollator by the Rehab Manager or designee. The Log will be reviewed on a weekly basis by the Rehab Manager for 1 month; then monthly for 3 months to ensure the temperature is within the specified range of 160-165 degrees Fahrenheit. Adjustments to the temperature settings will be made by the Facilities Manager as needed. 4. The results of the temperature log	7/14/17

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F 456	Continued From page 13 specification sheet due to concerns with the temperature being out of range. OS #3 verbalized that she would look for the specifications and present them. On 5/31/17 at 4:00 p.m. OS #3 presented the hydrocollator specification sheet that read "[...] Temperature range 160 F [Fahrenheit] - 165 F [...]" OS #3 also presented a chapter from a therapy book (book title unknown) pointing out an overview of what a heat pack was and indicating temperatures of a heat pack ranges from 158 to 170 degrees. OS #3 verbalized that she was unaware of the actual specification range according to the hydrocollator manual. On 5/31/17 at 4:45 p.m. the above finding was presented to the director of nursing and administrator. No other information was provided prior to exit conference on 6/1/17.	F 456	reviews will be reported to the monthly QAPI Committee for recommendations and to ensure ongoing compliance. 5. All corrective action will be completed by July 14, 2017.	