Kissito Healthcare
Hot Springs

PO Drawer I
167 Spring Street
Hot Springs, VA 24445
Phone: 540.839.2299
Fax: 540.839.2576

Integrity ♦ Passion ♦ Excellence ♦ Respect

Paul Wade, LTC Supervisor
Division of Long Term Care
Office of Licensure and Certification
9960 Mayland Drive
Suite 401
Richmond VA 23233

Dear Mr. Wade

Attached please find the 2567 Statement of Deficiencies for the survey conducted on April 27 and 28, 2016 at the Springs Nursing Center. The facility plan of correction is included in the appropriate column along with the completion date for the plan of correction. Please accept this plan as the facility's allegation of compliance.

If you have any questions concerning the plan of correction please contact me at 540-839-2299 ext. 100.

Thank You

Thomas M. Shelor, LNHA
Chief Administrative Officer
The Springs Nursing Center

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 04/26/2016 through 04/27/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 54 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents 1 through 12) and two closed record reviews (Residents 13 and 14).	F 000	Kissito Healthcare shares the state's focus on the health, safety and well being of facility residents. Although the facility does not agree with some of the findings and conclusions of the surveyors, we have implemented a plan of correction to demonstrate our continuing effort to provide quality care to our residents.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and group interview the facility staff failed to ensure previous Federal and State survey results were readily accessible to residents in the facility and failed to post a notice regarding the survey's availability. Findings were:	F 167	The facility survey results were moved into the main lobby area at an appropriate height for resident access. Signage was placed at the nurses' station visible to residents and visitors describing the location of the most recent survey results. Current residents in the center have the potential to be affected. Facility staff was educated by the Chief Administrative Officer(CA0)/designee on the placement of the most recent survey results and signage at the nurses station to alert residents and visitors of the location. The CAO/designee will verify the appropriate location of the survey results and signage of the location of the most recent survey results on a weekly basis.	06/10/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 05/04/16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 167	Continued From page 1 A group interview was conducted on 04/27/2016 at 10:30 a.m. with seven cognitively intact residents. As part of the interview process the group was asked if they knew where the results of the most recent survey conducted at the facility was located. None of the residents were aware of the location of the results and when asked if they had been aware that the results were available to them, all seven residents either verbally responded "No", or shook their head from side to side indicating they did not. After the group interview the survey results book was located in the entrance foyer to the facility. The foyer was separated from the main door entering the facility by another door. A resident wearing a wanderguard would not be able to exit the first door to obtain the results. The results were located in bookshelf/rack up on the wall at eye level for a standing individual. The rack was labeled with a small typed sticker "SURVEY RESULTS". The rack was not accessible to anyone at wheelchair height. There was no signage in the facility indicating the location of the survey results book. The administrator and the acting DON (director of nursing) were notified of the above information during an end of survey meeting on 04/27/2016 at approximately 12:50 p.m. No further information was received prior to the exit conference on 04/27/2016.	F 167	The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 309	Continued From page 2 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 clinical record review and staff interview, the facility staff failed to ensure a physician's order was followed for one of 14 residents in the survey sample, Resident # 10. Resident # 10's physician's telephone order for Thera-M tablet (multiple vitamins-minerals) was placed in another resident's chart (identified as Resident # 9), as a result Resident # 10 did not receive the physician ordered medication for 14 days. Findings include: Resident # 10 was admitted to the facility originally on 04/07/16. Diagnoses for Resident # 10 included, but were not limited to: atrial fibrillation, chronic kidney disease, anxiety disorder, DM (diabetes mellitus), encephalopathy, HTN (hypertension/high blood pressure), and hyperlipidemia. The most current MDS (minimum data set) was an admission assessment dated 04/14/16. This MDS assessed the resident as having a cognitive score of "9", indicating the resident had moderate impairment in daily decision making skills.	F 309	Resident #9 and resident #10 are receiving medications as ordered by the attending physician. The physician for resident #10 was notified of the resident not getting the ordered medication for 14 days on April 27, 2016. No new orders received. A review of the physician orders for the last 30 days along with the medication administration record was completed for all residents to ensure residents were receiving their physician ordered medications. Licensed nurses will be educated by the Director of Nursing/designee on transcription of orders onto the medication administration record. In addition, the education will include ensuring orders are placed on the appropriate resident's medical record. The Director of Nursing/designee will audit new physician orders during morning meeting to ensure the medication administration records accurately reflect the orders. The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	06/10/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 309	Continued From page 3	F 309		

During a medication reconciliation on 04/27/16 at approximately 8:50 a.m., Resident # 9's physician's orders were reviewed for a medication pass and pour observation/medication reconciliation verification. In Resident # 9's chart was a telephone order, that belonged to Resident # 10. The telephone order had Resident # 10's name and room number on it and was dated 04/12/16 and timed for 2:35 p.m. The telephone order was for, "Thera-M Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day for supplement...signature of LPN (Licensed Practical Nurse) # 2.

At approximately 9:00 a.m., LPN # 1 asked to review Resident # 10's MARs (medication administration records). The MARs were reviewed and did not include an order for Thera-M, as ordered on 04/12/16.

At approximately 9:15 a.m., LPN # 2 was interviewed regarding the above. LPN # 2 voiced that normally when a verbal order or telephone order is received, we [staff] enter it into the computer, print it off and then put it on the chart and that they [staff] also print off a MAR with the new medication and put that in the MAR book.

Resident # 9's clinical record was given to LPN # 2 to observe, Resident # 10's telephone order in the wrong chart. LPN # 2 stated, "Oh, it's in the wrong chart." LPN # 2 was asked if she had taken that order for Resident # 10. LPN # 2 voiced, yes. LPN # 2 voiced that sometimes she will rely on the nurse's to help with filing or putting the new orders or the new MARS where they go. The LPN was informed that Resident # 10 did not have a MAR with the Thera-M medication on it

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 309	Continued From page 4	F 309		

and the resident had not had the ordered medication for 14 days. LPN # 2 was asked if she printed off a MAR for this order. LPN # 2 voiced that she thought she did, and stated, "It may have gotten lost."

Resident # 10's clinical record was further reviewed. A nutrition assessment dated 04/12/16 was reviewed for Resident # 10. The nutrition assessment documented, "...Recommendations New Admit 76 yo [year old] F [female] with dx [diagnoses] as above...Rec: [Recommend] MVI [multivitamin] with minerals due to (3.4.16) Hgb [hemoglobin] and Hct [hematocrit] Low...."

The resident's CCP (comprehensive care plan) was then reviewed and documented, "...Altered nutrition status...Administer medications as ordered...RD [Registered Dietitian] to evaluate and make diet change recommendations PRN [as needed]...At risk for fluid overload/deficit...Provide diet and supplements per RD recommendation and physician order..."

The administrator and acting DON (director of nursing) were made aware of the above information in a meeting with the survey team on 04/27/16 at approximately 1:00 p.m.

No further information or documentation was presented prior to the exit conference on 04/27/16 at 1:30 p.m.

F 332 SS=D 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE — F 332

The facility must ensure that it is free of medication error rates of five percent or greater.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 332	Continued From page 5	F 332		

This REQUIREMENT is not met as evidenced by:
Based on a medication pass and pour observation, staff interview and clinical record review, the facility staff failed to ensure a medication error rate of less than 5 % (percent). There were 39 opportunities and 2 errors resulting in an error rate of 5.1%.

Findings include:

During a medication pass and pour observation on 04/27/16 at approximately 8:00 a.m., LPN (Licensed Practical Nurse) # 1 prepared medications for administration to Resident # 9.

One of the medications prepared for Resident # 9 was, one Aspirin 325 mg (milligrams) EC (enteric coated) tablet.

The above Aspirin, along with other medications were administered to Resident # 9.

At approximately 8:25 a.m., LPN # 1 prepared medications for Resident # 10.

One of the medications prepared for Resident # 10 was, one Aspirin 325 mg EC tablet.

The above Aspirin, along with other medications were administered to Resident # 10.

A medication reconciliation was completed for Resident # 9 and Resident # 10, on 04/27/16 at approximately 8:50 a.m.

Resident # 9's most current POS (physician's

Physician for resident's #9 and resident #10 was notified on 04/27/2016 of the residents receiving enteric coated Aspirin instead of the ordered plain Aspirin. New orders were received to reflect the enteric coated. Pharmacy was notified on 04/27/2016 of the discrepancy of the physician orders and the medication send from Pharmacy. LPN #1 was immediately educated on the 5 R(s) of medication administration. 06/10/2016

A review of current residents receiving aspirin was conducted to ensure the physician order and the medication send from pharmacy matches.

Licensed staff will be educated by the Director of Nursing/designee on the 5 R(s) of medication administration—right patient, right drug, right dose, right route, and the right time.

The Director of Nursing/designee will observe three nurses weekly to ensure compliance with the 5 R(s) of mediation administration.

The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 332	Continued From page 6	F 332		

order set), dated ("Active Orders As Of:") 04/01/16 included an order for, but not limited to: "...Aspirin 325 mg Oral Once Daily 325 mg Oral CEREBROVASCULAR DISEASE...Order Date 01/14/15 Start Date 01/14/15..."

The physician's order did not specify for the Aspirin to be EC (Enteric Coated).

Resident # 10's most current POS dated ("On or After Date:") 04/07/16 included an order for, but not limited to: "...Aspirin Tablet Give 325 mg by mouth one time a day related to ATHEROSCLEROTIC HEART DISEASE OF NATIVE CORONARY ARTERY...Order Date 04/07/16 Start Date 04/08/16..."

The physician's order again, did not specify for the Aspirin to be EC (Enteric Coated).

At approximately 9:00 a.m., LPN # 1 was interviewed regarding the above information. LPN # 1 was asked to pull the medication card for the Aspirin for Resident # 9. LPN # 1 pulled the Aspirin medication card and was asked to compare the medication card label with the resident's MAR. LPN # 1 voiced that both were Aspirin 325 mg. LPN # 1 was asked to look closer at the medication card; the EC on the label of the medication card was identified for LPN # 1. LPN # 1 was asked if the medication card label/medication and the MAR matched and was asked if those were the same medication. LPN # 1 voiced that Aspirin 325 mg EC is different than Aspirin 325 mg, but voiced that she would follow up and find out to be sure.

The LPN then reviewed Resident # 10's Aspirin medication card label and the resident's MAR.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 332	Continued From page 7 Again, the information did not match and LPN # 1 voiced that she would follow up and find out to be sure. At approximately 11:00 a.m., in a meeting with the survey team, the ADON (assistant director of nursing) and LPN # 1 voiced that the pharmacy was called regarding the above information and voiced that the pharmacy automatically sends Aspirin EC, when Aspirin is ordered. The ADON, was asked why the pharmacy would do that, when these are two different types of Aspirin and the physician's order did not say EC. The ADON voiced uncertainty and stated, "That's just what they do." The ADON was made aware that nursing should be aware of what medications are being administered. The ADON agreed. The ADON was then asked what would be the expectation if the physician orders Aspirin 325 mg. The ADON voiced that if it's ordered EC, it should be EC and if it isn't it [Aspirin] should be regular. The administrator and acting DON (director of nursing) were made aware of the above information, in a meeting with the survey team on 04/27/16 at 1:00 p.m. The facility medication error rate was 5.1 %. No further information or documentation was presented prior to the exit conference on 04/27/16 at 1:30 p.m.	F 332		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 465	Continued From page 8 residents, staff and the public.	F 465		

This REQUIREMENT is not met as evidenced by:
Based on observation, and staff interview, the facility failed to provide a safe and functional environment for residents, staff and the public.

Two outside fenced area's gates were in ill repair and a ceiling fan located in the main dining/activity area was not secured properly.

The Findings Include:

General observations were conducted on 4/26/16 at 2:30 p.m. in the main dining area/activity room. Three ceiling fans were observed running and one of the three was wobbling uncontrollably. At this time a Resident observed this surveyor looking at the ceiling fan and verbalized that the fan looked like it was ready to drop from the ceiling.

On 4/27/16 at 10:45 a.m. this surveyor conducted general observations outside of the facility. On the back-side of the building was an enclosed courtyard. The gate entering the courtyard was rusted with missing frame at the bottom of the gate. The gate was unable to be opened and closed without physically picking up the gate and moving it.

This surveyor then walked to the front of the facility to another enclosed sitting area where Resident's were allowed to smoke. A wooden gate was observed lying on the walkway completely torn down with screws pointing upward and blocking the sidewalk.

The ceiling fan in the dining room was addressed immediately. The gate in the rear of the facility was replaced and the gate in the front was repaired immediately. 06/10/2016

The Facility Maintenance Director and the Chief Administrative Officer conducted a facility safety round to insure that all equipment and fixtures were in proper working order.

Facility staff was educated by the CAO/designee on completing maintenance work orders. Staff members were instructed to complete orders when repair needs are observed. These needs include the interior and exterior portions of the facility.

The Facility Maintenance Director/designee will conduct facility surveillance weekly to ensure that all equipment and fixtures are in working order. Maintenance work orders will be reviewed in morning meeting to ensure timely follow up on needed repairs.

The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 465	Continued From page 9	F 465		

On 4/27/16 at 11:00 a.m. this surveyor showed the maintenance director (other staff, OS #1) the above findings and asked if he was aware of the problems. OS #1 director verbalized he was not aware of the problems and would get them fixed. OS #1 was asked how he was informed when something needs to be fixed. OS #1 verbalized usually staff will tell him. OS #1 was asked if he inspects the outside of the building. OS #1 verbalized that he does walk around the build, but doesn't come to where the broken gates were observed.

On 4/27/16 at 1:00 p.m. at meeting with the administrator and the director of nursing took place. The above information was presented, the administrator indicated understanding by nodding his head.

No other information concerning the above information was presented prior to exit conference on 4/27/16.

F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514	Resident #9 and resident #10 are receiving medications as ordered by the attending physician. The physician for resident #10 was notified of the resident not getting the ordered medication for 14 days on April 27, 2016. No new orders received. The medical records for residents #9 and #10 were reconciled to make sure they were accurate and that all orders were for the appropriate resident.	06/10/2016

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;

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 514	Continued From page 10 and progress notes.	F 514		

This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility staff failed to ensure a complete and accurate clinical record for two of 14 residents in the survey sample, Resident # 9 and Resident # 10.

Resident # 10's telephone order for a medication was located in Resident # 9's clinical record.

Findings include:

Resident # 9 was admitted to the facility on 02/17/11. Diagnoses for Resident # 9 included, but were not limited to: renal insufficiency, history of stroke, chronic ischemic heart disease and chronic pain.

The most current MDS (minimum data set) with CAAS (care area assessment summary) for Resident # 9 was an annual assessment dated 01/16/16. This MDS assessed the resident as having a cognitive score of "3", indicating the resident had severe impairment in daily decision making skills.

Resident # 10 was admitted to the facility originally on 04/07/16. Diagnoses for Resident # 10 included, but were not limited to: atrial fibrillation, chronic kidney disease, anxiety disorder, DM (diabetes), encephalopathy, HTN (hypertension/high blood pressure), and hyperlipidemia.

A review of the current residents' medical records was completed to ensure the information in each chart pertains to the appropriate resident.

Facility staff will be educated by the Director of Nursing/designee on ensuring records being filed on a medical record correlates to the resident name on the chart.

Medical Records Coordinator/designee will conduct weekly audits of 10 resident's medical records to ensure the medical record is complete and accurate.

The results will be reported monthly to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 514	Continued From page 11	F 514		

The most current MDS (minimum data set) was an admission assessment dated 04/14/16. This MDS assessed the resident as having a cognitive score of "9", indicating the resident had moderate impairment in daily decision making skills.

During a medication reconciliation on 04/27/16 at approximately 8:50 a.m., Resident # 9's physician's orders were reviewed for a medication pass and pour observation/medication reconciliation verification. In Resident # 9's chart was a telephone order, that belonged to Resident # 10. The telephone order had Resident # 10's name and room number on it and was dated 04/12/16 and timed for 2:35 p.m. The telephone order was for, "Thera-M Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day for supplement...signature of LPN (Licensed Practical Nurse) # 2.

At approximately 9:15 a.m., LPN # 2 was interviewed regarding the above. LPN # 2 voiced that normally when a verbal order or telephone order is received, we [staff] enter it into the computer, print it off and then put it on the chart and that they [staff] also print off a MAR with the new medication and put that in the MAR book.

Resident # 9's clinical record was given to LPN # 2 to observe, Resident # 10's telephone order in the wrong chart. LPN # 2 stated, "Oh, it's in the wrong chart." LPN # 2 was asked if she had taken that order for Resident # 10. LPN # 2 voiced, yes. LPN # 2 voiced that sometimes she will rely on the nurse's to help with filing or putting the new orders or the new MARS where they go. The LPN was informed that Resident # 10 did not have a MAR with the Thera-M medication on it and the resident had not had the ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495220	A. BUILDING _____ B. WING _____	04/27/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS NURSING CENTER	167 SPRING STREET HOT SPRINGS, VA 24445

(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 514	Continued From page 12	F 514		

medication for 14 days. LPN # 2 was asked if she printed off a MAR for this order. LPN # 2 voiced that she thought she did, and stated, "It may have gotten lost."

The administrator and acting DON (director of nursing) were made aware in a meeting with the survey team on 04/27/16 at approximately 1:00 p.m.

No further information or documentation was presented prior to the exit conference on 04/27/16 at 1:30 p.m.