STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495409		R-C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24211

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
	An unannounced Abbreviated Medicare and Medicaid survey was conducted 8/8/18 through 8/9/18. Three complaints were investigated during the survey. The facility requires corrections for substantial compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 120 bed facility was 111 at the time of the survey. The sample consisted of 4 current Resident reviews (Resident # 1, Resident # 2, Resident #3 and Resident #7) and 3 closed record reviews (Resident # 4, #5 and #6).			
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		8/24/18
	§ 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. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to assess and document a skin tear for 1 of 6 residents (Resident #1). The findings included: The facility staff failed to assess a skin tear to Resident #1's left arm initially after the incident occurred on 4/25/18, failed to write the physician order for the skin tear care that was provided by		F684 1.It is duly noted that the skin tear Resident# 1 obtained on 4/25/18 was not immediately assessed and treatment provided was not accurately documented. Resident #1'□s acquired skin tear obtained 4/25/18 was resolved without complication with treatment discontinued on 5/19/18. 2.Any resident admitted to facility is at risk	

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

Electronically Signed — 08/31/2018

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 684 Continued From page 1

the assistant director of nursing and the unit manager and failed to document when skin care had been provided by the ADON, unit manager, and licensed practical nurse #2.

Resident #1's clinical record was reviewed 8/8/18 and 8/9/18.

Resident #1 was admitted to the facility 2/27/16 and readmitted 7/23/18 with diagnoses that included but not limited to dementia without behavioral disturbances urinary tract infections, hypertensive and chronic kidney disease, osteoporosis, type 2 diabetes mellitus, osteoarthritis, depressive disorder, anemia, hyperlipidemia, anxiety, gastroesophageal reflux disease, and overactive bladder.

Resident #1's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/23/18 assessed the resident with short-term memory impairment, long-term memory impairment, and severely impaired cognitive skills for daily decision-making. Functional Status (Section G) assessed no impairment/limitation in range of motion of any extremity. Bladder and Bowel (Section H) assessed the resident to be incontinent always of urine and frequently incontinent of bowel. Skin Conditions (Section M) assessed the resident to be at risk for developing pressure ulcers. Resident #1 was assessed to have a skin tear.

The current comprehensive care plan initiated 3/1/16 and revised 3/15/18 identified the resident to be at risk for additional impairments in skin integrity r/t (related to) fragile skin, decreased mobility, and incontinence. Interventions: Apply protective cream/ointment as needed, apply

F 684

for delayed assessment and lack of documentation for an acquired skin tear. An audit will be conducted of all skin tears since August 1, 2018. This audit is to determine if we have any residents without timely assessment, or lacking documentation or physician orders to treat. Any discrepancies will be addressed and corrected as identified.

3.DON and ADON educated licensed staff on August 21-22, 2018 on documentation requirements per the facility's skin assessments/wound care policy to include timely completion of the required documentation, assessment, and obtainment of physician orders for treatment.

4.DON or designee will audit 24 hour report to identify any resident with an acquired skin tear and will review resident EMR to ensure timely assessment, documentation, and obtainment of physician order for treatment when indicated daily (M-F) x4 weeks, then weekly x8 weeks to ensure appropriate documentation of physician notification.

Any discrepancies will be addressed promptly and findings will be reported monthly to Quality Assurance committee for review and further analysis of findings.

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Renew skin repair lotion to bilateral arms daily, and keep skin clean and dry.

The complaint allegation stated that Resident #1 had been injured the morning of 4/25/18 and was bleeding and no one even attempted to dress it or put any type of medication on it.

The 4/25/18 10:50 a.m. progress note read, "This (sic) notified of skin tear by C.N.A. (certified nursing assistant). Resident has skin tear to left lower arm. Dressing applied and family aware. MD (medical doctor) and unit manager notified. Will continue to monitor this shift." Signed by licensed practical nurse #1."

The surveyor interviewed the director of nursing on 8/9/18 at 8:00 a.m. and stated the assistant director of nursing had details about the incident on 4/25/18.

The surveyor interviewed the assistant director of nursing (ADON) on 8/9/18 at 8:37 a.m. The ADON stated, "L.P.N. #1 had assessed the area and the unit manager registered nurse #1 had assessed the area but the administrator wanted the ADON to look at Resident #1's arm. The ADON stated she was not familiar with the wound care protocol. The ADON stated it looked like a clear dressing. The ADON stated she took it off, cleaned the area with normal saline got steri strips and applied them. The ADON stated the area on the arm was approximately 3-4 inches long. The ADON stated she would check the area every day and do the dressing changes until the area healed. The ADON stated she spoke with the complainant's husband and then with the complainant. The ADON stated the complainant did not verbalize any concerns after that. The

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F 684	Continued From page 3 ADON stated she didn't document any of the dressing changes that she did and stated "The DON (director of nursing) was big on documentation." The ADON was asked if she should have documented the care she provided and stated "Absolutely." Witness statement completed by the assistant director of nursing (ADON) on 4/25/18 read, "Called to unit by administrator to assess Resident #1's skin tear. Upon entering room, complainant was upset with nursing staff, stating that no one had done ar.ything with her mother's skin tear. Resident had hydrogel and clear dressing applied to LFA (left forearm). I removed the bandage, cleaned the area with saline and approximated the edges. Skin tear was approximately 3.5 cm (centimeters). I applied steri-strips and wrapped with kerlix. Complainant was very much appreciative after that. I explained to her that the unit manager registered nurse #1 had followed protocol for skin tears, which is to apply hydrogel and non-adhesive dressing (dsg)." Witness statement completed by the assistant director of nursing (ADON dated 5/1/18 read, "I checked resident's arm daily to ensure no s/sx (signs/symptoms) of infection. I wanted to speak with complainant to follow up on concern. Ran into complainant's husband in the hall and asked if she would be visiting that day. He said no, so I asked if he would have her call me. He called her on his cell phone and I was able to speak with her. She was very appreciative of what I had done for her mother." The surveyor interviewed licensed practical nurse #1 on 8/9/18 at 9:35 a.m. L.P.N. #1 stated, "The aide went in to change the resident and said she	F 684		

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had a skin tear to right arm. The aide (identified as C.N.A. #3 and no longer employed at the facility) had put a "wipe" over it. I was told that C.N.A. #3 had called the daughter and told her about the skin tear. I had pills on my cart and I told C.N.A. #3 I would take care of it in a second. The unit manager had left. In the meantime, the daughter came in and I told her I was going to dress the area. The unit manager had left and then came back to the unit after I called him and I told him I needed help because there was a new wound protocol. L.P.N. #1 stated the unit manager dressed the wound. I held the supplies. I then went on with my medication pass. I wrote my statement and turned it in to the director of nursing (DON) before I left that evening. L.P.N. #1 stated the wound care nurse took care of the area after that."

Witness statement provided by the facility and L.P.N. #1 was dated 4/25/18 and read "This nurse was doing her morning medication pass when C.N.A. #3 said she had to go change resident after she had eaten because she had wet through her brief onto the floor and her shirt was wet with urine as well. The C.N.A. #3 took resident to her room and changed her brief and shirt. Upon coming back out of residents room, C.N.A. #3 told this nurse that the resident had a skin tear on her arm. This nurse was preparing another residents medication when she was alerted about the skin tear. This nurse told C.N.A.#3 that she would tend to it and proceeded to take the medication that she had in her hands on the the (sic) residents room. C.N.A. #3 at this time covered residents skin tear with a wipe and brought her back to the open area of the nurses station. When (sic) back to the medication cart from taking medication (sic) to a different resident

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the residents family member came in to the open area at the nurses station. I had not addressed the skin tear at this time because I had just arrived back at my med cart and was checking off the medication that I had just given. The family member begain (sic) to ask me what was wrong with her mothers arm I told her she had received a skin tear when her shirt had been changed but I had not addressed it yet to which I immediately went over to the resident and looked at this skin tear and told the family member that I would call the unit manager and the wound care nurse to come and assess because at this time the family member was atament (sic) that it needed steri-strips. The family member asked the resident who did this to you at which the resident said the nurse did it when she took my shirt off. The family member repeated several times "the nurse did it" to which the nurse said it was the C.N.A. #3 that had changed her shirt. Upon walking away to call I turned around to see the residents family taking her cell phone out of her purse and taking a picture of the area. I tried to reach the wound care nurse but was unable to get her at the time. I had told the unit manager several minutes earlier when he was over to check on things that the resident had a skin tear so when I called him he came over immediately to help this nurse with dressing the area. At this time, the unit manager spoke to the resident's family member to whom he new and told her we would take care of it. The unit manager and this nurse went to the wound care cart as the residents family member took the resident back to her room. Wound care supplies were obtained and taken to the residents room and residents skin tear to her (L) arm was cleaned and dressed. Resident showed no s/s (signs/symptoms) or distress or pain at this time. Family member

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talked (sic) to the unit manager breifly (sic) about the situation and thanked us for taking care of her mother. Residents family member did state that we would need to be careful with her skin as it was very fragile to which the unit manager and this nurse both agreed. This nurse and the unit manager exited the room with nothing else being said.

The unit manager was not available for an interview 8/8/18 or 8/9/18. However, the facility provided the unit manager registered nurse #1's witness statement to the surveyor. The statement read, "April 25th I was notified at 0850 by L.P.N. #1 that the nurse aids (sic) told her Resident #1 had a skin tear to her left forearm. It wasn't until I received a call at 1050 by L.P.N. #1 asking for me to come see Resident #1's daughter was here and was upset because her mother had a skin tear. The complainant was concerned because she did not have a dressing to her skin tear. I cleaned the skin tear and applied hydrogel and covered with an Adaptic dressing per policy and procedure. The complainant seemed fine at this point and made no further complaints to me."

C.N.A #3 was no longer employed at the facility. However, the facility provided the surveyor with the witness statement written by C.N.A. #3 on 4/26/18 and read "I C.N.A. #3 on 4-25-18 around 8:20-8:30 set down at breakfast to help Resident #1 with her breakfast. I notice she needed some bathroom attention so I took her to get cleaned up that's when I notice a pot of blood on her shirt. When I took it off that's when I seen a skin tear on her left arm so I cleaned her up & took her straight to the nurse around 8:45 the nurse said she would take care of it."

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A witness statement dated April 26, 2018 read "DON and ADON interviewed C.N.A. #3. C.N.A. #3 reported that she was assisting Resident #1 with her breakfast and noticed she was wet and needed to be changed. She assisted her to the bathroom to clean her up and noticed a spot of blood on her shirt. When she removed her shirt is when she discovered the skin tear. She finished cleaning her up and then went and reported it to L.P.N. #1. C.N.A. #3 stated "She may have hit her arm under the table when I pushed her up to it and I didn't realize it."

The facility did send a Facility Reported Incident (FRI) to the Office of Licensure and Certification on 4/25/18 which read "Resident #1 received a skin tear to her left forearm on 4/25/18. First observed after taking her shirt off at 8:50 am. Area cleansed with NS (normal saline) and wound cleanser, dermasyn hydrogel and non-adhesive bandage applied and covered with kerlix per facility policy. Investigation initiated and will be completed within the 5-working day timeframe. Responsible party and physician notified 4/25/18 and APS (adult protective services) notified 4/26/18. Employees involved: L.P.N. #1 and C.N.A. #3."

May 2, 2018 This is the final report of an unknown origin incident reported to your office on April 26, 2018. Resident #1 was admitted to Abingdon Health & Rehab on 2/27/16 with a diagnosis of dementia, hyperlipidemia, DM II (diabetes mellitus type 2), OP (osteoporosis), OA (osteoarthritis), GERD (gastroesophageal reflux disease), anemia, heart failure, ASHD (atherosclerotic heart disease), and overactive bladder. On April 25, 2018, Resident #1 received

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a skin tear to her left forearm. It was first observed by C.N.A. #3 after taking her shirt off at 8:30 a.m. Area was cleaned with NS and wound cleanser, dermasyn hydrogel and non-adhesive dressing applied and covered with kerlix by the unit manager registered nurse #1.

DON and ADON began investigation on 4/25/18 after discussion with resident and resident's daughter to determine the cause of the skin tear. Resident #1 has very thin skin and tears easily. Her C.N.A. reported that resident may have hit her arm on the table while resident was fed her breakfast that morning and C.N.A. did not realize it. Education provided to staff regarding her care and to use caution when pushing her up to the table. Renew skin repair lotion will be applied to Resident #1's arms daily to help prevent skin tears. We are unable to determine the exact cause of the skin tear. Completed by the administrator.

The surveyor reviewed the April 2018 and May 2018 treatment administration records (TARS). The TARS did not have documentation of the wound care provided by the unit manager registered nurse #1 or the wound care provided by the assistant director of nursing on 4/25/18 or the physician orders for care provided.

The surveyor interviewed the director of nursing on 8/9/18 at 2:01 p.m. The DON stated the nurse entered the order in the computer on 4/28/18. The order read to cleanse the skin tear on left arm with wound cleanser, pat dry. Apply Hydrogel to wound bed, cover with dressing until resolved. Change on shower days and prn (whenever necessary). One time a day every wed (Wednesday), Sat (Saturday) for skin tear.

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F 684	Continued From page 9 Order Date: 4/28/18 Start Date 5/2/18." The surveyor asked the DON why there was a delay in treatment of the skin tear that occurred 4/25/18 and the order for care not written until 4/28/18. The DON stated the L.P N. #2 did the treatment to Resident #1's left arm on 4/28/18 but didn't chart the treatment. The DON was asked if the care provided by L.P.N. #2 should be documented. The DON stated it should. The DON was asked if orders for the wound care protocol used by the unit manager registered nurse #1 and the care provided by the ADON should be written and documented. The DON stated "It should." The surveyor requested the facility policy on skin assessments/wound care from the DON. The surveyor reviewed the "Quick Reference Guideline for Topical Wound Care" on 8/9/18. The "Skin Tear" guidance read "Cleanse and protect periwound skin as directed below. Apply DermaSyn Hydrogel and cover with non-adhesive dressing. Wrap with Kerlix and secure with tape. Leave in place for 5 days and then re-assess." The surveyor was unable to locate the treatment as outlined in the guidance above for Resident #1's skin tear. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern in the delay of treatment for 2 hours, the lack of documentation of wound care orders and the care provided to Resident #1on 8/9/18 at 2:05 p.m. No further information was provided prior to the exit conference on 8/9/18.	F 684		

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	Complaint deficiency			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		8/24/18
	§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation the facility staff failed to provide update timely safety interventions after a fall for 1 of 7 residents in the survey sample, (Resident #6). Findings: The facility staff failed to provide updated/timely fall precautions for Resident #6. Resident # 6 had a fall on 2/5/18, two days after her admission, but fall precautions/interventions (bedside mats) were not added until 2/7/18 following a request by a family member. Resident #6 was admitted to the facility on 2/3/18 and was discharged on 2/13/18. The resident was admitted from a hospital, following a left below the knee amputation and to receive "orthopedic aftercare". Additional diagnoses included: dysphagia, congestive heart failure, COPD (chronic obstructive pulmonary disease), Diabetes, and hypertension.		F689 1.It is duly noted that staff failed to provide updated/timely safety interventions following a fall on 2/5/18 for Resident #6. Resident #6 was discharged from facility on 2/13/18. 2.Any resident residing in center is at risk for not having timely fall prevention interventions care planned and implemented following a fall. An audit of residents who have incurred a fall as of 8/1/18 will be conducted to identify any resident lacking timely and appropriate post-fall interventions. Any discrepancies will be corrected as identified. 3.DON and ADON provided education to licensed staff on August 21-22, 2018 regarding updating care plans post-fall to include immediate implementation of fall	

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Resident #6's MDS (minimum data set) assessment, was incomplete at the time of discharge. She was assessed with mild cognitive impairment and memory problems. Her ADL (activities of daily living) assessment documented the resident required the assistance of at least one member of the nursing staff for all activity.

Resident #6's CCP (comprehensive care plan) was initiated on 2/3/18. She was CCP for the following issues:
1. Patient has pain. The interventions included administering pain medications as ordered and reporting breakthrough pain and/or unrelieved pain for further assessment and treatment. Pain assessments were ordered every shift.
2. Resident is at risk for falls r/t to decreased mobility and potential side effects of medication. The interventions included orienting the patient to the call bell, lighting and room and encouraging the use of the call bell tc request assistance from staff. The interventions were updated on 2/11/18 to include "Fall mats placed at bedside".

On 2/5/18 at 10:52 AM, a nursing staff member documented Resident #6's fall from her bed onto the floor. "When nurse entered room, resident at side of bed, sitting on bottom with right leg bent underneath her. No apparent injuries ROM to all extremities. No complaints of pain. Apparently trying to get up from bed."

There was only one note referring to the fall in the nursing progress notes. The resident was not documented with any injuries.

On 2/7/18 an "Area of Care Concern" was documented by nursing staff describing the

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prevention interventions.

4.DON/designee will conduct audits during daily clinical meeting (M-F) x4 weeks, then weekly x8 weeks. Audits will be conducted to ensure timely completion of care plan update post-fall and implementation of fall prevention intervention.

Any discrepancies will be addressed promptly and findings will be reported monthly to Quality Assurance committee for review and further analysis of findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495409		R-C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABINGDON HEALTH CARE LLC	15051 HARMONY HILLS LANE ABINGDON, VA 24211

(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

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suggested interventions for her surgical wound. The recommendation/interventions suggested were: Wound vac. Fall mats per RP (responsible party) request. This was the only documentation referring to safety mats found in the clinical record.

On 8/9/18 at 8:45 PM the fall was discussed with the facility DON. She said she didn't know why the fall mats weren't placed at the bedside sooner. The DON said they always had a meeting in the morning to address issues that occurred in the previous 24 hours. The DON said the CCP was not updated until 2/11/18, but the fall mats were placed, after a request from the RP, at the bedside on the seventh.

No other information was provided prior to the survey team exit.

This was a complaint deficiency.