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
	495403	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD MANOR	1900 LAUDERDALE DRIVE RICHMOND, VA 23238

(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 standard survey was conducted on 5/10/2016-5/12/2016. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Sefety Code survey/report will follow. The census in this 96 certified bed facility was 71 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents 1-12) and 3 closed record reviews (Residents13-15).	F 000	The submission of the Plan of Correction does not constitute agreement on the part of Lakewood Manor that the deficiencies cited within the report represent deficient practices on the part of Lakewood. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed for one resident (Resident #5) of 15 residents in the survey sample, to complete a significant change Minimum Data Set (MDS).	F 274	RECEIVED MAY 23 2016 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] MS LNHA
TITLE: Administrator
(X6) DATE: 5/20/16

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.

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Resident #5 had a decline in dressing, and bathing, and an improvement in toileting activities of daily living. These 3 changes were not coded as a significant change assessment, giving an inaccurate clinical description of the Resident's needs to the Centers for Medicare/Medicaid Services (CMS).

The findings included:

Resident #5 was originally admitted 10-26-13, and re-admitted to the facility on 11-25-15 with the diagnoses of, but not limited to, cardiac disease, hypotension, and falls at home with fracture.

On 5-11-16 Resident #5's clinical record was reviewed. The review revealed the most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 3-3-16. The MDS coded Resident #5 with a Bims (Brief Interview for Mental Status) score of 15 points of a possible 15 points, indicating no cognitive impairment. The following are Activities of Daily Living coding for the 3-3-16 MDS at area " G ";

For the 3-3-16 MDS the Resident required supervision of one staff member for dressing, was independent for toileting, and required limited hands on assistance of one staff member for bathing.

The most recent (Annual) comprehensive MDS assessment with an ARD of 9-30-15 was also reviewed, and compared to the recent quarterly assessment. The following are Activities of Daily Living coding for the 9-30-15 MDS at area " G ";

F274 Comprehensive Assessment after Significant Change:

1. A significant change assessment was completed on resident #15 with an ARD date of 5/26/16.
2. A 100% of audit of those residents who completed therapy during the months of March through May will be completed to determine compliance.
3. Staff will be educated on the criteria to complete a significant change assessment and have reviewed the RAI manual.
4. A 100% audit of residents who have completed therapy will be conducted weekly and those resident's ADL scores will be reviewed to ensure compliance with completing significant change assessments. Results of the audits will be reviewed and reported at the next scheduled QA meeting for recommendations.

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PRINTED: 05/18/2016
FORM APPROVED
OMB NO. 0938-0391

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For the 9-30-15 MDS the Resident was independent for dressing, required hands on limited assistance of one staff member for toileting, and required supervision or cueing only for bathing.

Further review of Resident #5's MDS assessments revealed a significant Change full MDS with an ARD of 12-2-15 which was completed after a hospitalization for a broken toe on 11-25-15. The following are Activities of Daily Living coding for the 9-30-16 MDS at area " G ";

For the 12-2-15 MDS the Resident required limited hands on assistance of one staff member for dressing, requiring hands on limited assistance of one staff member for toileting, and was completely dependent on one staff member for bathing.

Because of Resident #5's change from the significant change MDS of 12-2-15 to the quarterly MDS of 3-3-16 in the areas of dressing, toileting, and bathing, a Significant Change MDS should have been completed. The Resident no longer required hands on assistance for dressing and toileting, and had improved from total dependence on staff for bathing, to only needing limited assistance, and was highly involved in the activity. This reveals that the Resident had become much more independent, requiring less care from the facility staff. At this time the staff is required by the MDS/RAI (Resident Assessment Instrument) manual guidelines, to prepare a significant change assessment. The MDS/RAI guidelines for a significant change in resident status instructions included:

This plan will be effective 6/24/16 and measures will be maintained to ensure ongoing compliance.

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Decline or improvement in two or more of the following:
-ADL physical functioning area where a resident is newly coded at the area "G".

On 5-11-16 at 2:00 p.m. an interview was conducted with the MDS Coordinator. When asked why a significant change MDS wasn't completed for Resident #5's declines, and improvements, the MDS Coordinator stated that the staff thought the Resident would return to her baseline (the 9-30-15 annual assessment) after her hospitalization in November, and after the significant change assessment in December. This had not however occurred, and a Significant Change assessment was not completed within 14 days after the 3-3-16 assessment. The Resident did not return to her baseline of independent for dressing, limited assistance for toileting, and only supervision for bathing. The baseline assessment was reflected in her annual 9-30-15 assessment.

On 5-11-16 at approximately 4:00 p.m., the Administrator and Director of Nursing were informed of the significant change MDS omission.

No further information was provided by the facility staff.

F 311 SS=E — 483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS — F 311

A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced

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by:

Based on observation, resident and staff interview, and clinical record review, the facility staff failed to ensure services were consistently provided to maintain and improve abilities for one Resident (Resident #12) in the survey sample of 15 residents.

Resident #12 was not consistently provided restorative walking as indicated in his comprehensive assessment and Physical Therapy discharge plan. Between the months of January 2016 and May 2016, there were 43 occasions in which Resident #12 did not receive restorative walking in accordance with the his restorative walking schedule.

The findings included:

Resident #12 was admitted to the facility 1/22/15. Diagnoses included Vertigo (dizziness) , Ataxic (lack of muscle control) gait, depression, hypertension and generalized weakness.

Resident #12's most recent MDS (minimum data set) with an ARD (assessment reference date) of 4/28/16 was coded as a quarterly assessment. Resident #12 was coded as having a BIMS (brief interview of mental status) score of "15"out of a possible 15 or no cognitive impairment. Resident #12 was coded as requiring set up of one staff person for meals, and limited assistance with transfers and ambulation. Under Section O, Special Treatments, Procedures, and Programs, Resident #12 was coded as having received Training and Skill Practice in Walking for five (5) of the seven (7) days of the assessment reference period.

F 311

F311 Treatment/Services to Improve/Maintain ADLs:

1. Those staff members who did not provide the restorative program for resident #12 were given education and corrective action to ensure that the walk to dine restorative program is offered and provided as ordered.
2. 100% audit of those residents on walk to dine RNA programs to ensure staff compliance.
3. Staff will be educated on their responsibility to offer to provide restorative nursing programs as ordered and appropriate documentation of the resident's acceptance/performance/ tolerance.
4. 100% of residents on walk to dine restorative nursing programs will be audited weekly x 4 weeks, then monthly to ensure compliance. Any infractions will be addressed at the time of discovery with progressive discipline and reported in QA.

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F 311	Continued From page 5 Resident #12 was observed during the Resident Group Interview on 5/11/16 at 1:30 p.m. During the Group Interview, Resident #12 expressed his desire to be able to walk more with the use of his walker. Resident #12 said he was to receive restorative walking to the dining room for all his meals and stated, "The CNAs (certified nursing assistants) sometimes walk with me but are often too busy with other residents to walk with me." On 5/11/16 at approximately 3:45 p.m., an interview was conducted with Resident #12 in his room. Resident #12's wife was sitting in a chair in the corner of the room and Resident #12 was sitting in his wheelchair across from his wife. During the interview, Resident #12 said, "The CNAs (Certified Nursing Assistant) are pretty good about walking with me to the dining room for the breakfast and lunch meals, but they aren't coming for me that often for the dinner meal." Resident #12 specifically mentioned CNA A and CNA B as the staff that often walk with him to the dining room for breakfast and lunch meals. Resident #12 said he really wants to walk as much with his walker as possible so that he doesn't want to lose the walking abilities he had gained through his physical therapy. Resident #12's wife said her husband would come to their apartment and was able to self transfer from the wheelchair and do some walking there. Located in Resident #12's bathroom was a small dry eraser board with the following instructions, "Resident to use walker to walk to the dining room for all meals". The word 'all' was underlined three times. A review of the clinical record revealed the following: 1. PT (physical therapy) Discharge Plan and	F 311	This plan will be effective 6/24/16 and measures will be maintained to ensure ongoing compliance.	

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[illegible]OLC

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Instruction, 1/15/16, "Discharge Instructions include Discharge patient to remain in healthcare services where he will continue with RNA (restorative nursing assistant) program for strengthening, ambulation, continued program for walking to dining...."

2. A comprehensive care plan dated 1/8/16, "RESTORATIVE NURSING PROGRAM: Walk to Dine. Resident will participate in ambulation to and from meals daily through next review as evidence by RNA/CNA notes. RNA/CNA will walk resident to and from meals daily using gait belt and CGA (contact guard with ambulation)/MIN (minimum) A (assistance).

3. The RNA/CNA Daily Charting of the Walk to Dine was reviewed from January 8, 2016 through May 11, 2016. Documentation included Walk to Dine Minutes, Distance and Tolerance. Restorative Walking was consistently provided for Breakfast and Lunch Meals as evidence by the staff's complete documentation of the minutes, distance and tolerance. Between January and May, there were only two (2) documentations of Resident #12 refusing to participate in the restorative walking program. Review of the Dinner Walk to Dine documentation revealed 42 occasions in which Resident #12 was not provided restorative walking to the diningroom. On these dates, staff documented a coding of zero (0), 'Not tolerated at all'.

Interviews were conducted as follows:
A. On 5/11/16 at approximately 3:50, the ADON (assistant director of nursing), provided copies of the RNA/CNA Daily Charting on Resident #12's Restorative Walk to Dine documentation. The ADON stated the expectation was for Resident

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F 311	Continued From page 7	F 311		

#12 to be accompanied by a RNA/CNA to the dining room for all three of his meals. The ADON said if the Resident was unable to tolerate walking the staff was expected to document a code of zero (0), write a note in his record, and also and notify the Charge nurse immediately. The ADON requested time to review Resident #12's clinical record and to speak with the nursing staff.

B. On 5/11/16 at approximately 4 p.m., the evening shift CNA assigned to Resident #12, CNA C, said it would help if Resident #12 would remind the staff when he was ready to walk to the dining room. When asked if she was aware of Resident #12's Restorative Walk to Dine instructions, CNA C said, "Yes, I know, and it's written on a board in his bathroom. But sometimes it gets so busy. Sometimes he just gets in his wheelchair and comes to the dining room." CNA C had documented walking Resident #12 with his walker to dinner on three occasions during the month of May. CNA C stated, "He had no difficult walking when I walked with him."

C. On 5/12/16 at 9:40 a.m., a follow-up interview with the ADON revealed there was no documentation by the RNA/CNA or Nursing staff of Resident #12 not being able to tolerate his restorative walk to dine therapy for the dinner meals. The ADON said there was no evidence that the staff had provided restorative walking to the dinner meal on the 42 occasions that were coded with a zero (0).

D. On 5/12/16 at 9:50 a.m., an MDS nurse, Admin C, explained the Walk to Dine program was a free benefit for the residents. Admin C

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F 311	Continued From page 8 stated, "It is captured on the MDS, but it is a free service that we offer our residents." E. On 5/12/16 at 9:55 a.m., CNA A and CNA B discussed their experiences in walking with Resident #12. Both CNAs were also RNAs. CNA A said, "He tolerates walking with his walker very well. I suggested that for dinner, he ring his call bell to remind them to walk him to dinner." CNA B stated, "He's always eager to walk. Therapy put the little board up in the bathroom with instructions to walk him to all his meals" F. On 5/12/16 at 10:45 a.m., the DON (director of nursing) was informed of the staff's inconsistency in walking Resident #12 to the dining room for the dinner meal. The DON said she was made aware and she said some training had already been started. On 5/12/16 at 11:45 a.m., the administration was informed of staff's failure to provide Resident #12's restorative walking therapy on a consistent basis. No additional information was provided.	F 311		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This REQUIREMENT is not met as evidenced by:

Based on observations, and staff interviews, the facility staff failed to prepare and serve food under sanitary conditions.

During the initial tour and observations of the main kitchen made on 5-10-16, at 6:15 p.m., during preparation of the evening meal the staff failed to:

1. Ensure an air gap at the drainage juncture for the ice machine.
2. Ensure that staff did not "wet nest" patient dishes to include; bowls, plates, and cooking baking pans, and mixing bowls. The items were last washed after the lunch meal.

The findings included:

On 5-10-16 from 6:15 p.m. to 7:00 PM, observations were made of the Main Kitchen area with the Dining services Director, and a second surveyor. The observations were as follows:

1.) 6:15 p.m. The ice machine was observed to be draining into a white 2 inch PVC pipe which terminated directly onto the floor, and was resting on the floor drain cover which was a 12 inch by 12 inch white plastic grid covered with holes of approximately 1 inch square over it's entire surface to allow water to pass through it. This floor drain cover which the drain was laying on, was coated in spots with a black and brown substance appearing to be mold or mildew. The Dining Services observed this and stated he would have it fixed immediately, as he was aware that the drain could back up and the contents travel into the ice that was served to Residents.

F 371

F371 Food Procure, Store/Prepare/Serve –Sanitary:

1. At the time of the survey, all items that were wet nested were re-washed and dried. The drainage juncture for the ice machine was repaired to ensure an adequate air gap.
2. Daily checks by the dietary management staff for four weeks as well as ongoing monthly checks by the consultant RD will be completed for compliance.
3. In-service education, regarding wet nesting and ice machine drainage juncture will be completed for all kitchen production staff which includes cooks, porters and dishwashers. Discrepancies will be corrected and documented immediately.

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F 371	Continued From page 10 2). 6:30 p.m. Dishes and preparation pans were inspected laying on wire racks in the kitchen clean and ready for use. 14 plates, and 3 bowls which were used to serve resident meals on were found to be stacked together wet, and with moisture between them. Also found were 16 large metal baking pans approximately 12 inches wide by 24 inches long and 3 inches deep each, which had also been stacked, one inside the other, wet, and still had moisture between them. Finally 2 large metal mixing bowls, approximately 24 inches each in diameter, were found which had also been stacked, one inside the other, wet, and still had moisture between them. The Dining Services Director observed this and told dining staff to rewash them immediately, and stated that they had been "wet nested." The Administrator, and Dining Services Director were informed of the findings on 5-11-16 at approximately 5:00 PM at the end of day debriefing. No further information was submitted by the facility.	F 371	4. An audit of the main kitchen to include wet nesting and ice machine air gap will be conducted by the management staff and consultant dietitian monthly. Results of these audits will be shared at the QI meetings. Recommendations will be made and any necessary changes or solutions will be implemented as needed. This plan will be effective 6/24/16 and measures will be maintained to ensure ongoing compliance.	

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F 000	Initial Comments An unannounced Medicare standard survey and bienniel State licensure Inspection was conducted on 5/10/2016-5/12/2016. The facility was not in compliance with 42 CFR Part 483 Federal Long Term Care requirement and the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Corrections are required for compliance. The Life Sefety Code survey/report will follow. The census in this 96 bed facility was 71 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents 1-12) and 3 closed records (Residents 12-14).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the licensing of nursing facilities: 12 VAC 5-371-250 (B.2) Please Cross-Reference to F274 12 VAC 5-371-220 Please Cross-Reference to F 311 12 VAC 5-371-340(A) Please Cross-Reference to F371	F 001	12 VAC 5-371-250 (B.2) Cross Reference to F-274 12 VAC 5-371-220 Cross Reference to F-311 12 VAC 5-371-340 (A) Cross Reference to F-371	

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