STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495160	A. BUILDING _____ B. WING _____	03/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAPPAHANNOCK WESTMINSTER CANTE	132 LANCASTER DRIVE IRVINGTON, VA 22480

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/7/17 through 3/9/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 42 certified bed facility was 39 at the time of the survey. The survey sample consisted of 9 current Resident reviews (Residents #1 through #9) and 2 closed record reviews (Residents #10 through #11).	F 000		
F 386 SS=D	PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS CFR(s): 483.30(b)(1)-(3) (b) Physician Visits The physician must-- (1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; (2) Write, sign, and date progress notes at each visit; and (3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the physician signed and dated all orders at each visit for three Residents (Residents' #4, #7 and #6) in	F 386	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.	4/17/17

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

Electronically Signed | 03/20/2017

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F 386	Continued From page 1 a survey sample of 11 Residents. 1. For Resident #4, no "Physician's Orders" (a recapitulation of the plan of care) was signed after 11/1/16 (101 days); 2. For Resident #7, no "Physician's Orders" were signed by the physician after 11/28/16; and 3. For Resident # 6, the facility staff failed to ensure Physicians orders were signed timely. No signed Physicians orders were noted between 11/2/2016 and 2/4/2017 resulting in 94 days between the last signed orders. The findings included: 1. For Resident #4, no "Physician's Orders" (a recapitulation of the plan of care) was signed after 11/1/16 (101 days). Resident #4, a female, was admitted to the facility 8/10/16. Her diagnoses included dementia with behavioral disturbances, muscle weakness, generalized edema, incontinence, atrial fibrillation, pain, hypertension, breast cancer, osteoporosis, post polio syndrome, functional dyspepsia, Vitamin D deficiency, and constipation. Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/16/17 was coded as a quarterly assessment. Resident #4 was coded as having short term memory deficits and required moderate assistance with making daily life decisions. She was coded as requiring limited to extensive assistance of one staff member to perform her activities of daily living with the exception of	F 386	To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates included. Immediate Corrective Actions: 03/17/17 All current resident charts were audited to assure that physician visits are on the schedule and in compliance with F386 Physician Visits and all Physician Order Sheets are signed and dated. Systemic Changes: 4/17/17 All Nurses will be in-serviced on F386 Physician Visits and will be taught how to access and print the Physician Order Sheets for physician visits. Physicians will receive a letter from the Administrator and CEO explaining this Survey outcome as well as the requirements of F386 Physician Visits. In the letter, Physicians will also be invited to meet with the CEO, Administrator, and DON to discuss physician service requirements and work through any obstacles that the physicians face while visiting and recertifying their patients. All required Physician Visits and Physician Order Sheets will be documented in a spreadsheet by the Unit Secretary or Designee. The Unit Secretary will assure	

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F 386	Continued From page 2 bathing. For bathing she was coded as requiring total assistance. Review of Resident #4's clinical record revealed no "Physician's Orders" were signed by the physician after 11/1/16. The "Physician's Orders" were evidence the physician had reviewed and approved the total plan of care, including medications and treatments, for Resident #4. A progress note was apparent that the physician had been in to the facility and examined Resident #4 on 2/15/17. Upon review of the clinical record, the "Physician's Orders for the months after 11/1/6 were in the electronic medical record, however no signature was evident on the orders. When interviewed 3/9/17 at 2:52 p.m., Other A and Other B stated they were responsible for creating the "Physician's Orders" within the computer. Other A and Other B stated they printed the "Orders" and gave them to the physician's to review and sign. Other A stated sometimes the physician's would take the listing with them and complete the orders at their offices. The physician's would then send the orders back to the facility for scanning into the electronic record. Other A and B stated the orders for 11/1/16 were the last signed orders they could find for Resident #4. The administrator and DON (director of nursing) were informed of the failure of the physician's to sign and date orders at each visit, 3/9/17 at 3:35 p.m. 2. For Resident #7, no "Physician's Orders" were signed by the physician after 11/28/16.	F 386	that all physicians are informed in writing of due dates 14 days and then 7 days prior to the due date. The Unit Secretary will follow up with the DON (or Administrator) if the visit has not taken place by the due date. The DON (or Administrator) will contact the Physician directly if the visit has not taken place by the due date. The DON will encourage physicians to sign Physician Order Sheets while visiting the facility instead of taking them to their offices. Monitoring: Ongoing The DON will monitor the Physician Visit and Physician Order Sheet spreadsheet for compliance. The Director of Quality and Compliance will audit 100% of all Physician Visits and Physician Order Sheets every month and inform the DON and Administrator of compliance concerns. The DON and/or Administrator will discuss due dates with the Primary Care Physicians and Medical Director as needed to assure compliance with F386. A Physician not in compliance with F386 will be informed in writing by the Administrator and CEO that his or her facility privileges may be revoked for non-compliance with State and Federal regulations.	

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F 386	Continued From page 3	F 386		

Resident #7, a male, was admitted to the facility 9/28/16. His diagnoses included pacemaker, overactive bladder, atrial fibrillation, depression, atrial fibrillation, Parkinson's, dementia, hyperlipidemia, congestive heart failure, and hypertension.

Resident #7's most recent MDS with an ARD of 12/22/16 was coded as a quarterly assessment. Resident #6 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #4 was also coded as needing limited assistance of one to two staff members to perform his activities of daily living with the exception of bathing. For bathing he was coded as requiring total assistance of one staff member.

Review of Resident #7's clinical record revealed no "Physician's Order" signed by the physician since 11/28/17. A thorough review of Resident #7's clinical record revealed he was seen and examined by the physician 9/28/16, 10/28/16, 12/16/16, and 3/5/17.

Other A and Other B stated 3/9/17 at 2:52 p.m., the orders signed by the physician 11/28/16 were the only orders signed by the physician that were evident in the electronic medical record.

The administrator and DON were informed of the failure of Resident #7's physician to signed and date all orders with each visit, 3/9/17 at 3:35 p.m.
3. For Resident # 6, the facility staff failed to ensure Physicians orders were signed timely. No signed Physicians Orders Sheets were noted between 11/2/2016 and 2/4/2017 resulting in 94 days between the last signed orders.

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F 386	Continued From page 4	F 386		

Resident # 6, an 82 year old female, was admitted to the facility on 5/23/2016. Diagnoses included but were not limited to Alzheimer's Disease, Dementia with Behaviors, Psychotic Disorder, Hypertension, Osteoporosis, Sicca Syndrome, Chronic Kidney Disease and Sjogren's Syndrome.

The most recent MDS (minimum data set) was a Quarterly Assessment with an ARD (assessment reference date) of 2 /2/2017. Resident # 6 was coded as having a BIMS (Brief Interview for Memory Status) score of 5 indicating severe cognitive impairment. Resident # 6 was coded as requiring minimal assistance of one staff person for her ADLs (activities of daily living), except requiring extensive assistance of one staff person for bathing. Resident # 6 was coded as being frequently incontinent of bladder and occasionally incontinent of bowel.

Review of Resident # 6's clinical record revealed her most recently signed POS (Physicians Orders Sheets) were dated as having been signed on 2/4/2017 to recapitulate and reinstitute the Resident's medication, and treatment orders. A thorough review of Resident #6's clinical record revealed the previously signed Physicians Orders Sheets were dated on 11/2/2016.

On 3/8/2017 at 2:42 PM, an interview was conducted with the Director of Nursing who stated the expectation was that the Physicians would sign Physicians Order sheets every 30 days for the first 90 days and then every 60 days.

On 3/8/2017 at 4 PM, the Administrator and Director of Nursing were informed that the last

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F 386	Continued From page 5 signed Physicians Orders Sheet noted in the electronic medical record was dated on 2/4/2017 and the one prior was dated on 11/2/2016. The surveyor asked for a copy of the most recent signed Physicians Order Sheets. On 3/9/2017 at 2:52 PM, an interview was conducted with the two unit secretaries (Other A and Other B) who stated they work together on the task of generating a list on the computer that keeps up with which residents are due to be seen by the physicians. Both Other A and Other B stated they would send a note to the physician, the nurse in charge was supposed to pull the Physicians Orders Sheet form off of the chart. Both stated that some physicians would sign the Physicians Orders sheets while they were in the facility, one would sign orders electronically, while other physicians would sign the orders and mail them back in to the facility. Other A and Other B stated they would scan the returned signed POS form into the electronic records. Other A and Other B stated the expectation was that the Physicians would sign Physicians Order sheets at least every 60 days. During the end of day debriefing on 3/9/2017 at 3:10 PM, the facility Administrator, Administrator in Training (Admin C) and the Director of Nursing were informed of no signed Physicians Orders between 11/2/2016 and 2/4/2017. No further information was provided.	F 386		
F 387 SS=D	FREQUENCY & TIMELINESS OF PHYSICIAN VISIT CFR(s): 483.30(c)(1)(2) (c) Frequency of Physician Visits	F 387		4/17/17

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F 387	Continued From page 6 (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the physician visited the Residents in a timely manner for two Residents (Residents' #4 and #5) in a survey sample of 11 Residents. 1. For Resident #4, the physician had not examined and completed a progress note between 11/1/6 and 2/15/17 (106 days); and 2. For Resident # 6, the facility staff failed to ensure physicians' visits were completed in a timely manner. Resident # 6 was not seen by the physician between 11/3/2016 and 2/3/2017 resulting in 92 days between visits. The findings included: 1. For Resident #4, the physician had not examined the Resident and completed a progress note between 11/1/6 and 2/15/17 (106 days). Resident #4, a female, was admitted to the facility 8/10/16. Her diagnoses included dementia with behavioral disturbances, muscle weakness, generalized edema, incontinence, atrial fibrillation, pain, hypertension, breast cancer, osteoporosis, post polio syndrome, functional	F 387	The statements made in this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The plan constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates included. Immediate Corrective Actions: 03/17/17 All current resident charts were audited to assure that physician visits are on the schedule and in compliance with F387 Frequency of Physician Visits. Systemic Changes: 4/17/17 All Nurses will be in-serviced on F387 Frequency of Physician Visits. Physicians will receive a letter from the Administrator and CEO explaining this Survey outcome as well as the requirements of F387 Frequency of Physician Visits. In the letter, Physicians	

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F 387	Continued From page 7 dyspepsia, Vitamin D deficiency, and constipation. Resident #4's most recent MDS (minimum data set) with an ARD (assessment reference date) of 2/16/17 was coded as a quarterly assessment. Resident #4 was coded as having short term memory deficits and required moderate assistance with making daily life decisions. She was coded as requiring limited to extensive assistance of one staff member to perform her activities of daily living with the exception of bathing. For bathing she was coded as requiring total assistance. Review of Resident #4's clinical record revealed no evidence was present that Resident #4 had been examined by her physician between 11/1/16 and 2/15/16. No progress notes for visits within the dates in question was evident. When interviewed 3/9/17 at 2:52 p.m., Other A and Other B stated they were responsible for scanning the physician progress notes. Other A stated sometimes the physician's would complete their progress notes after their visits with the Resident and the physician was responsible for sending the progress note to the facility. Other A stated the progress notes evident within Resident #4's electronic medical record were all the progress notes available. The administrator and DON (director of nursing) were informed of the failure of the physician's to conduct timely physician visits for Resident #4, 3/9/17 at 3:35 p.m. 2. For Resident # 6, the facility staff failed to ensure physicians visits were completed in a timely manner. Resident # 6 was not seen by the	F 387	will also be invited to meet with the CEO, Administrator, and DON to discuss physician service requirements and work through any obstacles that the physicians face while visiting and recertifying their patients. Due dates for all required Physician Visits will be documented in a spreadsheet by the Unit Secretary or Designee. The Unit Secretary will assure that all physicians are informed in writing of due dates 14 days and then 7 days prior to the due date. The Unit Secretary will follow up with the DON (or Administrator) if the visit has not taken place by the due date. The DON (or Administrator) will contact the Physician directly if the visit has not taken place by the due date. The DON will encourage physicians to complete and sign re-certifications and Physician Order Sheets while visiting the facility instead of taking them to their offices. Monitoring: Ongoing The DON will monitor the Physician Visit and Physician Order Sheet spreadsheet for compliance. The Director of Quality and Compliance will audit 100% of all Physician Visits and Physician Order Sheets every month and inform the DON and Administrator of compliance concerns. The DON and/or Administrator will discuss due dates with the Primary Care Physicians and Medical Director as needed to assure compliance with F387.	

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F 387	Continued From page 8 physician between 11/3/2016 and 2/3/2017 resulting in 92 days between visits. Resident # 6, an 82 year old female, was admitted to the facility on 5/23/2016. Diagnoses included but were not limited to Alzheimer's Disease, Dementia with Behaviors, Psychotic Disorder, Hypertension, Osteoporosis, Sicca Syndrome, Chronic Kidney Disease and Sjogren's Syndrome. The most recent MDS (minimum data set) was a Quarterly Assessment with an ARD (assessment reference date) of 2/2/2017. Resident # 6 was coded as having a BIMS (Brief Interview for Memory Status) score of 5 indicating severe cognitive impairment. Resident # 6 was coded as requiring minimal assistance of one staff person for her ADLs (Activities of Daily Living), except requiring extensive assistance of one staff person for bathing. Resident # 6 was coded as being frequently incontinent of bladder and occasionally incontinent of bowel. Review of Resident # 6's clinical record was conducted on 3/8/2017 at 8:45 AM. Review of the Physicians Progress notes revealed the last signed Progress note sheet was dated on 2/15/2017 by the nurse practitioner for "Psychotropic med." The prior Progress note was dated 2/3/2017 for "recertification." Further review of her clinical record revealed a clinician's visit by the nurse practitioner was made on 11/16/2016 for a sick visit for a "rash corners of mouth" and Resident # 6 was seen by her physician on 11/3/2016 for "recertification." There were no other visits documented in the clinical record between 11/3/2016 and 2/3/2017	F 387	A Physician not in compliance with F387 will be informed in writing by the Administrator and CEO that his or her facility privileges may be revoked for non-compliance with State and Federal regulations.	

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F 387	Continued From page 9	F 387		

resulting in 92 days between physician visits for recertification.

On 3/8/2017 at 2:42 PM, an interview was conducted with the DON who stated the expectation was that physicians would write Progress Notes at least every 60 days.

On 3/8/2017 at 4 PM, the Administrator , Director of Nursing, and Administrator in Training (Admin C) were informed that the last signed Progress Note for recertification noted in the electronic medical record was dated on 2/3/2017 and the prior Progress Note for recertification was dated on 11/3/2016.

On 3/9/2017 at 11 AM, Admin C stated no other Progress Notes for recertification were found in the electronic record between 11/3/2016 and 2/3/2017.

On 3/9/2016 at 3:00 PM during the end of day debriefing, the administrator, Admin C and Director of Nursing were informed of the failure of the staff to ensure Resident #6 was seen by her physician and a progress note written in a timely manner.

No further information was provided.