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
	495085	A. BUILDING ______ B. WING ______	01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ON THE APPOMATTOX HEALTH & REHAB CENTER	201 EPPS STREET HOPEWELL, VA 23860

(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 1/20/16 through 1/21/16 and 1/26/16. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Survey/Report will follow. The census in this 124 certified bed facility was 112 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #20) and 5 closed records (Residents # 21 through #25).	F 000	The Submission of the Plan of Correction does not constitute agreement on the part of River View Health & Rehab Center that the deficiencies cited within the report represent deficient practices on the part of River View Health and Rehab Center. Submission of this plan of correction is a requirement of Federal Law. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements. This response to the Statement of Deficiencies is the Facility's allegation of compliance.	
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced	F 205	1. Resident #21 was discharged from the center on 9/22/15. 2. The Director of Nursing or Designee will audit the medical record for hospital transfers/discharges for the past 24hrs to verify resident or responsible party received a written bed hold notification.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lauren M. Monkester
TITLE: Administrator
(X6) DATE: 2/5/16

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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by:
Based on staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to provide written bed hold information to one resident (Resident #21) of 25 residents in the survey sample within 24 hours of discharge to the hospital.

Written bed hold information was not given to Resident #21 nor his Responsible Party (RP) when discharged to the hospital on 9/22/15.

The findings included:

Resident #21 was admitted to the facility on 6/30/15 with the diagnoses of, but not limited to, cerebral infarct (stroke), mild cognitive impairment, dysphagia (difficulty swallowing), feeding tube, and hypertension. Resident #21 was no longer at the facility therefore a closed record review was conducted.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 8/28/15. The MDS coded Resident #21 with severe cognitive impairment; required extensive assistance from staff for bed mobility, transfers, dressing and eating; was dependent on staff for toileting, hygiene and bathing; and always incontinent of bowel and bladder.

On 1/21/16 Resident #21's clinical record was reviewed. The review revealed he was sent to the hospital emergency room, per the RP's request, on 9/22/15 due to decreased alertness, slower speech and edema to left side of upper and lower extremities. Resident #21 did not

F 205

3. The Assistant Director of Nursing or Designee will educate the licensed nurses and social services personnel on ensuring a written bed hold notification is given to residents or responsible party at the time of a hospital transfer from the center.

4. The Unit Manager or Designee will review hospital transfers/discharges, where applicable, weekly x 4 weeks then random 2 hospital transfer/discharges monthly x 2 months to ensure compliance with the written bed hold notification process. The Director of Nursing or Designee will review audit findings and report findings to the QA Committee for any further recommendations.

5. Date of Compliance 2/23/16.

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return to the facility.

The "Admission Agreement" which the facility staff reviewed with the RP on 7/1/15 contained the following bed hold information:

"BED HOLD POLICY When discharged to the hospital or out of the Center, insurance companies including Medicaid and Medicare will not cover the cost of holding your bed during your absence from the Center......I understand that the payment must be collected and a Bed Hold Agreement signed within 24 hours....."

A progress note written on 9/24/15 by the Director of Social Services (Admin-C) read:
"RP in 9/23 to pick up belongings and stated he will not be returning here." There was no written information in the clinical record stating the bed hold information was given to or reviewed with the RP at that time.

On 1/21/16 at 5:20 p.m. an interview was conducted with the Administrator (Admin-A). When asked if bed hold information was given at the time of discharge, Admin-A stated "RP was offered a bed hold at the time of discharge" and "On 9/24/15 the RP declined the bed hold." No documentation regarding offering a bed hold was available from the facility staff.

On 1/26/16 at 11:30 a.m. an interview was conducted with the Director of Nursing (Admin-B) and Admissions (Admin-E). When asked what the bed hold procedure was when a resident is discharged to the hospital, Admin-E stated "We call that next morning to ask about a bed hold." At 12:15 p.m. Admin-B stated, "No bed hold information was given at the time of discharge or

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within 24 hours."

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Complaint Deficiency

F 309 SS=D 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and clinical record review the facility staff failed for 1 resident (Resident #8) of 25 residents in the survey sample to ensure the highest practable well being.

On 1/20/16 at 2:50 p.m., Resident #8 was observed lying in bed with an undated dressing to her left foot. There was no physician order for the dressing. It was documented in a physician note written on 1/19/16 to leave the scabbed area to the left foot open to air.

The findings included:

Resident #8, a 61 year old, was admitted to the facility on 9/18/15. Her diagnoses included diabetes, chronic kidney disease, hypertension, reflux, epilepsy and encephalophy.

Resident #8's most recent Minimum Data Set

F 309

1. The physician and responsible party for resident #8 have been notified that a protective dressing was applied to the scabbed area on the resident's left foot without a physician order and Prevalon Boots intervention was not in place on observation. Resident #8 left foot has been assessed and wound care treatments are being administered as ordered and preventive plan of care is in place.

2. The Unit Manager or Designee will assess residents with impaired skin conditions who have wound care orders to leave open to air to ensure compliance with the treatment order. The Unit Manager or Designee will assess residents with Prevalon Boots orders to ensure compliance with intervention implementation.

3. The Assistant Director of Nursing or Designee will educate licensed nurses on ensuring wound care treatments are administered according to physician's order. The

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assessment was a quarterly assessment with an assessment reference date of 10/28/15. She was coded with a Brief Interview of Mental Status score of 10 indicating moderate cognitive impairment. She required extensive assistance with her activities of daily living. She was not coded to have any skin issues.

On 1/20/16 at 2:50 p.m., Resident #8 was observed lying in bed with a dressing to her left foot. A pair of blue prevalon protective boots were on top of the resident's closet. The inside of one of the boots contained dried brown drainage. The resident complained of left leg pain.

There was no physician order for the dressing to the left foot. A telephone order was written on 12/30/15 to discontinue the dressing to the left foot, as the area had healed.

At the end of the day meeting on 1/20/16, the Director of Nursing (DON) was asked to schedule an observation of Resident #8's dressing change during the following morning.

On 1/21/16 at 8:30 a.m., Resident #8 was observed in bed. The prevalon boots were on top of the closet. She stated that the boots bothered her sometimes.

On 1/21/16 at 9:35 a.m., Licensed Practical Nurse D (LPN D), wound care nurse, stated that she was unsure why Resident #8 had a dressing to the left foot. She stated she was unaware of any wounds. LPN D reviewed Resident #8's physician orders. She stated there was no order for a dressing. LPN D stated there had been a dressing to the left foot, but the area had healed and the dressing was discontinued. LPN D also

F 309

Assistant Director of Nursing will educate the licensed nurses and certified nursing assistants on ensuring Prevalon Boots are implemented as ordered.

4. The Unit Manager or Designee will assess 2 residents with impaired skin conditions who have wound care orders to leave open to air, where applicable, and 2 residents who have Prevalon Boots ordered weekly x 4 weeks then monthly x 2 months to ensure compliance. The Director of Nursing or Designee will review audit findings and report findings to the QA Committee for further recommendations.

5. Date of Compliance 2/23/16.

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stated that she had just been in the room and noticed that Resident #8's prevalon boots were not applied.

At 9:45 a.m., LPN D and two surveyors entered Resident #8's room. The prevalon boots were on top of the closet. The left bandaged foot was pressed up against the foot board of the bed.

LPN D removed the bandage to Resident #8's left foot. When asked if the bandage included a date or initials, LPN D stated no. The bandage stuck to Resident #8's foot when it was pulled away. There was a moderate amount of old, brown drainage on the dressing. An open area was found under the bandage. The open area was beefy red. It did not have any odor or swelling. LPN D was asked to provide documentation of her assessment once completed.

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LPN D's note read "1/21/16 12:59 Resident in bed. Writer in to assess resident with state surveyors. Resident approved. Resident voiced some pain. UM (unit manager) made aware. Resident was cooperative in allowing writer to

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observe left leg: scar tissue over dorsal (directed toward the back surface) foot also noted small open area over scar tissue area measure 0.4x0.4x0.1 with remaining scar epithelized (covered with epithelial tissue which is the outer layer of skin). with scant serosangious (composed of blood) drainage no odor on left foot above dorsal foot. Resident was admitted with compromised skin to this area and preventative boots on admission. Left heel is clear no pressure area present."

Definitions from
<http://medical-dictionary.thefreedictionary.com>

prevalon boots- padded boots for pressure ulcer heel protection

Resident #8's care plan documented that she was at risk for impaired skin integrity. An intervention initiated on 9/10/15 read "prevalon boots when in bed."

On 1/21/16 at 10:00 a.m., the Director of Nursing (DON) was notified that Resident #8 had a dressing on her left foot with no order. The DON was notified that an open area was observed under the dressing. She was asked to provide any information regarding the left foot wound.

On 1/21/16 at 4:30 p.m., the DON provided follow up information regarding the open area. She provided a physician progress note dated 1/19/16 that documented a scabbed area to the left foot. The past medical history section of the progress note documented "Lt (left) foot diabetic ulcer (healed). The progress note "Key Findings" read

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"Lt (left) foot (dorsum) scab no signs of infection will keep it open to air."

In an effort to determine which staff applied Resident #8's dressing, the DON contacted the nurses who had cared for the resident. The DON provided a timeline put together by the facility staff titled "(Resident #8) Chronic Left Dorsal Foot Diabetic Ulcer Timeline." The following information was documented in the timeline:

"1/19/16 Night Shift- Unable to contact nurse who cared for (Resident #8) to determine if he applied the gauze and Kerlix that was observed on (Resident #8) with surveyor and Wound Care Nurse on morning of 1/21/16. Nurse is out with family emergency.

"The nurse who cared for (Resident #8) on day shift on 1/20/16 noted the Kerlix in place, but she did not apply it. She states nursing has on occasion placed the gauze and Kerlix for protection of the scab with the Prevalon boot."

When asked if the staff felt that the boot was rubbing on the scabbed area, the DON stated that is what was explained to her. It was reviewed with the DON that there was dried, brown drainage observed in the Prevalon boot. It was also reviewed with the DON that the resident had been observed three times without her boots applied. The DON also stated that the wound care nurse thought she pulled off the scab when she removed the dressing.

On 1/26/16 at 1:00 p.m., the DON provided a copy of a request for an extended bed for Resident #8. The DON was asked if it was acceptable

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F 309	Continued From page 8 that a nurse applied a dressing to the scabbed area when the physician had written in his assessment that the area was to be left open. The DON stated that the nurse should have asked someone about putting a dressing on the area if there was concern about it being rubbed by the Prevalon boot. The issue was reviewed with the Corporate Nurse and DON at the end of day meeting on 1/26/16.	F 309		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to administer oxygen per physician's order for one Resident (Resident #11) in a survey sample of 25 Residents. For Resident #11, the facility staff administered oxygen at a rate of 2 l/min (liters per minute) instead of the physician ordered rate of 3 l/min.	F 328	1. The physician and responsible party for Resident #11 have been notified of the resident not receiving oxygen according to physician order. The assigned licensed nurse has received educational counseling. Resident #11 is receiving oxygen according to physician orders. 2. The Unit Manager or Designee will conduct rounds on residents receiving continuous oxygen to verify prescribed flow rate according to physician orders. 3. The Assistant Director of Nursing or Designee will educate licensed nurses on ensuring continuous oxygen is administered according to physician orders.	

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The findings included:

Resident #11, a male, was initially admitted to the facility 5/30/14 and readmitted after a hospitalization 10/23/15. His diagnoses included chronic obstructive pulmonary disease, benign prostatic hypertrophy, idiopathic peripheral neuropathy, emphysema, anxiety, congestive heart failure, major depressive disorder, nonrheumatic valve disorder, edema, gout, hypertension, and acute/chronic respiratory failure.

Resident #11's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/18/15 was coded as a quarterly assessment. He was coded as having no memory deficits and was able to make his own daily life decisions. Resident #11 was also coded as needing standby to limited assistance with his activities of daily living. He was coded as requiring oxygen since his readmission.

Resident #11 was observed on initial tour of the facility 1/20/16 at approximately 11:50 a.m., 1/20/16 at 4:10 p.m., and 1/21/16 at 8:20 a.m. At all observations, Resident #11 was out of bed and in his wheelchair in his bedroom. He was alert, oriented and verbally responsive. Resident #11 was noted to be receiving oxygen at 2 l/min via nasal cannula. A nasal cannula is a flexible, plastic tubing that delivers oxygen directly into the nostrils.

Review of Resident #11's clinical record revealed a signed physician's order that included:

"10/24/15 O2 (oxygen) at 3 L/min via nasal cannula continuously every shift for Shortness of

F 328

4. The Unit Manager or Designee will conduct rounds on 2 residents receiving continuous oxygen, where applicable, weekly x 4 weeks then monthly x 2 months to ensure correct flow rate per MD orders. The Director of Nursing or Designee will review audit findings and report findings to the QA Committee for further recommendations.

5. Date of Compliance 2/23/16.

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breath." The order was initially written upon his readmission to the facility from the hospital. The order was also on the most recently "Order Summary Report" signed and dated by the physician on 12/29/15.

1/21/16 at 10 a.m., LPN (licensed practical nurse) C, stated she was taking care of and administering medications to Resident #11. After observing the rate of 2 l/min on the oxygen tank, LPN C stated Resident #11 should be receiving oxygen at 3 l/min. LPN C said Resident #11 would tell people he was supposed to be receiving 2 liters of oxygen and she surmised that one of the staff had changed it from 3 l/min to 2 l/min.

Review of the facility's policy entitled "General Guidelines For Medication Administration" included:

"4. Open the medication administration book/eMAR (electronic medication administration record) to the appropriate resident and note the first medication to administer. The nurse is responsible for noting:
a. Any changes on the Medication Administration Record (MAR) ...
5. Read the label three times before preparing the medication. If the medication is discontinued or outdated, remove medication for proper disposal.."

Additionally. guidance for the administration of oxygen was provided within "Fundamentals of Nursing 7th Edition, Potter-Perry, page. 951, "Oxygen therapy is cheap, widely available, and used in a variety of setting to relieve or prevent tissue hypoxia. The goal of oxygen therapy is to

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prevent or relieve hypoxia. Oxygen is not a substitute for other treatment, however, and is used only when indicated. Oxygen is a medication. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any medication, the dosage or concentration of oxygen is continuously monitored. Routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

Hypoxia (www.medicaldictionary.thefreedictionary.com <http://www.medicaldictionary.thefreedictionary.com> decreased availability of oxygen to the tissues)

Atelectasis (www.medicaldictionary.thefreedictionary.com -partial or total collapse of the lung)

Emphysema (www.medicaldictionary.thefreedictionary.com - a chronic respiratory disease where there is over-inflation of the air sacs (alveoli) in the lungs, causing a decrease in lung function)

An entry was noted on the eMAR that included: "O2 at 3 L/min via nasal cannula continuously every shift for Shortness of breath." Nurses' initials were evident that nursing had assessed Resident #11's oxygen administration each shift daily since 10/24/15.

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	495085	A. BUILDING ______ B. WING ______	01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ON THE APPOMATTOX HEALTH & REHAB CENTER	201 EPPS STREET HOPEWELL, VA 23860

(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 328	Continued From page 12 The administrator, DON (director of nursing) and corporate consultant were informed of the failure of the staff to ensure oxygen was administered at 3 l/min per physician's orders, 1/21/16 at 4:30 p.m.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility failed for one resident	F 329	1. The physician and responsible party for resident # 5 have been notified of the resident receiving blood pressure medications outside of ordered parameters. Resident # 5 has been assessed and is receiving blood pressure medications according to physician ordered parameters. Resident #22 was discharged from the center on 3/3/15. 2. The Unit Manager or Designee will audit medication administration records for the past 2 weeks for residents receiving blood pressure medications with parameters to assess compliance with blood pressure medications being administered according to physician ordered parameters. Any variances will be reported to physician.	

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(Resident #5 and Resident #22) in a survey sample of 25 residents, to ensure the resident was free from from un- necessary medications.

1. Resident #5 was given his blood pressure medication although the systolic blood pressures were below the physician ordered parameters.

2. For Resident #22, the facility staff administered blood pressure medications when the blood pressure was lower than the physician ordered parameter to hold the medications.

The findings included:

Resident #5 was admitted to the facility on 4/6/15. Diagnoses for Resident #5 included but are not limited to high blood pressure, depression, dementia, anxiety and encephalopathy. Resident #5's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 10/3/15 coded Resident #5 with a BIMS (brief interview of mental status) of "7" out of a possible 15, or moderate cognitive impairment. Resident #5 required extensive to total dependence on staff, for Activities of Daily Living care and was incontinent of bowel and bladder.

On 1/20/16 at 1:30 PM, Resident #5 was observed in the bed with a splint to the left hand and a bed alarm on the bed.

Review of the clinical record revealed a physician's order dated 11/6/15 for Norvasc (antihypertensive medication) 2.5 mg (milligrams) daily: Hold for systolic (top number) blood pressure less than 120.

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3. The Assistant Director of Nursing or Designee will educate licensed nurses on the Medication Administration Policy for Administering Blood Pressure Medications with Parameters.

4. The Unit Manager or Designee will audit medication administration records for 2 residents with blood pressure medications with parameters, where applicable, weekly x 4 weeks then monthly x 2 months to ensure blood pressure medications are being administered according to physician ordered parameters. The Director of Nursing or Designee will review audit findings and report findings to the QA Committee for further recommendations.

5. Date of Compliance 2/23/16.

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Review of the November MAR (medication administration record) revealed the following:

11/6/15: BP 112/76; Medication documented as given.
11/20/15: BP 101/64; Medication documented as given.
12/4/15: BP 118/78; Medication documented as given.
12/6/15: BP 118/80; Medication documented as given.
12/7/15 : BP 118/78; Medication documented as given.

Saunders Nursing Drug Handbook, 2011, pp 754-755, include the following: "Overdose may produce profound bradycardia (low heart rate) , hypotension.

On 1/21/16, an interview was conducted with RN (registered nurse) A. RN (A) stated, " A checkmark indicates the medication was given, a "5" if it was withheld." She also stated, "The nurses should follow the directions of the medication and hold it." RN (A) stated that the facility had "discovered the issue yesterday (1/20/16)." A medication error report was presented.

On 1/21/16 at 12:00 PM, the DON (director of nursing) and Administrator were notified of above findings.

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2. For Resident #22, the facility staff administered blood pressure medications when the blood pressure was lower than the physician ordered parameter to hold the medications.

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Resident #22, a female, was admitted to the facility 12/2/14. Her diagnoses included non Alzheimer's dementia, gastrointestinal bleed, type II diabetes mellitus, hyperlipidemia, hypothyroidism, osteoarthritis, anemia, deep vein thrombosis, hypertension, and gastroesophageal reflux disease. Resident #22 was discharged home on 3/2/15.

Resident #22's most recent MDS (minimum data set) with an ARD (assessment reference date) of 10/9/14 was coded as an admission, five day assessment. Resident #22 was coded as needing extensive assistance of one staff member to perform her activities of daily living with the exception of eating. For eating, Resident #22 was coded as needing supervision only.

Review of Resident #22's clinical record revealed signed a physician's orders:

"Benicar 20 mg (milligram) 1 tablet by mouth one time a day related to unspecified essential hypertension. Hold for SBP (systolic blood pressure) less than 140 and heart rate less than 60", and

"Norvasc tablet 10 mg Give 1 tablet by mouth one time a day related to unspecified essential hypertension. Hold for SBP less than 140 and Heart rate less than 60."

A corresponding entry was placed on the eMAR (electronic medication administration record. Review of the eMAR revealed Benicar and Norvasc were administered when Resident #22's systolic blood pressure was less than 140 mmHg (millimeter of Mecury):

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Benicar 12/31/14 blood pressure 132/78, 1/2/15 blood pressure 138/72, 1/3/15 blood pressure 124/70, 1/4/15 blood pressure 132/68, 1/6/15 blood pressure 120/60, 1/7/15 blood pressure 127/64, 1/9/15 blood pressure 124/71, 1/10/15 blood pressure 132/72, 1/11/15 blood pressure 136/74, 1/15/15 blood pressure 120/68, 1/23/15 blood pressure 124/78, 1/24/15 blood pressure 132/70, 1/25/15 blood pressure 128/68, 1/26/15 blood pressure 128/70, 2/6/15 blood pressure 130/74, 2/11/15 blood pressure 130/70, 2/12/15 blood pressure 126/72, 2/14/15 blood pressure 134/80, 2/19/15 blood pressure 126/70

Norvasc 12/31/14 blood pressure 132/78, 1/2/15 blood pressure 138/72, 1/3/15 blood pressure 124/70, 1/4/15 blood pressure 132/68, 1/6/15 blood pressure 120/60, 1/9/15 blood pressure 124/71, 1/10/15 blood pressure 132/72, 1/11/15 blood pressure 136/74, 1/15/15 blood pressure 120/68, 1/23/15 blood pressure 120/60, 1/24/15 blood pressure 132/70, 1/25/15 blood pressure 128/68, 1/26/15 blood pressure 128/70, 2/6/15 blood pressure 130/74, 2/11/15 blood pressure 130/70, 2/12/15 blood pressure 126/72, 2/14/15 blood pressure 134/80, 2/19/15 blood pressure 126/70

When informed of the failure of the staff to ensure Benicar and Norvasc were not administered when Resident #22's systolic blood pressure was less than 140 mg/hg (millimeter of mercury), 1/21/16, the DON (director of nursing) had no response.

Review of the facility's policy entitled "General Guidelines for Medication Administration" included:

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F 329	Continued From page 17 "4. Open the medication administration book/eMAR (electronic medication administration record) to the appropriate resident and note the first medication to administer. 5. Read the label three times before preparing the medication.... 11. Obtain and record any vital signs as necessary prior to medication administration." Guidance for implementing physician's orders was included in "Fundamentals of Nursing 7th Edition, Potter-Perry, page 336, The physician is responsible for directing medical treatment. Nurses follow physician's orders unless they believe the orders are in error or harm clients. Therefore you need to assess all order, and if you find one to be erroneous or harmful, further clarification from the physician is necessary." The administrator, DON, and corporate consultant were informed of the failure of the staff to follow physician's orders by not administering Norvasc and Benicar when Resident #22's systolic blood pressure was less than 140 mmHg, 1/21/16 at 4:30 p.m.	F 329	RECEIVED FEB 05 2016 VDH/OLC	
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	1. Resident #12 discharged from the center on 1/28/16. The physician and responsible party for resident #9 have been notified of the resident being placed on contact precautions for a non-resistant organism in her urine. Resident #9 contact precautions were discontinued on 1/25/16. The observed ice chest has been washed and an ice scoop holder has been	

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Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review, and clinical record record review, the facility failed to ensure an effective infection control program was developed and implemented.

1. For Resident #12, an inaccurate contact precaution policy was developed and

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attached. C.N.A – D will receive educational coaching on proper storage of ice scoop. The housekeeping employee will receive educational coaching on proper cleaning of a contact precaution room.

2. Any resident is at risk when the center's staff fail to implement appropriate precautions to contain and prevent spread of transmissible organisms. The Assistant Director of Nursing or Designee will conduct rounds to verify staff compliance with CDC guidelines in donning appropriate attire upon entering and exiting rooms and will observe housekeeping staff cleaning rooms of residents on contact precautions. The Assistant Director of Nursing or Designee will review medical records for current residents on contact precautions to verify appropriate diagnosis to support placing resident on precautions. The Assistant Director of Nursing or Designee will perform an infection control observation of ice being passed to assess compliance with the ice scoop being placed appropriately.

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implemented;

2. Resident #9 was placed on contact isolation for CRE (carbapenenem resistant enterobacteriaceae) but was not resistant; staff did not use a gown when entering the resident's room; and

3. During the initial tour of the facility on 1/20/15, Certified Nursing Assistant D (CNA D) was observed to use an ice scoop and then store it in the chest of ice on two occasions.

The findings included:

1. For Resident #12, an inaccurate contact precaution policy was developed and implemented.

Contact precautions are defined by www.cdc.gov as:

"Contact precaution guidelines recommended by the Centers for Disease Control (CDC) and Prevention for reducing the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Direct-contact transmission involves skin-to-skin contact and physical transfer of microorganisms to a susceptible host from an infected or colonized person. This can occur when health care personnel perform patient-care activities that require physical contact, such as turning or bathing the patient. Direct-contact transmission can also occur between two patients, such as by hand contact, with one patient serving as the source of infectious microorganisms and the other as a susceptible host. Indirect-contact transmission involves contact of a susceptible

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3. The Director of Nursing or Designee will educate center staff on CDC guidelines for personal protective equipment and room cleaning of contact precaution rooms. The Director of Nursing or Designee will educate the Assistant Director of Nursing and licensed staff on the accurate implementation of contact precautions for residents with infectious organisms. The Director of Nursing or Designee will educate center staff on ensuring ice scoops are appropriately placed during the passing of ice.

4. The Assistant Director of Nursing or Designee will perform an infection control room observation for 1 resident on contact precautions, where applicable, weekly x 4 weeks then monthly x 2 months to ensure staff compliance with donning of personal protective equipment upon entering the room. The Assistant Director of Nursing or Designee will audit the medical record of 1 resident on contact precautions, where applicable, weekly x 4 weeks

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host with a contaminated intermediate object, usually inanimate, in the patient's environment. Contact Precautions apply to specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct or indirect contact."

Resident #12, a male, was admitted to the facility 4/20/09. His diagnoses included klebsiella pneumonia, paraplegia, anemia, multiple sclerosis, major depressive disorder, hypokalemia, neuromuscular dysfunction of bladder, and type II diabetes mellitus.

Resident #12's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/10/15 was coded as a quarterly assessment. Resident #12 was coded as having some short and long term memory deficits and required minimal assistance with making daily life decisions. He was coded as needing extensive to total assistance with all of his activities of daily living. He was also coded as being incontinent of bowel. Upon readmission to the facility from the hospital, Resident #12 had a Foley catheter, a flexible tube, inserted into the meatus to drain urine into a collection bag.

During initial tour of the facility, 1/20/16 beginning at 11:50 a.m., Resident #12's bedroom was observed. On the door was a container with a sign that directed staff or visitors to check with the nurse before entering the bedroom. LPN (licensed practical nurse) B, the unit manager, stated Resident #12 was in "contact" precautions as he had been diagnosed as having "ESBL in his urine during his last hospitalization." According to LPN B, Resident #12 had returned to the

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then monthly x 2 months to ensure precautions have been accurately implemented. The Assistant Director of Nursing or Designee will perform an infection control observation of ice being passed weekly x 4 weeks then monthly x 2 months to ensure compliance with the ice scoop being placed appropriately. The Director of Nursing or Designee will review audit findings and report findings to the QA Committee for further recommendations.

5. Date of Compliance 2/23/16.

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facility 1/19/16 from the hospital.

According to www.cdc.gov, "ESBLs are enzymes that mediate resistance to extended-spectrum (third generation) cephalosporins (e.g., ceftazidime, cefotaxime, and ceftriaxone) and monobactams (e.g., aztreonam) but do not affect cephamycins (e.g., cefoxitin and cefotetan) or carbapenems (e.g., meropenem or imipenem)."
When asked, LPN C stated 1/20/16 at 12:10 p.m., staff should don gloves whenever they entered Resident #12's bedroom. If the staff determine that direct care was necessary, according to LPN C, they should exit Resident #12's room and don gowns and gloves.
The following observations were made:
1/20/16 1:45 p.m. Door closed, CNA (certified nursing assistant) J entered Resident #12's bedroom. Donned gloves upon entering, exited room. CNA J stated gloves should be donned whenever entering the room
1/20/16 3:35 p.m. A male housekeeper was sweeping Resident #12's bedroom. He swept the dirt and debris outside of the bedroom and used a dustpan from his housekeeping cart, swept the debris into the pan and threw it in the bag on his cart. The housekeeper reentered Resident #12's bedroom and continued to clean. He left the room, went to another room and retrieved a wet floor sign. The housekeeper entered the bedroom and put down the sign. The housekeeper left the bedroom. During the entire observation, the housekeeper did not don any gloves nor did he wash or clean his hands.
1/20/16 3:38 p.m. CNA I entered Resident #12's bedroom. CNA I gave Resident #12 some crackers, lying them on his abdomen. CNA I left Resident #12's bedroom and went into the activity room (next door to Resident #12's bedroom).

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CNA I scratched her face with her hand. During the entire observation, CNA I did not don gloves nor wash or clean her hands.
1/21/6 at 8:15 a.m. Attempted to interview Resident #12. No gowns were available in the container on Resident #12's door. After a bit of time, LPN C was asked for gowns and she retrieved them from the supply area. LPN C said staff should don gloves upon entering the bedroom and if necessary, should don gowns to perform direct care.
Review of the facility's policy "Contact Precautions" dated 4/2005 and referenced the CDC guidelines at that time included:
"Wear clean gloves when entering the resident's room or unit if a multi-bed room.
Remove gloves before leaving resident area.
Wash hands immediately with soap and water, or alcohol hand sanitizer if handwashing facilities are unavailable. If the organism being isolated is VRE (Vancomycin-resistant enterococci), antimicrobial soap is recommended.
Wear a gown when entering resident area if you anticipate that you will have substantial contact with the resident, resident items or environmental surfaces or if the resident is incontinent.
Remove gown carefully before leaving the room and wash hands."
The policy was listed as having been revised "04/2005."
The infection control nurse, RN (registered nurse) A, was interviewed 1/21/16 at 4:30 p.m. RN A stated staff should don gloves upon entering Resident #12's bedroom. If the staff need to perform care, they should leave the room, don a gown and new gloves. RN A stated staff should always wash or clean their hands upon removing gloves. RN A further stated the policy that was revised during April, 2005 was the current policy

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for implementation of contact precautions.
Guidance for the management of MDRO (multidrug resistant organism) infections are provided by www.cdc.gov:
"Contact Precautions. Contact Precautions are a set of practices used to prevent transmission of infectious agents that are spread by direct or indirect contact with the patient or the patient's environment. Contact Precautions also apply where the presence of excessive wound drainage, fecal incontinence, or other discharges from the body suggest an increased transmission risk. A single patient room is preferred for patients who require Contact Precautions. When a single patient room is not available, consultation with infection control is helpful to assess the various risks associated with other patient placement options (e.g., cohorting, keeping the patient with an existing roommate). In multi-patient rooms, > (greater than) 3 feet spatial separation of between beds is advised to reduce the opportunities for inadvertent sharing of items between the infected/colonized patient and other patients. Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning of gown and gloves upon room entry, removal before exiting the patient room and performance of hand hygiene immediately upon exiting are done to contain pathogens."
RN A, when interviewed 1/21/16 at 4:30 p.m., was unaware that the facility policy did not meet the CDC guidelines for contact precautions.
The administrator, DON (director of nursing), and corporate consultant were advised of the failure of the facility to develop or implement an infection control program for contact precautions that met

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	495085	A. BUILDING ______ B. WING ______	01/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERVIEW ON THE APPOMATTOX HEALTH & REHAB CENTER	201 EPPS STREET HOPEWELL, VA 23860

(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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the CDC guidelines, 1/21/16 at 4:30 p.m.

2. Resident #9 was placed on contact isolation for CRE (carbapenenem resistant enterobacteriaceae) but was not resistant; staff did not use a gown when entering the resident's room.

Resident #9 was admitted to the facility on 9/18/15. Diagnoses for Resident #9 included but are not limited to high blood pressure, depression, diabetes, anxiety, and congestive heart failure. Resident #9's Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 12/25/15 coded Resident #9 with a BIMS (brief interview of mental status) of "15" out of a possible 15, or no cognitive impairment. Resident #9 required limited to extensivel dependence on staff, for Activities of Daily Living care.

On 1/20/16 at 1:40 PM, CNA (certified nursing assistant) (C) entered the room, putting on gloves. CNA (C) left the room, and took the gloves off. The CNA procceded to the next room and entered without washing her hands.

On 1/21/16 at 8:15 AM, Resident #9's door was closed. CNA A entered the room after donning gloves, but no gown. Isolation supplies were on the door in an enclosed container which contained gowns, gloves and masks.

On 1/21/16 at 8:20 AM, CNA (A) was questioned as to the type of isolation the resident was placed.

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CNA (A) stated, "Something in her urine." He went on to state I always put on gloves, if we give care, will suit up (gown)."

1/21/16 at 10:45 AM, Resident #9 was questioned about her isolation. She stated, "I wish to Lord I knew." She went on to relate that she had been on isolation for 2-3 weeks. She stated, "I can go out of the room when I want."

On 1/21/16 at 11:00 AM, LPN (licensed practical nurse) A was also questioned about Resident #9's isolation. She stated, "She is on contact isolation due to Klebsiella in urine."

Review of the clinical record revealed the resident was on on contact isolation for Klebsiella pneumoniae in the urine. The care plan dated 12/24/15 revealed the following: "Contact precautions per facility protocol." Review of the 12/24/15 urinalysis with culture and sensitivity (C/S) revealed the resident had greater than 100,000 CFU/ml (colony forming unit per milliliters) of Klebsiella pneumoniae which was sensitive to and treated with Levofloxin (oral antibiotic). The C/S also showed the resident's infection was sensitive to Ertapenem (carbepenem type) antibiotic.

The Virginia Department of Health stated the following: "If a patient is infected with CRE, additional infection control measures are taken. These are called " contact precautions " . The patient is usually placed in a private room. The care provider wears gloves and a gown any time he/she is in the patient's room. The patient must stay in the room and visitors may be restricted." (March 2013).
Review of the Facility Contact Precautions

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revealed the following: "Private room is desirable... wear gloves when entering room or unit and change gloves after contact with infective matreial. Wash hands after every resident contact. Wear a gown if you anticipate that your clothing may become contaminated."
On 1/21/16 12:50 PM, an interview was done with the infection control nurse. She stated, "She is on contact isolation for Klebsiella pneumoniae in the urine." She also stated that gloves were to be worn and to "wear gowns related to amount of fluid exposure." The infection control nurse could provide no documentation that the resident had a CRE infection, only that the resident was treated for a UTI (urinary tract infection), currently being treated with an oral antibiotic.
On 1/26/16, the DON (director of nursing) stated, "we could not find anything in the records regarding CRE."
On 1/21/16 at 12:00 PM, the Administrator and DON were notified of the above findings.

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3. During the initial tour of the facility on 1/20/16, Certified Nursing Assistant D (CNA D) was observed to use an ice scoop and then store it in the chest of ice on two occasions.

The initial tour of the facility ended at 12:06 p.m.

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At this time, CNA D was passing ice to the residents living in room 216. She asked both residents if they would like ice. Both residents agreed. CNA D exited the room with the first empty water cup. She removed the scoop from the ice chest and filled the cup. She placed the ice scoop back into the ice chest and closed the ice chest lid. She went back into the room to get the second cup. She returned to the chest and opened it to remove the scoop. She filled the cup and placed the scoop back into the ice chest. CNA D entered the room and to return the second cup. She used hand sanitizer upon exiting the room.

Registered Nurse A (RN A), the Infection Control nurse, was present during the ice scoop observation. RN A was asked if it was acceptable that CNA D stored the ice scoop in the chest of ice. RN A stated no and that she would talk with CNA D about the issue.

Another CNA was observed to be passing ice on the 300 hall at this time. The ice scoop was observed to be appropriately stored in the scoop holder on the outside of the ice chest.

The Administrator and Director of Nursing were notified of the infection control issue at the end of day meeting on 1/21/15.

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