STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495406	A. BUILDING ______ B. WING ______	10/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	**1000 LITTON LANE** **BLACKSBURG, VA 24060**

(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 10/24/17 through 10/26/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety survey/report will follow. The census in this 60 certified bed facility was 51 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents #1 through #12) and 5 closed record reviews (Residents #13 through 17).	F 000		
F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES 483.10 (c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. (g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F 155	RECEIVED NOV 28 2017 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi L. Blake, LNHA
TITLE: Administrator
(X6) DATE: 11-23-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	Continued From page 1 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. 483.24 (a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to have a complete and accurate DDNR (Durable Do Not Resuscitate) for 1 of 17 residents in the survey sample. (Resident #8)	F 155	1. The notice for the availability of the survey results has been posted in the same position for 8 years. The facility created a new sign and placed it on the counter at the visitor log the same day it was noted by the surveyor to no longer be acceptable. 2. All residents had the potential to be effected. 3. The facility has also placed the notice in the bulletin board in the corridor near the entrance to the NH and at the activity bulletin board at near the activity calendar. The results book is kept in the front lobby for easy access and contains 3 years of surveys. 4. QA will verify placement of survey results notice for 6 months.	5. 10/31/17

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F 155	Continued From page 2 The findings included: The facility staff failed to date the DDNR for Resident #8. Resident #8 was admitted to the facility on 8/1/14 with the following diagnoses of, but not limited to high blood pressure, diabetes, depression, restless leg syndrome, retention of urine and insomnia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/28/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #8 was also coded as requiring supervision of one staff member for dressing and personal hygiene. The surveyor conducted a clinical record review on 10/24/17 at which time, the surveyor noted that the DDNR was not dated when the form was signed by the responsible party and physician. At 3:35 pm, Licensed Practical Nurse (LPN) #1 was notified of the above documented findings by the surveyor. LPN #1 stated "I will get that fixed as soon as possible." On 10/25/17 at 2:05 pm, the administrative team was notified of the above documented findings by the surveyor in the end of the day conference with the team. No further information was provided to the surveyor prior to the exit conference on 10/26/17.	F 155		
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE	F 167		

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

PRINTED: 11/14/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 167	Continued From page 3 (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, Resident group interview and staff interview the facility staff failed to post the availability of the most recent survey results in a prominent area of the facility. The findings included: The notice of availability of survey results was not posted in a prominent area.	F 167	1. The notice for the availability of the survey results has been posted in the same position for 8 years. The facility created a new sign and placed it on the counter at the visitor log the same day it was noted by the surveyor to no longer be acceptable. 2. All residents had the potential to be effected. 3. The facility has also placed the notice in the bulletin board in the corridor near the entrance to the NH and at the activity bulletin board at near the activity calendar. The results book is kept in the front lobby for easy access and contains 3 years of surveys. 4. QA will verify placement of survey results notice for 6 months.	5. 10/31/17

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F 167	Continued From page 4 The survey team entered the facility on 10/24/17 at approximately 1330. An initial tour was conducted upon arrival. Surveyor observed the facility for the survey results and the posting of availability at this time. Surveyor did not locate the survey results or the posting of availably of such at this time. On 10/25/17 at approximately 1030, a member of the survey team met with 9 interviewable Residents of the facility. These Residents did not know where the survey results were located. On 10/25/17 at approximately 1500, surveyor made general observations of the facility, and again could not locate the survey results or posting of availability of results. On 10/25/17 at approximately 1545, surveyor asked the administrator for the results of the previous years survey results, and was directed to a small, round, 3-tiered table located in the lobby of the facility. The survey results were located in a white binder, on the middle tier of the table. The surveyor then asked where the posting was that stated where the survey results were located. The facility receptionist stated that the sign was located in the foyer, and proceeded to show the surveyor the location of posting. Posting of availably of survey results was located on a card approximately 3" x 5", attached to a cork board in the foyer. The card was located on the far right side of the board, approximately midway, and could not be fully read due to the edge being under the frame of the board. The concern of the posting of the survey results was discussed with the administrative team during a meeting on 10/26/17 at approximately 1230.	F 167		

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F 167	Continued From page 5	F 167		
	No further information was provided prior to exit.			
F 244 SS=E	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION	F 244		

(f)(5) The resident has a right to organize and participate in resident groups in the facility.

(iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.

(A) The facility must be able to demonstrate their response and rationale for such response.

(B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, and facility document review the facility staff failed to act promptly upon grievances from the resident council.

The findings include:

On the morning of 10/25/17, the surveyor requested 3 months of the resident council meeting minutes. The surveyor was provided copies of the resident council meeting minutes for the previous 3 months. The minutes provided were for July, August, and September of 2017. July and September both had documented that the food was cold.
During the resident council meeting held on

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F 244	Continued From page 6 10/15/17 at 10:30am, the surveyor asked the 9 residents if they liked the food served at the facility. All nine residents were in agreement in saying it was cold some of the time if not all of the time. Both in their rooms and in the dining room. During the lunch meal on 10/25/17, two surveyors went to the serving line to observe the food being served. The tray line temps had been observed by a surveyor and were found to be correct. The tray line dietary server was asked to let the surveyor feel one of the plates and the insulated container it was placed in. Upon touching the plate and container they were both found to be cool to touch. The dietary food server informed the surveyors the plate warmer was not working. And begin to place the insulated containers in the steam cabinet and she was observed placing an empty plate in the microwave for warming. At 2:20pm, the survey team met with the administrator and the director of nurses. During the meeting the cold food issue was discussed. The surveyor requested to speak with the social worker who took the resident council meeting minutes. The social worker met with the surveyor on 10/25/17 at 2:45pm. She was asked if she followed up on the complaints the resident council had. She stated, "I send the meeting notes to the department heads including the administrator, director of nurses, dietary manager and dietitian." She was asked if the department heads follow up on the complaints. She said, "I try to get follow up from the department heads and I know it should be in writing but don't always get it they usually tell me they go and talk to the residents." The surveyor requested the resident council minutes	F 244	1. The departmental responses to the Resident Council minutes cannot be corrected as it happened in the past. 2. All residents who express concerns in the Council meeting have the potential to be effected. 3. Monthly Resident Council meetings are held, and minutes are distributed to managers and responses or action plans are required. Managers will respond to the Resident Council concerns within a week of receipt of minutes. 4. The Council facilitator, or their designee, will submit the council minutes and responses to QA monthly for 6 months. 5.	11/20/17

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F 244	Continued From page 7 starting in January 2017. In January, the residents complained about the food not being the correct temperature both in their rooms and in the dining room. In February, March, and April, there was no mention of cold food in the minutes. In May, the food was again documented as not being the correct temperature. The maintenance man had a work order in March 2017, and stated the plated warmer had been fixed at that time. He was asked by the general dietary manager to look at the plate warmer on 10/25/17. The maintenance man informed the survey team later in the day that the warmer had been fixed. On 10/26/17 at 8:55am, the general dietary manager informed the survey team that the plate warmer was not working. He said, "It has stopped working and if we cannot identify the problem, we will need to get a new one." The general manager was asked if he had been notified that the resident council had complained of cold food. He said, "I was copied on it but unfortunately, did not follow up." The concern was reported to the administrator and director of nursing during a summary meeting on 10/26/17 at 11:40am. Prior to exit on 10/26/17, no further information was provided to the surveyor related to staff failure to act promptly upon grievances from the resident council.	F 244		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 8 (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to accurately code a MDS (Minimum Data Set) for 1 of 17 residents in the survey sample. (Resident #8) The findings included:	F 278		

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F 278	Continued From page 9 The facility staff failed to accurately code the MDS for Resident #8. Resident #8 was admitted to the facility on 8/1/14 with the following diagnoses of, but not limited to high blood pressure, diabetes, depression, restless leg syndrome, retention of urine and insomnia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/28/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #8 was also coded as requiring supervision of one staff member for dressing and personal hygiene. The surveyor conducted a clinical record review on 10/24/17 at which time, the surveyor noted that Resident #8 had a physician order dated on 8/16/17 to discontinue Hospice services on 8/19/17. The surveyor also noted that on the above documented MDS the resident was coded as receiving Hospice services. This MDS had an ARD of 8/28/17. Registered Nurse (RN) #1 was notified of the above documented findings by the surveyor at 4:30 pm. RN #1 stated "I'll have to make a correction on that." On 10/25/17 at 2:05 pm, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 10/26/17.	F 278	1. Resident 8's MDS was corrected on 10/24/17 and a modification was shown to the surveyor. 2. All residents who receive hospice have the potential to be effected. 3. The two MDS nurses will review each other's hospice assessments prior to locking and transmitting. 4. QA team will review MDS hospice admission and discharge assessments for 6 months to ensure accuracy.	5. 11/27/17
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 10	F 279		

483.20
(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

483.21
(b) Comprehensive Care Plans

(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -

(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and

(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the

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F 279	Continued From page 11 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to develop a comprehensive care plan to address pain for 1 of 17 residents in the survey sample, Resident # 5. Findings include: Facility staff failed to develop a comprehensive plan of care to address pain that triggered on the admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/20/17 for Resident #5. Resident # 5 was originally admitted to the facility on 6/8/17 and was readmitted on 9/13/17 with diagnoses including but not limited to: nausea and vomiting, bilateral lower abdominal pain,	F 279	1. The pain care plan was completed on 10/26/17 and provided to the surveyor. 2. Any resident with a care plan has the potential to be effected. 3. Once a care plan is written, MDS section V (the CAA) will be checked for each triggered area requiring a care plan by the MDS nurse not writing that care plan to verify each section triggered has a care plan written. 4. The MDS nurses will audit 10% of Section V (CAA) and will submit the audit to QA monthly,.	5. 11/30/17

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F 279	Continued From page 12 anemia, and esophagitis. The most recent MDS (minimum data set) assessment was a Medicare 30 day assessment with an ARD (assessment reference date) of 10/11/17. Resident #5 was coded as cognitively intact with a total summary score of 15 out of 15. The clinical record for Resident #5 was reviewed on 10/25/17 at 8:10 a.m. The MDS assessment dated 10/11/17 was reviewed including section J. According to the pain intensity interview in J0600, Resident #5 was asked "please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine." It is documented that Resident #5 rated her pain at 10. The Admission MDS assessment with an ARD of 9/20/17 was reviewed including the CAA's (care area assessments). Resident #5 triggered for pain and the facility staff checked "yes" to develop a plan of care for pain. Resident # 5's plan of care was reviewed, and there was no care plan to address pain. On 10/25/17 at 11:30 a.m. the surveyor spoke with the MDS nurse in reference to locating the plan of care for pain for Resident #5. The MDS nurse along with the surveyor reviewed the CAA's and current plan of care for Resident #5. MDS nurse then stated "It's not there." "I will get a pain one in ASAP" (as soon as possible). On 10/25/17 at 2:05 pm the administrator and DON (director of nursing) were made aware of the above findings. On 10/26/17 at 11:57 am the DON presented the surveyor with a plan of care for pain for Resident	F 279		

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F 279	Continued From page 13 #5 that was dated 10/25/17. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 279		
F 280 SS=E	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or	F 280		

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F 280	Continued From page 14 resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 280	1. The care plans for Residents 5,6 ad 8 cannot be corrected. Resident 4's care plan was corrected on 10/26/17 and was shown to the surveyors prior to exit. 2. All residents with a care plan have the potential to be effected. 3. The facility implemented a new form of weekly Risk Management in June, 2017 to capture trends and concern issues. This meeting has evolved through that process. Each resident is discussed in depth with changes, skin concerns, behaviors, falls, current interventions and devices, etc. and includes discussion of any other interventions that might be used. The meeting includes a nurse and CNA to help identify needs. Care Plans are updated at that time if needed, and staff is encouraged to	

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F 280	Continued From page 15 disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review facility staff failed to review and revise the comprehensive plan of care for 4 of 17 residents in the survey sample, Resident #5, Resident #6, Resident #4, and Resident #8. The findings include: 1. Facility staff failed to review and revise the comprehensive plan of care to address excoriation and pressure ulcer development for Resident #5. Resident #5 was originally admitted to the facility on 6/8/17 with a readmission date of 9/13/17. Admitting diagnoses include but not limited to: nausea and vomiting, bilateral lower abdominal pain, anemia, and esophagitis. The most recent MDS (minimum data set) assessment was a Medicare 30 day assessment with an ARD (assessment reference date) of 10/11/17. Resident # 5 was coded as cognitively intact. The clinical record for Resident #5 was reviewed on 10/25/17 at 8:10 a.m. The admission MDS assessment with an ARD of 9/20/17 was reviewed including section M. According to the	F 280	update the care plan as often as needed. The Activity Department will work with nursing, resident representatives and residents on preferred non-pharmacological interventions and keep a list in the nurses station for easy access by all staff for updating and removing of interventions so it is a constant work in progress. 4. Weekly Risk Management notes will be submitted to QA and QA will compare to the care plans for need to include and/or discontinue interventions. Staff Education will provide in-services on behaviors and the use of non-pharmacological interventions during competency training and as needed.	5. 12/21/17

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F 280	Continued From page 16 documentation in section M, Resident #5 had no wounds, ulcers, or skin problems. The skin risk/weekly assessment that was completed on upon admission on 9/13/17 reflected that Resident #5's skin was intact upon admission to the facility. A physician's telephone order dated 10/9/17 was written as follows "to coccyx wash with soap & H2O, pat dry, then apply 2 guard BID (twice a day) for excoriation." Another physician's telephone order dated 10/23/17 was written for "duoderm to sacral/coccyx area after cream to decubitus." Physician's telephone order dated 10/24/17 was written to state "change tx (treatment) to coccyx with normal saline pat dry apply pea sized amount of silver sulfazide QD & PRN (every day and as needed) stage 3 wound." The comprehensive plan of care for pressure ulcer risk/skin integrity for Resident #5 was reviewed. There was no documentation to address the development or treatment of the wound to the sacral/coccyx area. On 10/25/17 at 2:05 p.m. the administrator and DON (director of nursing) were made aware of the above findings. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. Facility staff failed to review and revise the comprehensive plan of care to identify behaviors and interventions associated with the use of Seroquel for Resident #6. Resident #6 was originally admitted to the facility on 9/5/13 with a readmission date of 10/17/16. Diagnoses included but not limited to: weakness, deconditioning, failure to thrive, hypertension, and	F 280		

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F 280	Continued From page 17 anxiety. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 10/16/17. Resident #6 was coded as cognitively intact with a total summary score of 15 out of 15. On 10/24/17 at 3:10 p.m. the surveyor conducted an interview with. Resident #6. When asked if she had privacy while making phone calls Resident # 6 responded " I worked in the pentagon and years ago they had me electronically bugged so no I don't have privacy on the phone, someone is always listening." The clinical record for Resident #6 was reviewed on 10/24/14 at 3:28 p.m. While reviewing the current MAR (medication administration record) it was noted that Resident #6 received Seroquel 25 mg (milligrams) 1 tablet by mouth every morning and at bedtime for psychosis Upon further review of the clinical record Geriatric Psychiatry Consult Notes were noted. On the note dated 2/6/17 it was documented that nursing reported that Resident#6 was "seeing bugs that are not there, written postcard to FBI (federal bureau of investigation) about device in head placed to monitor thoughts/location." Another note dated 3/9/17 had documentation that stated that nursing reported that Resident #6 "falls asleep on the toilet, constantly wanting pain and breathing meds, constantly wearing multiple briefs at a time, and had tissue boxes on her feet." On the note dated 4/24/17 the documentation stated that nursing reported that Resident #6 "continues to have on multiple briefs at a time, sleeps on commode, frequently requests extra pain medication, increased confusion and agitation,	F 280		

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and sleeps more. On the note dated 10/9/17 the documentation stated that Resident #6 "has decreased confusion, more alert, does more for herself, interacts more with staff and residents" The current comprehensive plan of care for Resident #6 was reviewed. There was no documentation in the plan of care to identify behaviors or interventions used to manage the behaviors.

On 10/26/16 at 10:25 a.m. surveyor requested and was presented with a copy of the facility policy "Behaviors Identification and Interventions." According to the facility policy "the interdisciplinary team will develop a plan of care to attain or maintain the highest practicable level of psychosocial wellbeing while pursuing causes and interventions for disruptive behaviors through behavior management. Evaluation of the behavioral management plan and interventions can be analyzed and changes made by the care plan team at any time. Evaluation should occur at least quarterly with the care plan review."

On 10/26/17 at 11:40 a.m. the administrator and DON (director of nursing) were made aware of the above findings.

No further information was provided to the survey team prior to the exit conference.
3. For Resident #4, facility staff failed to review and revise her care plan to show her pressure ulcer was healed.

Resident #4 was admitted to the facility on 8/29/13, with diagnoses including but not limited to: anemia, atrial fibrillation, dementia, stroke, and pain.

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On the MDS assessment dated 8/17/17, the resident scored 12 on the brief interview for cognitive status; she was coded to understand and to be understood. In section M of the MDS, she was coded to not have a pressure area.

The surveyor reviewed the clinical record of Resident #4 on 10/24/17 to find she had had a pressure ulcer that was healed on 7/25/17, that was not reflected on her compressive care plan. The Wound Care Specialist Evaluation record dated 7/25/17 stated "Resolved with hyperpigmented scar."

The MDS Nurse was shown Resident #4's compressive care plan and asked if it had been updated to show the healing of the wound. After reviewing the care pan she stated, "You are right; it hasn't been updated."

The concern was reported to the administrator and director of nursing during a summary meeting on 10/25/17 at 2:40pm.

Prior to exit on 10/26/17, no further information was provided to the surveyor related to the care plan issue.

4. The facility staff failed to review and revise the CCP (Comprehensive Care Plan) for Resident #8 regarding use of non-pharmacological interventions prior to the administration of pain medication.

Resident #8 was admitted to the facility on 8/1/14 with the following diagnoses of, but not limited to high blood pressure, diabetes, depression, restless leg syndrome, retention of urine and insomnia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment

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Reference Date) of 8/28/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #8 was also coded as requiring supervision of one staff member for dressing and personal hygiene.

The surveyor conducted a clinical record review on 10/24 and 10/25/17 at which time, the surveyor noted that CCP for Resident #8 did not have non-pharmacological interventions for pain listed. Under "My Concerns and my Strengths" section on the care plan, it was noted to state the following: "I have chronic pain due to Osteoarthritis and take pain medicine for this. I also have problems with constipation." Under the section of "My preferences for Care" the following interventions for pain were listed as follows:

"1) Give me my pain medicine as ordered.
2) Check placement of my pain patches ordered.
3) Monitor my v/s (vital signs).
4) Monitor me for any SE (side effects) from my pain medicine especially constipation for which I take medicine.
5) You may do a pain assessment.
6) Notify my doctor if it appears my pain medicine isn't working.
7) Record my BM's (bowel movements)."

The director of nursing (DON) was notified of the above documented findings on 10/25/17 at 9:20 am by the surveyor. The DON stated "I see what you are saying. She loves to garden."

The administrative team was notified of the above documented findings at 2:05 pm by the surveyor.

No further information was provided to the

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F 280	Continued From page 21 surveyor prior to the exit conference on 10/26/17.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 309		

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F 309	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide the highest practical level of well-being for 1 of 17 residents in the survey sample (Resident #8). The findings included: For Resident #8, the facility staff failed to provide non-pharmacological interventions prior to the administration of pain medication. Resident #8 was admitted to the facility on 8/1/14 with the following diagnoses of, but not limited to high blood pressure, diabetes, depression, restless leg syndrome, retention of urine and insomnia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/28/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #8 was also coded as requiring supervision of one staff member for dressing and personal hygiene. The surveyor conducted a clinical record review on 10/24 and 10/25/17 at which time, the surveyor noted that Resident #8 had a physician order for the following pain medications: "Dilaudid 1 mg/ml (milligram/milliliter) Take 2 ml (2 mg) by mouth every 3 hours as needed for pain and Oxycodone 10 mg Take 1 Tab (tablet) by mouth every 6 hours as needed for pain." The MAR (Medication Administration Record) for Resident #8 was also reviewed by the surveyor for the month of October, 2017. During this	F 309	1. This episode occurred in the past and cannot be corrected. 2. Any resident receiving pain medication has the potential to be effected. 3. The Activity Department will work with nursing, resident representatives and residents on preferred non-pharmacological interventions and keep a list in the nurses station for easy access by all staff for updating and removing of interventions so it is a constant work in progress. 4. Staff Education will provide in-services on behaviors and the use of non-pharmacological interventions during competency training, monthly staff meetings and as needed.	5. 12/21/17

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F 309	Continued From page 23 period of time, the resident was given a total of 28 doses of Oxycodone and 5 doses of Dilaudid as ordered by the physician for pain. The nurses' notes for the month of October was also reviewed by the surveyor. There was no documentation of non-pharmacological interventions provided to the resident prior to the administration of these medications. The director of nursing (DON) was notified of the above documented findings on 10/25/17 at 9:20 am by the surveyor. The DON stated "I see what you are saying. She loves to garden." The administrative team was notified of the above documented findings at 2:05 pm by the surveyor. No further information was provided to the surveyor prior to the exit conference on 10/26/17.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote	F 314		

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THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	**1000 LITTON LANE** **BLACKSBURG, VA 24060**

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F 314	Continued From page 24 healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, family interview,and clinical record review, the facility staff failed to provide care to prevent pressure ulcer development for 1 of 17 residents in the survey sample, Resident #5. The findings included: Facility staff failed to implement interventions to prevent pressure ulcer development for Resident #5. Resident # 5 was originally admitted to the facility on 6/8/17 and was readmitted on 9/13/17 with diagnoses including but not limited to: nausea and vomiting, bilateral lower abdominal pain, anemia, and esophagitis. The most recent MDS (minimum data set) assessment was a Medicare 30 day assessment with an ARD (assessment reference date) of 10/11/17. Resident # 5 was coded as cognitively intact. The clinical record for Resident #5 was reviewed on 10/25/17 at 8:10 a.m. The admission MDS assessment with an ARD of 9/20/17 was reviewed including section M. According to the documentation in section M, Resident #5 had no wounds, ulcers, or skin problems, however the facility did document in section M0150 that Resident #5 was at risk for developing pressure ulcers. The skin risk/weekly assessment that was completed on upon admission on 9/13/17	F 314	1. The documentation of the skin area cannot be fixed as it happened in the past. 2. All residents are at risk for skin breakdown and have the potential to be effected. 3. Skin assessments are completed weekly on each resident and any areas of concern are addressed at that time, and orders written for appropriate treatments. Any staff providing care or who see an area of concern are empowered to complete an I&A form (internal document) and seek interventions. The wound physician sees residents weekly and follows up with areas as needed. The facility implemented a new form of weekly Risk Management in June, 2017 to capture trends and concern issues. This meeting has evolved through that process.	

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	495406	A. BUILDING ______ B. WING ______	10/26/2017

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F 314	Continued From page 25 reflected that Resident #5's skin was intact upon admission to the facility. An evaluation for bowel and bladder training was completed on 9/13/17. On the evaluation it was documented that Resident #5 had" incontinence at times and aware of bowel and bladder needs staff to assist.' No bowel and bladder program was initiated at that time. A review of the interdisciplinary progress notes has documentation to support that Resident #5 could ambulate with a walker with a steady gait and required assistance with ADLs (activities of daily living) and transfers. A physician's telephone order dated 10/9/17 was written as follows "to coccyx wash with soap & H2O, pat dry, then apply 2 guard BID (twice a day) for excoriation." Another physician's telephone order dated 10/23/17 was written for "duoderm to sacral/coccyx area after cream to decubitus." Physician's telephone order dated 10/24/17 was written to state "change tx (treatment) to coccyx with normal saline pat dry apply pea sized amount of silver sulfazide QD & PRN (every day and as needed) stage 3 wound." The clinical record was reviewed including the interdisciplinary progress notes, the physician's progress notes, TR (treatment record) and the comprehensive plan of care. The TR has Follow KHCC skin care protocol unless otherwise noted as FYI (for your information) that was initiated on 9/13/17 upon admission. There was no documentation noted on TR to indicate that the skin care protocol had been implemented. There was no documentation located that described the "excoriated" area that was noted on 10/9/17 or it's response to the treatment initiated. The comprehensive plan of care for pressure ulcer risk/skin integrity for Resident #5 was reviewed. There was no documentation to address the development or treatment of the wound to the	F 314	Each resident is discussed in depth with changes, skin concerns, behaviors, falls, current interventions and devices, etc. and includes discussion of any other interventions that might be used. The meeting includes a nurse and CNA to help identify needs. Care Plans are updated at that time if needed, and staff is encouraged to update the care plan as often as needed. The CNA staff will receive instruction on completing the I&A form for areas of concern. Staff Education and the DON will provide continuing information about skin integrity and potential for compromise. 4. QA will monitor risk management tracking form and report any discrepancies for 6 months.	5. 11/30/17

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F 314	Continued From page 26 sacral/coccyx area. On 10/25/17 at 2:05 p.m. the administrator and the DON was made aware of the above findings. On 10/25/17 at 2:40 p.m. the surveyor observed the area to the sacrum/coccyx during the dressing change with the consent of Resident #5. Wound bed was noted to be pink in color with a pinpoint area of depth in the center of the wound. Surrounding skin was red, intact and blanchable. On 10/25/17 at 2:56 p.m. the surveyor conducted a family interview with the family representative of Resident #5. During the interview, the family representative was asked if she was aware of Resident # 5 having any prior skin breakdown and family representative stated "no." Family representative stated that she has not seen the area but "I know she's hurting because I notice that she tries to scoot down in her chair to get off of her bottom." On 10/25/17 at 3:50 p.m. the surveyor was presented with a copy of the facility wound care protocol per request and a pressure ulcer record dated 10/24/17 that had measurements for stage 3 pressure ulcer. Surveyor asked DON if she had any documentation on the wound assessment from the time the "excoriation" was noted on 10/9/17 and DON stated "no." According to the wound and skin care protocols the general policy states that the facility will utilize a multidisciplinary risk management team to review all wounds on a weekly basis. The interdisciplinary plan of care will address goals and treatment interventions directed toward the prevention and/or treatment of impaired skin	F 314		

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F 314	Continued From page 27 integrity/pressure injury. On 10/26/17 at 11:40 a.m. the administrator and the DON were made aware of the above findings. On 10/26/17 at 11:45 a.m. the surveyor was presented with a copy of wound care specialist initial evaluation that reflected that Resident #5 was seen on 10/24/17 and was dated by nursing on 10/25/17. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 314		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 329		

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F 329	Continued From page 28 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic 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 resident interview, staff interview, facility document review, and clinical record review the facility staff failed to ensure that 1 of 17 residents in the survey sample was free from unnecessary medications (Resident #6). The findings included: Facility staff failed to adequately identify behaviors, implement interventions and monitor the effectiveness of Seroquel for Resident #6. Resident #6 was originally admitted to the facility on 9/5/13 with a readmission date of 10/17/16. Diagnoses included but not limited to: weakness, deconditioning, failure to thrive, hypertension, and anxiety. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 10/16/17.	F 329		

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F 329	Continued From page 29 Resident #6 was coded as cognitively intact with a total summary score of 15 out of 15. On 10/24/17 at 3:10 p.m. the surveyor conducted an interview with Resident #6. When asked if she had privacy while making phone calls Resident # 6 responded " I worked in the pentagon and years ago they had me electronically bugged so no I don't have privacy on the phone, someone is always listening." The clinical record for Resident #6 was reviewed on 10/24/14 at 3:28 p.m. While reviewing the current MAR (medication administration record) it was noted that Resident #6 received Seroquel 25 mg (milligrams) 1 tablet by mouth every morning and at bedtime for psychosis. Upon further review of the clinical record Geriatric Psychiatry Consult Notes were noted. On the note dated 2/6/17 it was documented that nursing reported that Resident#6 was "seeing bugs that are not there, written postcard to FBI (federal bureau of investigation) about device in head placed to monitor thoughts/location." Another note dated 3/9/17 had documentation that stated that nursing reported that Resident #6 "falls asleep on the toilet, constantly wanting pain and breathing meds, constantly wearing multiple briefs at a time, and had tissue boxes on her feet." On the note dated 4/24/17 the documentation stated that nursing reported that Resident #6 "continues to have on multiple briefs at a time, sleeps on commode, frequently requests extra pain medication, increased confusion and agitation, and sleeps more. On the note dated 10/9/17 the documentation stated that Resident #6 "has decreased confusion, more alert, does more for herself, interacts more with staff and residents" The current comprehensive plan of care for	F 329	1. Documentation for the need for the medication cannot be fixed as it happened in the past. 2. Any resident receiving antipsychotic medication has the potential to be effected. 3. Resident #6 has a long history of altered thinking about the government and other paranoid thoughts which has a history of interfering with her daily functioning. She has had a medication reduction, and elevation, medication changes and is followed by a geriatric psychiatrist. Resident #6 is now at a level of medication which allows her to have minimal paranoid thoughts and behaviors and she is able to maintain good relationships with others for her optimal quality of life. The care plan has been updated to reflect the family request of no change in medication as long as her condition remains stable. The KHCC Behavior/Intervention	

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F 329	Continued From page 30 Resident #6 was reviewed. There was no documentation in the plan of care to identify behaviors or interventions used to manage the behaviors. On 10/25/17 at 2:42 p.m. surveyor spoke with the DON (director of nursing) and requested documentation of the behaviors that warranted the use of Seroquel and the effectiveness of the medication and interventions. On 10/25/17 at 3:00p.m. the DON presented the surveyor with a copy of a Behavior/Intervention Monitoring form for Resident #6. There was only one notation documented on this form for day shift on 4/21/17. The surveyor asked the DON if this was all of the documentation that she had and the DON stated "yes." On 10/26/17 at 8:55 a.m. surveyor conducted staff interviews with 2 CNAs. (certified nursing assistants) Surveyor asked staff members if Resident #6 displayed any unusual behaviors? CNA #1 stated "yes she thinks that men are coming in her room in the middle of the night and taking her things." CNA #2 stated that "she (Resident #6) gets confused about her medicine a lot." On 10/26/17 at 9:00 a.m. surveyor interviewed LPN#2 and asked if Resident # 6 had been displaying any unusual behaviors? LPN #2 stated that Resident #6 had started getting confused about her pills. LPN#2 stated that Resident #6 would spit her pills back out and say no this pill is too big. LPN#2 stated that she would then get the whole card of pills and show Resident #6 the pills in the card and that the pills have her name on them and then Resident #6 would take the pills.	F 329	Monitoring form states "Document by shift if behavior occurs. If no behavior occurs, it is not necessary to document". Staff has reported no adverse behaviors which interfere with her daily quality of life. The facility implemented a new form of weekly Risk Management in June, 2017 to capture trends and concern issues. This meeting has evolved through that process. Each resident is discussed in depth with changes, skin concerns, behaviors, falls, current interventions and devices, etc. and includes discussion of any other interventions that might be used. The meeting includes a nurse and CNA to help identify needs. Care Plans are updated at that time if needed, and staff is encouraged to update the care plan as often as needed.	

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F 329	Continued From page 31 On 10/26/16 at 10:25 a.m. surveyor requested and was presented with a copy of the facility policy "Behaviors Identification and Interventions." According to the facility policy "the interdisciplinary team will develop a plan of care to attain or maintain the highest practicable level of psychosocial wellbeing while pursuing causes and interventions for disruptive behaviors through behavior management. Evaluation of the behavioral management plan and interventions can be analyzed and changes made by the care plan team at any time. Evaluation should occur at least quarterly with the care plan review." The policy also states "any change in behavioral symptoms, frequently or alterability will require assessment and documentation by the licensed charge nurse on the Behavior/Intervention Monitoring Sheet. The licensed charge nurse and/or social services will notify the attending physician, psychologist/psychiatrist, family representative and/or MDS coordinator as indicated. Nurse will document the effects on the Behavior/Intervention sheet." On 10/26/17 at 11:40 a.m. the administrator and DON were made aware of the above findings. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 329	4. Staff Education will provide in-services on behaviors and the use of non-pharmacological interventions during competency training, monthly staff meetings and as needed.	5. 11/30/17
F 333 SS=D	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS 483.45(f) Medication Errors. The facility must ensure that its-	F 333		

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F 333	Continued From page 32 (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 17 residents in the survey sample was free of a significant medication error (Resident #8). The findings included: The facility staff failed to follow physician orders to give insulin to Resident #8 if blood sugar was over 350. Resident #8 was admitted to the facility on 8/1/14 with the following diagnoses of, but not limited to high blood pressure, diabetes, depression, restless leg syndrome, retention of urine and insomnia. On the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/28/17 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #8 was also coded as requiring supervision of one staff member for dressing and personal hygiene. The surveyor conducted a clinical record review on 10/24 and 10/25/17 at which time, the surveyor noted a physician order dated for 8/29/16 stated "Novolog Flex Pen ...Insulin Pen Inject 10 units subcutaneously as needed for BS (blood sugar) > (greater than) 350. The surveyor also reviewed the MAR (Medication Administration Record) for the month of October, 2017 for Resident #8. On 10/11/17 at 1300 (1:00 pm) the nurse documented a blood sugar of 361.	F 333	1. The medication documentation error happened in the past and cannot be corrected. 2. Any resident receiving insulin has the potential to be effected. 3. Staff received education on the importance of complete documentation. Staff perform a 24-hour chart check for documentation review. 4. DON will audit 10% of charts for the chart review and will report audit to QA monthly for 6 months.	5. 11/30/17

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F 333	Continued From page 33 The above documented physician order for the administration of Novolog insulin was not given for the blood sugar of 361. On 10/25/17 at 9:20 am, the surveyor notified the director of nursing (DON) of the above documented findings. The DON stated "They should have given it." At 2:05 pm, the administrative team was notified of the above documented findings by the surveyor. No further information was provided to the surveyor prior to the exit conference on 10/26/17.	F 333		
F 364 SS=F	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature; This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to maintain safe and appetizing food temperatures for the residents of the facility. The findings included: The facility staff failed to maintain safe and appetizing food temperatures for the residents of	F 364		

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

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F 364	Continued From page 34 the facility. On 10/25/17 at approximately 10 am, a surveyor of the survey team conducted a group interview which consisted of 9 residents of the facility. During this meeting, the residents complained that the food on their trays was cold when they received them from the facility kitchen. At 11:35 am, this surveyor went into the kitchen to observe the dietary staff obtaining temperatures of the food on the serving tray line. The surveyor observed the dietary staff member #1 obtain temperatures on the pureed peas which was 123 degrees and roast beef with a temperature of 125 degrees. The dietary staff member #1 stated to the surveyor, "I'll take these foods back into the kitchen and reheat them until they are at least 140 degrees." These foods were reheated and the repeated temperatures of the pureed peas was 145 degrees and the roast beef was 171 degrees. These foods were placed back on the serving tray line to be used on the resident's trays. At 11:50 am, this surveyor and the surveyor that conducted the group interview went into the kitchen to the serving tray line and asked dietary staff member #1 to let the surveyors feel the temperature of the plates that were located in the plate warmer holder. The dietary staff member #1 gave the 2 surveyors the first plate off the top of the stack in the warmer and the surveyors noted the plate to be cool to touch. The surveyors asked the dietary staff member #1 to obtain a plate from the middle of the plate holder warmer. The plate was handed to the surveyors and the plate from the middle was also noted to be cool to touch. The dietary staff member #1	F 364	1. Food received on cold plates was heated to the preferred temperature. 2. All residents have the potential to be effected. 3. The kitchen began using their hot holding unit to maintain the heat on plates on 10/25/17 prior to the surveyors' exit. Cold items are kept under refrigeration until service. Meals that are delivered to rooms are divided by hall for faster delivery service by nursing staff. 4. Dining services will temp 2 test trays/wk and document on the Meal Assessment Log. The Log will be submitted to QA monthly for 6 months.	5. 11/30/17

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F 364	Continued From page 35 notified the dietary manager that the plate holder warmer was not keeping the clean plates warm until the food could be served on the plates. The dietary manager stated to the surveyors, "We will put these plates in this steamer here and keep the plates warm until the staff is ready to put food on them." The 2 surveyors conducted (2) test tray observations and tasting along with the dietary manager. The food cart with the resident trays were taken out to Hall #2 at 12:18 pm with the last tray being delivered to the last resident at 12:22 pm. The 2 test trays were removed and taken to the nurses' station where the dietary manger obtained food temperatures as follows on the tray that the plate was taken out of the plate holder warmer in the kitchen: Roast beef and gravy over a slice of bread 112 degrees, peas 110 degrees, mashed potatoes 114 degrees and hamburger soup 142 degrees. The surveyors and dietary manager performed food tasting of this tray. The consensus of this group was that the food was warm but not warm enough to their liking. The test tray that contained the plate that was put in the steamer in the kitchen to keep the plate warm had the following food temperatures that were obtained by the dietary manager: Roast beef with gravy over slice of bread 116 degrees, peas 129 degrees and mashed potatoes 140 degrees. The surveyors and dietary manager performed food tasting of this tray. The consensus of the group was the food that was on this plate was much warmer to the taste and appetizing to eat. At 2:05 pm, the administrative team was notified of the above documented findings by the surveyor.	F 364		

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THE WYBE AND MARIETJE KROONTJE HEALTH CARE CENTER	1000 LITTON LANE BLACKSBURG, VA 24060

(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 364	Continued From page 36 At 3:30 pm, the dietary manager returned to the conference room and stated to this surveyor, "I have put in a work order to get the plate holder warmer to be repaired by the maintenance department." The surveyor was provided a copy of the work order. At approximately 4:20 pm, the maintenance director came into the conference room and stated to the surveyor, "I have fixed the plate warmer in the kitchen. The switch at the bottom was accidentally turned off." On 10/26/17 at 8:55 am, the dietary manager came into the conference room and informed this surveyor that the plate warmer was not working again this morning and the plates were being placed in the steamer to keep warm. The surveyor asked the dietary manager if he had been notified of any problems of the plate warmer not working or of the resident's complaining that their food on the trays were cold. The dietary manager stated, "I was made aware of the problem of food temperatures by emails but I did not follow up on the problem. If the resident's food was not at the temperature that the residents liked, we would give them another tray or reheat the tray the resident had." At approximately 10 am, the maintenance director provided the surveyor with a copy of a work order dated for March 20, 2017 which stated " ...Plate warmer is not heating ..." The completed date was documented as March 29, 2017. No further information was provided to the surveyor prior to the exit conference on 10/26/17.	F 364		
F 371	483.60(i)(1)-(3) FOOD PROCURE,	F 371		

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F 371 SS=F	Continued From page 37 STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to maintain equipment in proper working condition in the facility kitchen. The findings included: The facility staff failed to maintain the plate holder warmer in proper working condition in the facility kitchen.	F 371	1. The plate warmer was broken and unable to be fixed at this time. The hot box was used for meal service beginning on 10/25/17. 2. All residents have the potential to be effected. 3. The plate warmer was disposed of on 10/26/17. The staff use the hot box to maintain the heat temperature on the plates. Dining services conducts weekly huddle meetings and supervisors will prompt for any issues of concern in the kitchen. This is documented and attendance as well. The supervisor will encourage staff to submit maintenance concerns at time of notice to the receptionist who documents the issues in an electronic work order system. Maintenance receives the notification and follows up with receptionist once the work order is complete.	

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F 371	Continued From page 38 On 10/25/17 at approximately 10 am, a surveyor of the survey team conducted a group interview which consisted of 9 residents of the facility. During this meeting, the residents complained that the food on their trays was cold when they received them from the facility kitchen. At 11:50 am, this surveyor and the surveyor that conducted the group interview went into the kitchen to the serving tray line and asked dietary staff member #1 to let the surveyors feel the temperature of the plates that were located in the plate warmer holder. The dietary staff member #1 gave the 2 surveyors the first plate off the top of the stack in the warmer and the surveyors noted the plate to be cool to touch. The surveyors asked the dietary staff member #1 to obtain a plate from the middle of the plate holder warmer. The plate was handed to the surveyors and the plate from the middle was also noted to be cool to touch. The dietary staff member #1 notified the dietary manager that the plate holder warmer was not keeping the clean plates warm until the food could be served on the plates. The dietary manager stated to the surveyors, "We will put these plates in this steamer here and keep the plates warm until the staff is ready to put food on them." At 2:05 pm, the administrative team was notified of the above documented findings by the surveyor. At 3:30 pm, the dietary manager returned to the conference room and stated to this surveyor, "I have put in a work order to get the plate holder warmer to be repaired by the maintenance department." The surveyor was provided a copy of the work order.	F 371	4. The administrator, QA director and Maintenance personnel will review weekly equipment work orders for completeness and make notes if materials are on order with estimated time of repair, or if equipment is unable to be repaired with estimated time to replace. QA will maintain the log for 6 months.	5. 11/30/17

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F 371	Continued From page 39 At approximately 4:20 pm, the maintenance director came into the conference room and stated to the surveyor, "I have fixed the plate warmer in the kitchen. The switch at the bottom was accidentally turned off." On 10/26/17 at 8:55 am, the dietary manager came into the conference room and informed this surveyor that the plate warmer was not working again this morning and the plates were being placed in the steamer to keep warm. The surveyor asked the dietary manager if he had been notified of any problems of the plate warmer not working or of the resident's complaining that their food on the trays were cold. The dietary manager stated, "I was made aware of the problem of food temperatures by emails but I did not follow up on the problem. If the resident's food was not at the temperature that the residents liked, we would give them another tray or reheat the tray the resident had." At approximately 10 am, the maintenance director provided the surveyor with a copy of a work order dated for March 20, 2017 which stated " ...Plate warmer is not heating ..." The completed date was documented as March 29, 2017. No further information was provided to the surveyor prior to the exit conference on 10/26/17.	F 371		
F 507 SS=D	483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS (a) Laboratory Services (2) The facility must-	F 507		

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F 507	Continued From page 40 (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to maintain laboratory test results in the clinical record for 1 of 17 residents in the survey sample (Resident #2). The findings included: The facility staff failed to maintain laboratory tests results in the clinical record for Resident #2. Resident #2 was readmitted to the facility on 4/8/15 with the following diagnoses of, but not limited to high blood pressure, diabetes, Alzheimer's Disease, Malnutrition, edema, allergies, gout and dementia. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/4/17, Resident #2 was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. The clinical record review of Resident #2 was reviewed by the surveyor on 10/25/17. On the Physician Order Sheets for the month of June, 2017, the following orders were noted: BMP, CBC and HgbA1C every 6 months in June and December. During the clinical record review, the surveyor could not find the above laboratory test results in the clinical record for the month of June. At 2:05 pm, the administrative team was notified of the above documented findings by the surveyor.	F 507	1. The DON called the hospital and the missing 2 routine labs were received on 10/25/17, placed in the resident record and were shown to the surveyors. 2. Any resident receiving routine labs is at risk to be effected. 3. The facility uses a Lab Tracking book and the log showed receipt of these labs, however they were not in the chart. Staff places labs in the folder for the physician to review and make recommendations if needed. Labs are then filed by the unit secretary or designee. 4. QA will audit 10% of routine labs for 6 months.	5. 11/30/17

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F 507	Continued From page 41 At 4:30 pm, the director of nursing (DON) provided the surveyor with copies of the above ordered laboratory tests for the month of June. The surveyor asked the DON where these copies were found and the DON replied, "The lab was called and these results were faxed to us." At the top of the copies that the surveyor was given, the date of 10/25/17 and time of 4:02 pm was noted. No further information was provided to the surveyor prior to the exit conference on 10/26/17.	F 507		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 514		

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F 514	Continued From page 42 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 1 of 17 residents in the survey sample, Resident #9. The findings included: Facility staff administered Lortab 5/325 mg to Resident #9 while having an active allergy to acetaminophen and failed to clarify sliding scale coverage for Novolog insulin. Resident #9 was originally admitted to the facility on 9/1/13 and was readmitted on 10/11/17. Diagnoses included but not limited to: chronic low back pain, IDDM, (insulin dependent diabetes mellitus) hypertension, anxiety, and depression. The most recent MDS (minimum data set) for Resident #9 was an admission assessment with an ARD (assessment reference date) of 10/18/17. Resident #9 scored 15 out of 15 on her cognitive status indicating that she was cognitively intact. On 10/25/17 at 3:55 p.m. the clinical record for Resident #9 was reviewed. Upon reviewing the clinical record it was noted that acetaminophen	F 514	1. The record for Resident #9 was corrected on 10/25/17 to remove the medication as an allergy, using previous admission records and assessment. The allergy was incorrect information from the hospital. The sliding scale Novolog was clarified on 10/25/17. 2. All residents with a medication allergy or receiving insulin have the potential to be effected. 3. The pharmacy sent the medication and the nurse did not double check the allergy list. The facility has since began service with a new pharmacy on 11/1/17. Their software has the ability to crosscheck allergies. The admitting nurse will verify list of allergies with the resident and/ or their representative at admission to ensure the allergy information is correct.	

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F 514	Continued From page 43 was listed as an active allergy for Resident #9. The current MAR (medication administration record) had an order for Lortab 5/325 mg (milligram) by mouth every 6 hours as needed for pain/ The current MAR reflected that Resident #9 received Lortab 5/325 mg on 10/12/17, 10/15/17, 10/17/17, and 10/24/17. Also noted on the current MAR for Resident #9 was an order for Novolog 100u/ml (units per milliliter) for SSC (sliding scale coverage) Q ac&hs (before meals and at hour of sleep) if blood sugar 150-200 give 2 units, 200-250 give 4 units, 250-300 give 6 units, >300 give 8 units. On 10/25/17 at 4:43 p.m. surveyor spoke with LPN #1 in reference to Resident #9 being administered Lortab while having an active allergy to acetaminophen, and regarding the need for clarification of the Novolog sliding scale coverage. LPN#1 stated "I believe the doctor is aware of that and said it's ok for her to take it." Surveyor then asked LPN #1 "If that were the case don't you feel that the allergy to acetaminophen should have been discontinued?' LPN #1 stated "yeah" LPN#1 stated that she would speak to someone about the acetaminophen allergy and would get the Novolog sliding scale coverage clarified. On 10/25/17 at 4:47 p.m. LPN #1 informed the surveyor that she had spoken with the nurse practitioner and had received an order to discontinue the acetaminophen allergy and that the Novolog sliding scale coverage had been clarified. On 10/26/17 at 11:40 am the administrator and DON (director of nursing) were made aware of	F 514	4. QA will audit 10% of charts for the allergy list to current medications for 6 months.	5. 11/30/17

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F 514	Continued From page 44 the above findings. No further information was provided to the survey team prior to the exit conference.	F 514		

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