COMMONWEALTH of VIRGINIA

Virginia Veterans Care Center
Department of Veterans Services

William J. Van Thiel
Administrator

4550 Shenandoah Avenue N.W.
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FACSIMILE TRANSMITTAL SHEET

TO:	FROM:
Mr. Rodney Miller	Bill Van Thiel
COMPANY:	DATE:
Office of Licensure and Certification	3/14/2016
FAX NUMBER:	TOTAL NO. OF PAGES INCLUDING COVER:
804-527-4501	29

Dear Mr. Miller,

Accompanying this cover is our plan of correction for the survey ending February 19, 2016.

While not required to be addressed in the written Plan of Correction, please be assured that we are addressing the citations on the "A' Form as well.

A "hard copy" is in the mail.

If you have any questions, or need additional information, please contact me.

Sincerely,

William J. Van Thiel
Administrator

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

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
	495274	A. BUILDING _____ B. WING _____	C 02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA VETERANS CARE CENTER	4550 SHENANDOAH AVE N W ROANOKE, VA 24017

(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 2/17/16 through 2/19/16. One complaint was 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 180 certified bed facility was 164 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents 1 through 22) and 3 closed record reviews (Residents 23 through 25).	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to provide dining services to promote the resident ' s dining experience with dignity and respect and the staff members also failed to respond in a dignified manner to residents with cognitive impairments while dining on 2 of 2 units. The facility failed to promote dignity for 1 of 25 residents (Resident #4) while dining. The findings include:	F 241	1. Resident #4 dignity while dining - was given his tray as soon as issue was identified. 2. All residents have the potential to be affected. 3. Staff received in-service on dining requirements, dignity and food/tray set-up requirements. Unit managers and/or charge nurses will monitor the dining rooms at meal times to ensure deficient practice will not reoccur. 4. Nursing Management will monitor the dining rooms to ensure that the solutions are maintained. Comp Date 3/30/16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	3/14/16

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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F 241	Continued From page 1	F 241		

For unit #1, the facility staff failed to respond in a dignified manner to residents with cognitive impairments by not serving residents timely and in order of seating in the main dining room.

On 2/18/16 at 8:20am, the surveyor walked into the dining room and observed residents sitting at various tables. Other residents were coming into the dining room by themselves, and also with the assistance of the staff. Three meal carts were observed in the room with the doors open on two of them.

Table one was observed to have 4 residents at the table; a CNA was serving one of the residents his meal tray. After she finished she left the room. A male CNA, CNA #9, walked to the table at 8:35am and set up trays for the two residents and then walked away from the table walking around the room and looked through the window on the door at the end of the room. The 4thResident at the table was not served his meal tray.

A resident came into the room and walked to table one and sat down with the assistance of a CNA.
Another resident rolled in his wheel chair to the end of table one. CNA #9 returned to the table and served these two men their meal tray; but did not serve the man who was already at the table not eating. CNA #9 went to table D and served another man his meal tray and began to feed him his meal. There were two other residents: one was eating, the other had not been served at the table.

The surveyor attempted to speak with the

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F 241	Continued From page 2	F 241		

resident at table one who was not served but he was cognitively unable to respond to questions.

At 8:45am, a CNA walked into the room and served the 4th resident his meal tray. Twenty minutes from the time the first resident at table one was served.

The restorative table was observed at 8:45am, all but one of the residents had been served and were eating. The Restorative CNA was at the table and was asked why this resident was not served. She said, " There is a seating assignment and he is at the wrong table. " She made no attempt to assist the resident to his table. At 9:05am, the restorative CNA was observed feeding the resident who was not at his correct table.

At 9:05am, Table D was observed to have the one Resident who had not been served his meal tray. At 9:10 am, CNA #9 was asked why the one resident at table D was not served and he said, " I don ' t know. I work night shift and not sure how it ' s done. "

On 2/18/16 at approximately 3:00 pm, during a meeting with the administrative staff the random serving of the meal trays and how the staff failed to respond in a dignified manner to residents with cognitive impairments by not serving residents timely and in order of seating in the main dining room was discussed.

Prior to exit on 2/19/16, no further information was provided to the surveyor related to the serving of the meal trays and failure of the staff to respond in a dignified manner to residents with cognitive impairments by not serving the resident

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F 241	Continued From page 3	F 241		

at the same time frame as the other residents at their table.
2 Facility staff failed to maintain dignity during the dining experience for Resident #4 The resident was admitted to the facility on 7/20/10. His diagnoses included dementia, hypertension, arthritis and asthma.

Resident #4's MDS (minimum data set) assessment coded the resident with severe cognitive impairment. The resident required the assistance of at least one staff member to accomplish the ADLs (activities of daily living.)

The resident's CCP (comprehensive care plan) revised on 1/28/16 documented the nutritional problem of weight instability... mechanically altered therapeutic diet. Significant weight loss x 180 days. The interventions to staff were "Provide and serve diet as ordered. Provide a variety of fluids on meal tray to promote hydration,...Provide foods that are dense in Kcal (calories) and protein as indicated by MD orders.

Resident #4's physician's orders, signed and dated electronically, on 1/5/16, included this diet order, "High protein high calorie diet, pureed texture."

The resident's weights were reviewed. The weight on 1/29/15 was 208 pounds. On 1/26/16 the resident's weight was 186. A 22 pound loss over twelve months.

On 2/18/16 at 12:00 noon the surveyor joined Resident #4 in the dining room for his lunch meal. CNA II was assisting at this meal.

Resident #4 was at a table with four other

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F 241	Continued From page 4 residents--they were eating unassisted while Resident #4 sat and watched them eat. His tray arrived 20 minutes later, after the other diners were finishing up. CNA II set up the tray (which was complete for all items listed on the card) but did not open and use the three packets of whipped spread/butter or use the packet of sugar. On 2/18/16 at 4:00 PM the administrator and DON were informed of all the above observations prior to exit that day. The DON said there was a better way to do that. No additional info was provided.	F 241		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and clinical record review, it was determined the facility staff failed to provide ADL (activities of daily living) assistance for 2 of 25 residents (Resident #4 and Resident #16) for food tray set-up and reconciliation of the items listed on tray card but missing from the plate. Findings: 1. Facility staff failed to set up Resident #4's dietician approved meal tray so the resident would benefit from all the calories provided on the	F 312	1. Resident #4 and #16 food tray setup - At the time the deficient practice was noted, the issue was corrected. 2. All residents have the potential to be affected. 3. Nursing staff will be educated regarding the importance of asking cognitively appropriate residents what their condiment preferences may be during meal set-up or feeding. Staff also educated on adhering to residents diet and caloric recommendations, 4. Nursing management will randomly audit tray setup in the dining room. Comp Date 3/30/16	

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F 312	Continued From page 5	F 312		

tray. The resident's clinical record was reviewed on 2/18/16 at 9:30 AM

The resident was admitted to the facility on 7/20/10. His diagnoses included dementia, hypertension, arthritis and asthma.

Resident #4's MDS (minimum data set) assessment coded the resident with severe cognitive impairment. The resident rquired the assistance of at least one staff member to accomplish the ADLs (activities of daily living.)

The resident's CCP (comprehensive care plan) revised on 1/28/16 documented the nutritional problem of weight instability....mechanically altered therapeutic diet. Significant weight loss x 180 days. The intervetions to staff were "Provide and serve diet as ordered. Provide a variety of fluids on meal tray to promote hydration.....Provide foods that are dense in Kcal (calories) and protein as indicated by MD orders.

Resident #4's physician's orders, signed and dated electronically, on 1/5/16, included this diet order, "High protein high calorie diet, pureed texture."

The resident's weights were reviewed. The wieght on 1/29/15 was 208 poinds. On 1/26/16 the resident's weight was 186 A 22 pound loss over twelve months.

On 2/18/16 at 8:15 AM Resident #4 was observed in the dining room eating breakfast. CNA I was assisting him with his meal. The surveyor reviewed the meal and observed two items on the tray card were missing from the tray - Prune Juice -4 oz. and Coffee - 8 oz. CNA I did

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F 312	Continued From page 6	F 312		

not seem to notice they were missing and did not replace the missing items during the meal.

The breakfast included pureed breakfast sausage, scrambled eggs, pureed toast and pureed fortified cereal. The lid was still on the oatmeal when the surveyor joined them. Three pats of butter/whipped remained unopened on the tray. One packet of artificial sweetner remained unopened.

CNA I opened the oatmeal and started feeding it to the resident. She never added the butter of sweetner to anything on the tray. Resident #4 finished his meal and the packets were disposed of--unopened.

On 2/18/16 at 9:00 AM the DOM (dietary operations mananger) was questioned about the fortified cereal content and the use of condiments on the resident's tray. The DOM said they fortified the cereals in the kitchen with fortified milk, sugar and margarines. The DOM went on to explain the dietician had determined the number of calories required by this resident and that all foods and condiments are added to meet these requirements. "I look at special diets as a prescription from the dietician. Any extra butter should be added to bread or eggs or cereal to ensure the entire caloric requirement is met.

When asked about the missing coffee and prune juice, included as extra fluids in Resident #4's CCP--but not on his tray when it arrived from the kitchen, he said whoever set up the tray should have notified the kitchen if anything was missing.

On 2/18/16 at 12:00 noon the surveyor joined Resident #4 in the dining room for his lunch meal.

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F 312	Continued From page 7	F 312		

CNA II was assisting at this meal.

Resident #4 was at a table with four other residents--they were eating unassisted while Resident #4 sat and watched them eat. His tray arrived 20 minutes later, after the other diners were finishing up. CNA II set up the tray (which was complete for all items listed on the card) but did not open and use the three packets of whipped spread/butter or use the packet of sugar

On 2/18/16 at 10:30 AM the DON (director of nursing) was informed of the breakfast observation. The DON said it was her expectation that the staff providing tray set-up would assist the resident to cut up all foods and add condiments as well. The DON said any discrepancies noted on the cards should be reported to the kitchen.

The administrator and DON were informed of all the above observations pror to exit that day. No additional info was provided.

2. Facility staff failed to assist Resident #16 obtain requested meal items and failed to set up tray with all selected items on the dietary card made by Resident #16. Resident #16's clinical record was reviewed on 2/18/16 at 10:00 AM

The resident was admitted to the facility on 2/24/15. The diagnoses included Anemia, Atrial-fibrillation, Hypertension, Diabetes, Seizures, Anxiety and Depression.

Resident #16's MDS (minimum data set) assessment dated 1/20/16 coded the resident as cognitively unimpaired. He required the assistance of nursing staff members for all the

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F 312	Continued From page 8	F 312		

activities of daily living with set-up and oversite only to eat.

Resident #16's CCP (comprehensive care plan) revised on 2/4/16, documented the problem, "Nutritional problem....nutritional problem of weight loss risk r/t diagnosis of dysphagia. Potential for diet texture intolerance r/t past history of such..." The interventions included, "Honor resident preferences...."

On 2/18/16 at 8:10 AM, Resident #16 called the surveyor over to his dining room table to speak to same. The resident's tray card (breakfast meal) was observed to have "omelet" on it. The resident's plate contained two (untouched) fried eggs.

Resident #16 told the surveyor he did not like fried eggs--he preferred an omelet with cheese. The surveyor called CNA I over to assist Resident #16 with his meal selection. CNA I said she was agency and did not know what the resident wanted--to ask another staff member.

RN I then came to the table to determine what Resident #16's needs were. She ordered an omelet with cheese from the kitchen.

At 9:00 AM the DOM (dietary operations manager) was interviewed. He acknowleged the resident preferred omelets for breakfast. "He didn't get one this morning because he was on the early feeding list and we didn't have anyone here that made omelets."

The administrator was informed of the surveyor's findings on 2/18/16 at 09:15 AM. The administrator noted, "We have pre-made

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F 312	Continued From page 9 omelets." The administrator told the surveyor the line manager had been interviewed and told him, "I just missed." On 2/18/16 at noon the resident's tray card had herbed pork loin-4 0z. The selection underneath was Gravy-4 oz. There was no gravy on Resident #16's tray. The resident told the surveyor he did like gravy on his pork. No additional info was provided prior to exit.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a hazard free environment in 2 resident rooms that affected 3 out of 25 residents (including Resident #13) and failed to ensure medications were secured on 1 of 3 units. The findings include: 1. The facility staff failed to ensure Resident #13's bathroom was free of hazards. The entrance to the shower had missing tiles and the dry wall above the missing tiles was jagged and protruded outward. Resident #13 was admitted to the facility 6/24/15	F 323		

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F 323	Continued From page 10	F 323		

with diagnoses that included hypothyroidism, hyperlipidemia, post-traumatic stress disorder, hypertension, atrial flutter, chronic pain, diabetes mellitus type 2, depressive disorder, insomnia, gastroesophageal reflux disease, and vascular dementia with behavioral disturbances.
Resident #13's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/31/15 assessed the resident with a cognitive summary score of 15 out of 15 in Section C. Resident #13 was assessed to need supervision for ambulation in room and corridor.
The surveyor interviewed Resident #13 on 2/17/16 at 3:50 p.m. The surveyor observed Resident #13's room including the bathroom. The bathroom was a connecting room and contained a toilet and a shower. At the base of the shower along the outside of the right wall, the surveyor observed multiple missing tiles. The area measured approximately 6 inches by 6 inches. Above the area where the tile was missing, the surveyor observed some of the dry wall to be missing and what was there was jagged and protruded outward at the base.
The surveyor observed the same area in the shower on 2/18/16 at 8:00 a.m. and again at 1:00 p.m. The surveyor notified the unit manager licensed practical nurse #3 of the above concern. The unit manager stated she would inform maintenance of the above concern.
The surveyor informed the administrator, the director of nursing and the director of quality improvement of the above concern on 2/18/16 at 2:20 p.m.
No further information was provided prior to the exit conference on 2/19/16.
2. Facility staff failed to maintain a safe, accident - free environment for facility residents.

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F 323 Continued From page 11

On 2/18/16 at 8:15 AM while on a tour through the building, the surveyor observed the bathroom adjoining room 238 and 240. The bathroom had an in-room shower with ceramic tile covering the bottom of the wall.

The tile was broken and sharp. In one area, all the tile was removed and a piece of metal was protruding out of the wall.

The administrator was notified of these findings on 2/18/16 at 2:30 PM.
3. During a medication pass and pour observation LPN (licensed practical nurse) #2 left a bottle of certavite senior on top of the medication cart and out of her direct observation. The surveyor was able to observe Residents and staff out in the hallway in the vicinity of the medication cart.

On 02/18/16 beginning at approximately 8:05 a.m. the surveyor observed LPN #2 during a medication pass and pour observation. During this observation LPN #2 pulled a bottle of certavite senior from the medication cart and placed it on top of the medication cart.

LPN #1 prepared unsampled Resident #1's medication, locked the medication cart, and entered the Residents room. LPN #1 left the certavite senior on top of the medication cart and out of her direct observation.

After leaving unsampled Resident #1's room LPN #2 pushed the medication cart to unsampled Resident #2's room. LPN #2 prepared the Residents medication for administration, placed all the medications back into the medication cart except the certavite senior, and entered the

F 323 1. One bathroom with safety concern related to hazardous tiles.
2. All residents have the potential to be affected.
3. Broken and/or missing tiles were immediately repaired after identification of hazard.
4. All staff reminded to monitor resident areas for safety concerns and report them immediately to maintenance for repair.

Comp Date 2/20/16

F 323 1. Residents safety concern related to medications not secured. As soon as deficient practice was brought to nursing attention, the issue was corrected.
2. All residents have the potential to be affected.
3. Medication nurse were reminded regarding the importance of not having any medications, including vitamins, on top of the med cart unless it is within eye line sight at all times.
4. Unit managers and supervisors will monitor to ensure deficient practice does not reoccur.

Comp date 3/30/16

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

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
	495274	A. BUILDING _____ B. WING _____	C 02/19/2016

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F 323	Continued From page 12 Residents room and administered the Residents medications. The surveyor observed Residents and numerous staff in the vicinity of the medication cart during this observation. On 02/18/16 at approximately 8:30 a.m. the surveyor interviewed LPN #2 and asked her about the certavite being left on top of the medication cart. LPN # 2 stated "I'm sorry." The administrator, DON (director of nursing), and QI (quality improvement) nurse were notified of the unsecured medication in a meeting with the survey team on 02/18/16 at approximately 2:25 p.m.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and clinical record review, it was determined the facility staff failed to provide a	F 325		

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	Continued From page 13	F 325		

physician ordered and dietician recommended diet complete with all calories for 1 of 25 residents who had a significant weight loss.

Findings:

1. Facility staff failed to set up Resident #4's dietician approved meal tray complete with all ordered food and drinks so the resident would benefit from all the calories provided on the tray. The resident's clinical record was reviewed on 2/18/16 at 9:30 AM.

The resident was admitted to the facility on 7/20/10. His diagnoses included dementia, hypertension, arthritis and asthma.

Resident #4's MDS (minimum data set) assessment coded the resident with severe cognitive impairment. The resident required the assistance of at least one staff member to accomplish the ADLs (activities of daily living.)

The resident's CCP (comprehensive care plan) revised on 1/28/16 documented the nutritional problem of weight instability....mechanically altered therapeutic diet. Significant weight loss x 180 days. The interventions to staff were "Provide and serve diet as ordered. Provide a variety of fluids on meal tray to promote hydration.....Provide foods that are dense in Kcal (calories) and protein as indicated by MD orders.

Resident #4's physician's orders, signed and dated electronically, on 1/5/16, included this diet order, "High protein high calorie diet, pureed texture."

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 325	Continued From page 14	F 325		

The resident's weights were reviewed. The weight on 1/29/15 was 208 pounds. On 1/26/16 the resident's weight was 186. A 22 pound loss over twelve months.

On 2/18/16 at 8:15 AM Resident #4 was observed in the dining room eating breakfast. CNA I was assisting him with his meal. The surveyor reviewed the meal and observed two items on the tray card were missing from the tray - Prune Juice -4 oz. and Coffee - 8 oz. CNA I did not seem to notice they were missing and did not replace the missing items during the meal.

The breakfast included pureed breakfast sausage, scrambled eggs, pureed toast and pureed fortified cereal. The lid was still on the oatmeal when the surveyor joined them. Three pats of butter/whipped remained unopened on the tray. One packet of artificial sweetener remained unopened.

CNA I opened the oatmeal and started feeding it to the resident. She never added the butter of sweetener to anything on the tray. Resident #4 finished his meal and the packets were disposed of--unopened.

On 2/18/16 at 9:00 AM the DOM (dietary operations manager) was questioned about the fortified cereal content and the use of condiments on the resident's tray. The DOM said they fortified the cereals in the kitchen with fortified milk, sugar and margarine. The DOM went on to explain the dietician had determined the number of calories required by this resident and that all foods and condiments are added to meet these requirements. "I look at special diets as a prescription from the dietician. Any extra butter

PRINTED: 03/03/2016
FORM APPROVED
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F 325 Continued From page 15

should be added to bread or eggs or cereal to ensure the entire caloric requirement is met.

When asked about the missing coffee and prune juice, included as extra fluids in Resident #4's CCP--but not on his tray when it arrived from the kitchen, he said whoever set up the tray should have notified the kitchen if anything was missing.

On 2/18/16 at 12:00 noon the surveyor joined Resident #4 in the dining room for his lunch meal. CNA II was assisting at this meal.

Resident #4 was at a table with four other residents--they were eating unassisted while Resident #4 sat and watched them eat. His tray arrived 20 minutes later, after the other diners were finishing up. CNA II set up the tray (which was complete for all items listed on the card) but did not open and use the three packets of whipped spread/butter or use the packet of sugar.

On 2/18/16 at 10:30 AM the DON (director of nursing) was informed of the breakfast observation. The DON said it was her expectation that the staff providing tray set-up would assist the resident to cut up all foods and add condiments as well. The DON said any discrepancies noted on the cards should be reported to the kitchen.

The administrator and DON were informed of all the above observations prior to exit that day. No additional info was provided.

F 325 1. Resident #4 missing food items on tray. At the time the deficient practice was noted, the issue was corrected.
2. All residents have the potential to be affected.
3. Nursing staff will be educated regarding the importance of adhering to residents diet and caloric recommendations. Dietary staff counseled and in-serviced on ensuring tray card menu is followed as listed.
4. Nursing management will randomly audit tray setup in the dining room.

Comp Date 3/30/16

F 328 SS=D 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS

F 328

The facility must ensure that residents receive

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

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

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F 328	Continued From page 16	F 328		

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 upon staff interview and clinical record review, the facility staff failed to check and record residual amounts of enternal tube feeding for 1 of 25 residents in the survey sample (Resident #3).
The findings included:
The facility staff failed to check and record residuals every shift while tube feeding was being administered to Resident #3.
Resident #3 was admitted to the facility on 2/11/13 with the following diagnoses, of but not limited to end stage renal failure, high blood pressure, anemia, diabetes, chronic obstructive pulmonary disease, gastrostomy and venous insufficiency. Resident #3 was readmitted to the facility on 12/29/15. On Resident #3 ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/11/16, the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of 15.
Resident #3 requires extensive assistance with 2 or more staff members with personal care and bathing.
During the clinical record review on 2/18/15, the following order was noted dated for 8/25/15 and under order status was documented as active: "

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FORM APPROVED
OMB NO. 0938-0391

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

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F 328	Continued From page 17 Enternal Feed Order every shift Check & record residuals q (every) shift while tube feeding running, if residual is greater than 100 Hold tube feeding, recheck q hour until less than 60 ml (milliliters), then resume tube feeding as ordered. Notify MD (medical doctor) of high residuals " . Upon further review of Resident #3 ' s clinical record, there were no residuals amounts recorded every shift while the tube feeding was being administered. On 2/18/16 at 2:30 pm, the director of nursing and administrator was notified of the above findings. The director of nursing stated that she went back and looked at all the residents that have this order but the order also stated to record. The director of nursing also stated " what we found was documentation all over the place with no consistency. We have put in a ticket into Point Click Care to have this resolved. No further information was provided to the surveyor prior to the exit conference on 2/18/16.	F 328	1. Resident #3 tube feeding residuals not recorded. After discussion with the facility Registered Dietician, Physician's Assistant and Medical Director, all tube feeding orders and documentation requirements will be clarified to ensure compliance with physician's orders. 2. All residents have the potential to be affected. 3. Nursing management will do random audits of tube feeding orders to ensure that tube feeding orders are adhered to. 4. DON and nursing supervisor will monitor current tube feeding orders for compliance. Comp Date: 3/30/16	
F 371 SS=C	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 371		

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
	495274	A. BUILDING _____ B. WING _____	C 02/19/2016

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F 371	Continued From page 18 facility staff failed to ensure a sanitary kitchen environment. The findings included: The facility staff failed to ensure kitchen employees hair/beard/moustache was covered while preparing Residents food. While observing tray line set up on 02/18/16 at approximately 1315, surveyor observed a female kitchen employee working on the tray line, setting up food trays. This female employee had a hair net on, but her hair was not completely contained beneath it. Surveyor also observed a male staff with full beard and moustache working on the tray line, placing food on trays. This male employee was wearing a beard restraint, but it did not cover his moustache. Surveyor pointed these two things out to the food service manager, who was accompanying surveyor at the time. The food service manager acknowledged the surveyor's concern. The concern of the unrestrained hair was brought to the attention of the administrative staff during a meeting on 02/18/16 at approximately 1425. No further information was provided prior to exit.	F 371	1. Kitchen employees did not follow sanitary requirement for food service. Beards were properly covered, and employee with mustache resolved issue by shaving his off several days later. 2. All residents have the potential to be affected. 3. All kitchen staff were educated on the requirement for proper hair and beard coverings. 4. The Director of Food Service will monitor all staff to ensure compliance with sanitary requirements. Comp Date: 3/30/16	
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal	F 386		

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

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

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F 386	Continued From page 19	F 386		

polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

This REQUIREMENT is not met as evidenced by:
Based upon staff interview and clinical record review, the facility staff failed to have the physician review the plan of care after a hospitalization for 1 of 25 residents in the sample survey (Resident #3).
The findings included:
The physician failed to review the plan of care after a hospitalization for Resident #3.
Resident #3 was admitted to the facility on 2/11/13 with the following diagnoses, of but not limited to end stage renal failure, high blood pressure, anemia, diabetes, chronic obstructive pulmonary disease, gastrostomy and venous insufficiency. Resident #3 was readmitted to the facility on 12/29/15. On Resident #3 ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/11/16, the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of 15.
Resident #3 requires extensive assistance with 2 or more staff members with personal care and bathing.
During the clinical record review on 2/18/16, it was noted that History and Physical note was not documented by the physician after Resident #3 was discharged from the hospital on 8/25/15. Resident #3 was discharged from the hospital on 9/8/15, 11/25/15 and 12/29/15. On all the History and Physical notes received from the hospital for these dates, the physician had made a notation that stated " H & P (History and Physical) to be approved for the facility ' s H & P " and signed by

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F 386	Continued From page 20 the attending physician at the facility. There was no such notation made on the H & P from the hospital when the resident was discharged back to the facility on 8/25/15. On 2/18/16 at 1:50 pm, registered nurse (RN) #1 was interviewed in the conference room. RN #1 stated " As far as the progress notes for 9/8/15, 11/25/15 and 12/29/15, the resident came back from the hospital and have H & P notes that the MD (medical doctor) signed the H & P to be approved for the facility ' s H & P. That ' s the way he usually does that. But on 8/25/15, there is not a notation on that H & P from the hospital stating that " . On 2/18/16 at 2:30 pm in the conference room, the director of nursing and administrator was notified of the above documented findings. No further information was given to the surveyor prior to the exit conference on 2/18/16.	F 386	1. Admission H&P paperwork process was not followed during the two readmission dates mentioned due to the absence of the facility Director of Medical Records. 2. All residents have the potential to be affected. 3. The admission staff and the medical records staff were educated on the need to ensure those documents are obtained in a timely manner and a change in protocol was put in place. 4. The Medical Records Director will track all H&P notes for compliance. The QI Director will conduct random audits to ensure compliance. Comp Date: 3/30/16	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW. REPORT IRREGULAR. ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based upon staff interview and clinical record review, the facility staff failed to have drug	F 428		

PRINTED: 03/03/2016
FORM APPROVED
OMB NO. 0938-0391

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

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F 428	Continued From page 21 regimen reviews on a monthly basis by pharmacy for 1 of 25 residents in the sample survey (Resident #3). The findings included: The pharmacy did not provide a monthly drug regimen review for Resident #3. Resident #3 was admitted to the facility on 2/11/13 with the following diagnoses, of but not limited to end stage renal failure, high blood pressure, anemia, diabetes, chronic obstructive pulmonary disease, gastrostomy and venous insufficiency. Resident #3 was readmitted to the facility on 12/29/15. On Resident #3 ' s MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 1/11/16, the resident had a BIMS (Brief Interview for Mental Status) score of 15 out of 15. Resident #3 requires extensive assistance with 2 or more staff members with personal care and bathing. During the clinical record review on 2/18/15, it was noted the following pharmacy reviews were dated and documented in the clinical record for Resident #3: 7/20/15, 8/22/15, 9/22/15 and 1/22/16. The director of nursing was notified of the above findings on 2/18/16 at approximately 3:30 pm. The director of nursing stated that she would look into this. On 2/19/16 at approximately 7:30 am in the conference room, the director of nursing stated that the resident was out of the building and in the hospital during the months of November and December for at least 25 days. The director of nursing stated, " I could not find a pharmacy review for the month of October ". No further information was provided to the surveyor prior to the exit conference on 2/18/16.	F 428	1. The pharmacy drug review for Resident #3 lacked documentation for October. 2. All residents have the potential to be affected. 3. The pharmacist conducting monthly drug regimen reviews will utilize current census sheet and drug cart checks to ensure that all residents are reviewed monthly. The initial monthly reviews will be conducted on an earlier date to allow for a second review date if needed. 4. QI Director will conduct random quarterly audits to ensure compliance. Comp Date: 3/30/16	

PRINTED: 03/03/2016
FORM APPROVED
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441 SS=D	Continued From page 22 483.65 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 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.	F 441	F 441 1. Infection Control program noncompliance. No resident was found to have been directly affected by this practice. 2. All residents have the potential to be affected. 3. Infection Control nurse educated regarding the importance of documenting all organisms on the infection control line item sheet. 4. Nursing management will monitor to ensure deficient practice does not reoccur. Comp Date: 3/30/16	

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

PRINTED: 03/03/2016
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
	495274	A. BUILDING _____ B. WING _____	C 02/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA VETERANS CARE CENTER	4550 SHENANDOAH AVE N W ROANOKE, VA 24017

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F 441	Continued From page 23	F 441		

This REQUIREMENT is not met as evidenced by
Based on staff interview and facility document review, the facility staff failed to ensure an effective infection control program.
The findings included:

During the entrance conference on 2/17/16, the surveyor requested the infection control line list (tracking form for facility infections) from March 2015 through February 2016 from the administrator.
When the infection control line listing was provided to the surveyor by the infection control registered nurse, the form was incomplete. The infection control line listing form did not provide information if the infection was community acquired or facility acquired, the identity of the organism/culture results or if the infection had been resolved or was ongoing.
The surveyor interviewed the infection control registered nurse on 2/18/16 at 7:30 a.m. The infection control R.N. #1 stated the only organism s that she tracked and placed on the infection control line listing form were those that required isolation. She gave examples of MRSA (methicillin resistant staphylococcus aureus) and ESBL (Extended-Spectrum ß-Lactamases). She stated she tracked organisms just didn't write them on the infection control line listing form. She also stated she didn't document when infections had been resolved.
The surveyor requested the facility infection control policy from the infection control R.N. #1 on 2/18/16.
The surveyor reviewed the facility policy titled "Infection Control Program" on 2/19/16. The

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	495274	A. BUILDING _____ B. WING _____	C 02/19/2016

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F 441	Continued From page 24	F 441		

policy read in part "The facility will maintain an Infection Control Program to provide systematic management of the infection control issues for residents and employees of the facility. 1. Infection Control Program elements will include: a. Collection and analysis of surveillance data to identify nosocomial infections and trends. b. A process for detection, investigation, and control of outbreaks of infectious diseases. c. Use of Standard and Transmission Based Precautions to reduce the risk of transmission. g. Monitoring of residents receiving antibiotics. h. Review and evaluation of products when indicated. i. Disease reporting to the Department of Health and other agencies as required. 3. The designated Infection Control Nurse is responsible for: f. Ongoing collection of data on healthcare-associated infections. h. Reviewing data and recommending infection control measures to correct identified problems. j. Calculate, analyze, and report nosocomial infection rates to the QI (quality improvement) committee. l. Implementing, monitoring, and evaluation of all aspects of the Infection Control Program."

The surveyor informed the administrator, the director of nursing and the director of quality improvement of the above finding on 2/19/16 at 10:20 a.m.

No further information was provided prior to the exit conference on 2/19/16.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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ATT
"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH EQUIVALENT POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER 495274	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING	DATE SURVEY COMPLETE 2/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA VETERANS CARE CENTER	4550 SHENANDOAH AVE N W ROANOKE, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES

The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility and make choices about aspects of his or her life in the facility that are significant to the resident

This REQUIREMENT is not met as evidenced by:
Based on observation, resident and staff interview and clinical document review, it was determined the facility staff failed to honor requested meal choices for 1 of 25 residents (Resident #16.)

Findings:

Facility staff failed to honor requested meal choices made by Resident #16. Resident #16's clinical record was reviewed on 2/18/16 at 10:00 AM.

The resident was admitted to the facility on 2/24/15. The diagnoses included Anemia, Atrial-fibrillation, Hypertension, Diabetes, Seizures, Anxiety and Depression.

Resident #16's MDS (minimum data set) assessment dated 1/20/16 coded the resident as cognitively unimpaired. He required the assistance of nursing staff members for all the activities of daily living with set-up and oversite only to eat.

Resident #16's CCP (comprehensive care plan) revised on 2/4/16, documented the problem, "Nutritional problem....nutritional problem of weight loss risk r/t diagnosis of dysphagia, Potential for diet texture intolerance r/t past history of such..." The interventions included, "Honor resident preferences...."

On 2/18/at 8:10 AM, Resident #16 called the surveyor over to his dining room table to speak to same. The resident's tray card (breakfast meal) was observed to have "omelet" on it. The resident's plate contained two (untouched) fried eggs.

Resident #16 told the surveyor he did not like fried eggs--he preferred and omelet with cheese. The surveyor called CNA I over to assist Resident #16 with his meal selection. CNA I said she was agency and did not know what the resident wanted--to ask another staff member.

RN I then came to the table to determine what Resident #16's needs were. She ordered an omelet with cheese from the kitchen.

At 9:00 AM the DOM (dietary operations manager) was interviewed. He acknowleged the resident preferred omelets for breakfast. "He didn't get one this morning because he was on the early feeding list and we didn't have anyone here that made omelets."

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

AH
"A" FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
NO HARM WITH POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	495274	A. BUILDING _____ B. WING _____	2/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIRGINIA VETERANS CARE CENTER	4550 SHENANDOAH AVE N W ROANOKE, VA

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 242	Continued From Page 1 The administrator was informed of the surveyor's findings on 2/18/16 at 09:15 AM. The administrator noted, "We have pre-made omelets." The administrator told the surveyor the line manager had been interviewed and told him, "I just missed." No additional info was provided prior to exit.
F 309	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 staff interview, clinical record review and facility document review, the facility staff failed to follow established bowel protocol for 1 of 25 Residents. Resident #1. The findings included: For Resident #1, the facility staff failed to follow bowel protocol. Resident #1 was admitted to the facility on 11/05/15 and readmitted on 12/07/15. Diagnoses included but not limited to anemia, hypertension, neurogenic bladder, diabetes mellitus, hyperlipidemia, thyroid disorder, dementia, seizure disorder, psychotic disorder, schizophrenia, chronic obstructive pulmonary disease, dysphagia, and constipation. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 01/25/16 coded the Resident as being severely impaired for cognitive skills for daily decision making. This is a significant change MDS. Resident #1's CCP (comprehensive care plan) was reviewed on 02/18/16. It contained a care plan for "has risk for constipation related to decreased mobility". Goals under this care plan are listed as "will pass soft, formed stool at a minimum of q3d (every 3 days)", with interventions for this plan listed as "monitor medications for side effects of constipation, monitor/document/report to MD PRN (as needed) s/sx (signs/symptoms) of complications related to constipation". Resident #1's bowel movement record was reviewed on 02/18/16. It indicated that Resident #1 had no bowel movements from 11/30/15-12/05/15, a total of 5 days and from 12/17/15-12/22/15, a total of 5 days. The surveyor spoke with the DON (director of nursing) on 02/18/16 at approximately 1330 regarding the

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

FORM CMS-2567(02-99) — Event ID: HHSM11 — If continuation sheet 3 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION — NOTE: BEFORE COMPLETING CORRECTIVE ACTION, KEY CORRECTIVE ACTION TO EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION FOR SSIG AND NFPA	PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER: 495274	MULTIPLE CONSTRUCTION: A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETED: 2/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 309	Continued From Page 2 missing bowel movements. The DON provided the surveyor with a copy of the facility's "Standing Orders For Minor Medical Problems". It contained a standing order for constipation which read in part "B. Constipation a) If no BM (bowel movement) x 3 days ... give Milk of Magnesia 30ml po (by mouth) daily PRN (as needed), times 2 days. If NO BM, then...b) Licensed Nurse check for impaction, c) Give Dulcolax suppository, 1 dose. If no relief within 1 hour, d) Give Fleet saline enema x1. If NO BM after 10-15 minutes, call MD." There was no documentation in the Residents clinical record that any of these steps had been taken. The concern of the bowel protocol not being initiated was discussed with the administrative staff during a meeting on 02/18/16 at approximately 1425. The facility QA (quality assurance) nurse stated to the surveyor that she did not understand why this had happened because she had the electronic record set up to alert nursing staff at 3 days and 5 days if a Resident did not have a bowel movement No further information was provided prior to exit.

Activity Report – Receive

Time : Mar-14-2016 03:41pm
Tel line :
Name :
Scan count : 100636 (0001891C)
Print count: 155391 (00025EFF)
Drum count : 77900 (0001304C)

Nbr.	Job	Date	Time	Duration	pgs	From	Dept.	Account	Mode	Status
401	965	Dec-26	01:54pm	00/35	001				EC 503	OK
402	966	Dec-31	12:31pm	00/58	002	7034420337			EC 502	OK
403	968	Feb-04	04:32pm	01/05	002	7575483370			G3 501	OK
404	971	Feb-27	11:07am	01/59	008				EC 503	OK
405	973	Mar-20	12:33pm	05/05	013	7036638826			EC 513	OK
406	985	May-05	03:05pm	00/50	001	8047302212			EC 512	OK
407	988	May-20	05:01pm	07/03	019	14346561329			EC 513	OK
408	003	Aug-15	03:05pm	00/52	002	804 725 0123			EC 502	OK
409	010	Oct-31	08:17am	00/24	000				EC 5 3	NG C1
410	011	Oct-31	08:19am	00/24	000				EC 5 3	NG C1
411	012	Oct-31	08:21am	00/24	000				EC 5 3	NG C1
412	013	Oct-31	08:23am	00/24	000				EC 5 3	NG C1
413	014	Oct-31	08:25am	01/07	004				EC 503	OK
414	026	Dec-02	04:58pm	00/58	002	703 670 0345			EC 512	OK
415	030	Dec-04	10:01am	00/33	001	8045274502			EC 502	OK
416	037	Dec-19	03:30pm	00/45	002	757 455 7092			EC 502	OK
417	052	Jan-28	01:22pm	00/57	002	5405368606			EC 513	OK
418	053	Jan-28	01:23pm	00/57	002	5405368606			EC 513	OK
419	058	Mar-18	09:44am	00/40	001	434 392 1569			EC 513	OK
420	059	Mar-20	01:40pm	00/42	002	4347994555			EC 503	OK
421	060	Mar-25	11:35am	00/41	002	7039314450			EC 502	OK
422	061	Apr-22	01:21pm	01/24	005				EC 503	OK
423	063	May-08	02:17pm	00/00	044	276 431 4718			EC 513	NG 20
424	064	May-08	02:35pm	24/34	063	276 431 4718			EC 513	NG 42
425	067	Jun-03	12:56pm	04/42	010				EC 512	OK
426	069	Jun-09	01:00pm	03/05	005	18189360160			G3 510	OK
427	072	Jul-10	11:39am	05/18	008	3012787406			EC 312	OK
428	076	Aug-07	10:51am	00/28	001	8045274502			EC 502	OK
429	081	Sep-01	07:59am	00/58	002	2061461			G3 501	OK
430	082	Sep-22	01:59pm	04/37	017				EC 503	OK
431	084	Sep-28	03:03pm	02/42	002	2766428090			EC 113	OK
432	087	Oct-30	01:45pm	00/37	002	804 967 9888			EC 503	OK
433	088	Nov-11	09:18am	00/54	002	8044384089			EC 503	OK
434	092	Dec-02	08:56am	00/41	002	2061461			EC 503	OK
435	095	Jan-07	05:20pm	00/40	002	276 628 8848			EC 503	OK
436	096	Feb-01	05:12pm	00/42	002	276 628 8848			EC 503	OK
437	097	Feb-01	06:25pm	00/48	002	276 628 8848			EC 503	OK
438	100	Feb-25	03:39pm	00/48	002				EC 513	OK
439	102	Mar-01	01:44pm	02/07	004	FOIPLY			EC 512	OK
440	104	Mar-14	03:34pm	07/21	029	5409828667			EC 503	OK