STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495316	A. BUILDING _____ B. WING _____	03/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARREN MEMORIAL HOSP LYNN CARE	1000 SHENANDOAH AVENUE FRONT ROYAL, VA 22630

(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 3/8/16 through 3/10/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 117 at the time of the survey. The survey sample consisted of 22 current resident reviews (Residents # 1 through # 21 and # 27) and five closed record reviews (Residents # 22 through # 26).	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a	F 278	F 278 MDS Comprehensive Assessments 1. Resident # 1, 3 and 4 MDS were corrected. 3/25/16 2. 100 percent audit of most recent comprehensive assessment for current residents was completed. Other variances were corrected. 3/25/16 3. MDS a. MDS Coordinators received re-education about reviewing section for accuracy of height and bowel continence . 3/25/16 b. MDS nurses to audit 100% of comprehensive assessments for accuracy before locking. 4. DON or designee will audit 10 comprehensive MDS for accuracy monthly. Any negative findings will be corrected immediately and results of monthly audit will be reviewed monthly the facilities QAPI meeting. 5. Corrective action will be completed on or before 3/31/16.	

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

[signature] | Administrator | 4/05/16

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 278	Continued From page 1	F 278		

resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for three of 27 residents in the survey sample, Resident #1, Resident #3, Resident #4.

1. The facility staff failed to correctly code Resident #1's height on the quarterly MDS assessment, with an ARD (assessment reference date) of 1/2/16.

2. The facility staff inaccurately coded Resident #3 as being totally continent of bowel on the admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/22/15.

3. Resident # 4's admission Minimum Data Set (MDS) assessment, with an ARD (assessment reference date) of 3/25/15, and the quarterly MDS assessment, with an ARD of 1/18/16, did not accurately reflect the resident's height.

The findings include:

1. Resident #1 was admitted to the facility on 10/15/15 and readmitted on 2/18/16 with diagnoses that included but were not limited to:

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F 278	Continued From page 2 chronic kidney disease, depression, diabetes, high blood pressure and elevated cholesterol. Resident #1's MDS, a quarterly assessment, with an ARD of 1/2/16 coded the resident as having a BIMS (brief interview of mental status) of nine, indicating the resident was moderately cognitively impaired to make daily decisions. The resident was coded as requiring staff assistance for all activities of daily living. In section K -- Swallowing/nutritional status under K0200 -- Height and weight coded Resident #1's height as 66 inches. Resident #1's admission MDS assessment, with an ARD of 10/22/15 in section K -- Swallowing/nutrition, under K0200 -- Height and weight coded Resident #1's height as 69 inches. An interview was conducted on 3/10/16 at 9:35 a.m. with RN (registered nurse) #1 and #2, the MDS coordinators. When asked who signed off the MDS assessments, RN #2 stated, "It's our responsibility." When asked what they looked for when signing off the MDS, RN #2 stated, "We look at the content (of the MDS) because it's our responsibility that it is accurate." When the heights from Resident #1's MDS assessments of 1/2/16 and 10/22/15 were reviewed with RN #1 and RN #2, RN #2 stated, "We missed it." On 3/10/16 at 1:20 p.m. the findings were reviewed with ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing. The facility's policy titled, "Minimum Data Sheets (MDS)/Care Plans" documented in part, "IV. Completion of the RAI (resident assessment	F 278		

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F 278	Continued From page 3 instrument)....The RN Assessment Coordinator with sign the MDS to certify it's completion within the timeline as directed by the RAI manual." No further information was provided prior to exit. 2. Resident #3 was admitted to the facility on 10/9/15 with diagnoses that included but were not limited to: *pneumonia, **Alzheimer's disease and ***epilepsy. Resident #3's most recent MDS, a quarterly assessment with an ARD of 1/13/16, coded the resident as being severely cognitively impaired. Section H coded Resident #3 as always incontinent of bowel. Resident #3's admission MDS with an ARD of 10/22/15 coded the resident as always continent of bowel. On 3/9/16 at 1:55 p.m., an interview was conducted with CNA (certified nursing assistant) #6. CNA #6 stated Resident #3 was somewhat incontinent of bowel and had been that way for a while. CNA #6 stated the resident's level of bowel continence hadn't drastically changed. On 3/9/16 at 2:06 p.m., RN (registered nurse) #1 (an MDS coordinator) was made aware of the above findings and asked to provide further information regarding Resident #3's level of bowel continence and coding of bowel continence on the MDS assessments. On 3/9/16 at 2:44 p.m., RN #1 stated she went through Resident #3's MDS assessments and care tracker (the program that tracks residents' activities of daily living). RN #1 stated she believed Resident #3's baseline was that the resident was fully incontinent of bowel and bladder. RN #1 stated she believed there was a	F 278		

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F 278	Continued From page 4 MDS coding issue but she couldn't speak for the MDS coordinator who completed the MDS. RN #1 stated that the MDS coordinator had left for the day but would return the next morning. On 3/9/16 at 5:20 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above findings. On 3/10/16 at 9:42 a.m., an interview was conducted with RN #2 (the MDS coordinator responsible for completing Resident #3's admission MDS). RN #2 stated she looked back at the nurses' notes through the ARD for Resident #3's admission MDS assessment. RN #2 stated she coded Resident #3's bowel continence wrong on the admission MDS and she should have coded a "3" (indicating the resident was always incontinent of bowel). RN #2 stated she references the RAI (Resident Assessment Instrument) manual when completing MDS assessments. On 3/10/16 at approximately 2:00 p.m., ASM #1 was made aware of the above concern. The facility policy titled, "Minimum Data Sheet (MDS)/ Care Plans" documented in part, "PURPOSE: To maintain ongoing holistic resident assessment in order to plan for delivery of quality care and quality of life, during staff at (name of facility). STATEMENT OF POLICY/PROCEDURE: Provides facility RAI process, to be used in conjunction with the Resident Assessment Instrument/Manual. Refer to CMS (Centers for Medicare & Medicaid Services) RAI version 3.0 SNF (Skilled Nursing Facility) Medicare Prospective Payment System	F 278		

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F 278	Continued From page 5 assessment schedule, manual with current updates..." The CMS RAI manual documented in part, "H0400 Bowel Continence: Coding Instructions: Code 0, always continent: if during the 7-day look-back period the resident has been continent of bowel on all occasions of bowel movements, without any episodes of incontinence...Code 3, always incontinent: if during the 7-day look-back period, the resident was incontinent of bowel for all bowel movements and had no continent bowel movements..." No further information was presented prior to exit. *Pneumonia is an infection of the lungs. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/pneumonia.html **Alzheimer's disease is a brain disorder that affects an individual's ability to carry out daily activities. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=alzheimer%27s+disease ***Epilepsy is a brain disorder that causes seizures. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=epilepsy 3. Resident # 4 was admitted to the facility on	F 278		

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F 278	Continued From page 6 3/18/15 with a readmission on 8/3/15. Resident # 4's diagnoses included but was not limited to: urinary tract infection* (an infection in the urinary tract), Parkinson's disease** (type of movement disorder), anxiety*** (a strong, irrational fear of something that poses little or no real danger), malnutrition, depression, chronic kidney disease**** (kidneys are damaged and can't filter blood as they should.), atrial fibrillation***** (a problem with the speed or rhythm of the heartbeat.) and osteoporosis (makes your bones weak and more likely to break). The most recent comprehensive MDS (minimum data set), an admission assessment with and ARD (assessment reference date) of 3/25/15 coded Resident # 4 as scoring a seven on the brief interview for mental status (BIMS) of a score of 0 - 15, seven- being severely impaired of cognition for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for activities of daily living. Review of Section K0200 "Height and Weight" coded Resident # 4's height as 64 inches. Review of the most recent MDS, a quarterly assessment with and ARD of 1/18/16 coded Resident # 4 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10- being moderately impaired cognition for making daily decisions. Review of Section K0200 "Height and Weight" coded Resident # 4's height as 62 inches. On 3/10/16 at 9:40 a.m., in an interview with RN (registered nurse) # 1, MDS coordinator, and RN # 2, MDS coordinator. When asked about the accuracy of MDS assessments, RN # 1 stated, "It's our responsibility to make sure the MDS is accurate." After reviewing Resident # 4's admission MDS with the ARD of 3/25/15 and the quarterly MDS with the ARD of 1/18/16, RN # 1	F 278		

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F 278	Continued From page 7 was asked about the height difference of 64 and 62 inches. RN # 1 stated, "It's a coding error on my part. It should be 64 inches." When asked what policy they follow for completing the MDS RN # 3 stated, "We follow the RAI (resident assessment instrument) manual." Review of the RAI manual documented, "Steps for Assessment for K0200A, Height 1. Base height on the most recent height since the most recent admission/entry or reentry. Measure and record height in inches. 2. Measure height consistently over time in accordance with the facility policy and procedure, which should reflect current standards of practice (shoes off, etc.). 3. For subsequent assessments, check the medical record. If the last height recorded was more than one year ago, measure and record the resident's height again." On 3/10/16 at 1:20 p.m. the ASM (administrative staff member) # 1, the administrator, was made aware of the findings. No further information was provided by the end of the survey. References: * This information was obtained from the website: Taken from: https://www.nlm.nih.gov/medlineplus/ency/article/000521.htm ** This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html *** This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html **** This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/chronickidne	F 278		

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F 278	Continued From page 8 ydisease.html ***** This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html ****** This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/osteoporosis.html	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 279	F 279 Develop Comprehensive Care plans 1. Resident # 1's Care plan was updated to include visual deficits. 3/10/16 2. 100 percent audit of most recent comprehensive care plan for current residents was completed. No other deficiencies were noted. 3/25/16 3. Nurse Managers and MDS nurses educated to make sure any new admissions that have visual deficits are care planned for appropriate interventions. 3/25/16	

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F 279	Continued From page 9 the facility staff failed to develop a comprehensive care plan for one of 27 residents in the survey sample, Resident #1. Tthe facility staff failed to develop a comprehensive care plan to address decreased vision that was triggered to be care planned in the CAA (care assessment area) section, of Resident #1's admission MDS (minimum data set), assessment, with an ARD (assessment reference date of 10/22/15. The findings include: Resident #1 was admitted to the facility on 10/15/15 and readmitted on 2/18/16 with diagnoses that included but were not limited to: chronic kidney disease, depression, diabetes, high blood pressure and elevated cholesterol. Resident #1's MDS, a quarterly assessment, with and ARD of 1/2/16 coded the resident as having a BIMS (brief interview of mental status) of nine, indicating the resident was moderately cognitively impaired to make daily decisions. The resident was coded as requiring staff assistance for all activities of daily living. In section B -- Hearing, speech and vision under B1000 -- vision, the resident was coded as having impaired vision defined as, "Sees large print, but not regular print in newspaper/books." Review of the CAA summary for Resident #1's admission MDS (minimum data set), assessment, with an ARD (assessment reference date of 10/22/15, documented, "A. Care Area Triggered." An "X" was marked in the box indicating that vision was triggered. Under "B. Care Planning Decision." An "X" was marked in	F 279	4. a. DON or designee will audit care plans of any resident admitted with visual deficits to ensure care plan is complete with appropriate interventions. 3/25/16 b. Any negative findings of Audit will be immediately corrected and reported to Monthly QAPI if indicated. 3/25/16 5. Corrective Action will be completed on or before 3/25/16.	

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F 279	Continued From page 10 the box indicating that vision would be care planned. Review of Resident #1's care plan initiated on 10/26/15 and reviewed on 3/8/16 did not evidence documentation that vision had been care planned. An interview was conducted on 3/10/16 at 9:35 a.m. with RN (registered nurse) #1, the MDS coordinator. When asked if the CAA summary was triggered and it was documented that a care plan was to be done did the resident get a care plan for that trigger, RN #1 stated, "Yes." When asked what manual they used to complete the MDS, RN #1 stated, "The RAI (resident assessment instrument." On 3/10/16 at 1:35 p.m. an interview was conducted with LPN (licensed practical nurse) #6. When asked who uses the care plan, LPN #6 stated, "Nurses, managers, doctors." When asked what the care plans were used for, LPN #6 stated, "Tells you exactly what they're here for, what they're being treated for." When asked if it was important for the staff to know if a resident had a visual impairment, LPN #6 stated, "Yes, because it can affect the ADL's (activities of daily living), daily life and routine." On 3/10/16 at 1:40 p.m. an interview was conducted with LPN #5, the unit manager. When asked who uses the care plan, LPN #5 stated, "Everyone does. The direct patient care staff and anyone who cares for the patient in anyway." When asked what the care plans were used for LPN #5 stated, "To keep track of the resident's status, any changes in them, any care needs, use (the care plan) as a guideline." When asked if it	F 279		

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was important for the staff to know if a resident had a visual impairment, LPN #5 stated, "Yes, I mean so you can decrease the risks of falls. If they don't have their glasses something might happen. Need (the staff) to know (the resident) has glasses or visual need to accommodate."

Review of the facility's policy titled, "Minimum Data Sheet (MDS)/Care Plans" documented in part, "VI. Care Plan Completion: The interdisciplinary plan of care (Care Plan) will be completed by the IDT (interdisciplinary team) based on the results of the MDS and CAA process. Triggered CAA's will be reviewed to determine if they warrant a resident-specific care plan. A comprehensive, individualized care plan will be created to address the needs and strengths of the resident during his or her stay at (name of facility). It will contain an identified problem or need, a measurable goal, and interventions specific to the resident's needs and abilities."

On 3/10/16 at 1:20 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient

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F 279	Continued From page 12 and is used to direct care...expect to review, revise and update the care plan regularly, when there are changes in condition, treatments, and with new orders..." (1) (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77. Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care."	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional	F 281		

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F 281	Continued From page 13 standards of practice for one of 27 residents in the survey sample, Resident #1. 1a. The facility staff failed to clarify a documented allergy to Tylenol prior to administering the medication to Resident #1. b. A facility staff member completed the influenza vaccination consent for Resident #1 after the consent was requested by the surveyor on 3/9/16. The findings include: 1a. Resident #1 was admitted to the facility on 10/15/15 and readmitted on 2/18/16 with diagnoses that included but were not limited to: chronic kidney disease, depression, diabetes, high blood pressure and elevated cholesterol. Resident #1's MDS (minimum data set assessment), a quarterly assessment, with and ARD (assessment reference date) of 1/2/16 coded the resident as having a BIMS (brief interview of mental status) of nine, indicating the resident was moderately cognitively impaired to make daily decisions. The resident was coded as requiring staff assistance for all activities of daily living. Review of the resident's care plan initiated on 10/26/15 and reviewed on 3/8/16 documented, "Problem. Pain. Approach. Administer medication as ordered (see MAR [medication administration record]) monitor effectiveness and SE (side effects) of meds (medications). Problem. (name of resident) is allergic/intolerant to .....Tylox...Approach. Do not administer listed meds (medications)/food to resident. Document	F 281	F 281 Services Provided to Meet Professional Standards 1. A. The order for resident #1 was clarified with the physician to verify that although resident had allergy to Tylox, he did not have an allergy to Tylenol and the medical record was updated. 3/10/16 B. The nurse who completed the consent for vaccination for resident # 1 was educated on professional standards for documentation on 3/10/16. 2. A. An audit of resident's physician orders and allergies was completed on 3/28/16. No other deficient practices were noted with physician orders. B. Nursing staff was interviewed and all voiced understanding of professional standards of documentation. 3/23/16-3/28/16 3. A. The policy on "Medication Orders" and procedure for verifying allergy information with the physician was reviewed and no changes are warranted. Nursing staff were re-educated on ensure physician clarification is obtained with any allergy warning. 3/23/16-3/28/16.	

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F 281	Continued From page 14 allergies in chart and on MAR/TAR (treatment administration record). Notify MD/pharmacy of allergies when ordered meds." Review of the physician's orders dated on 12/3/15 documented, "Acetaminophen 650 MG (milligrams) suppository. Commonly Known As: TYLENOL." The allergy section of the orders documented, "Tylox* (Oxycodone-Acetaminophen) [a pain medication] *. Reactions. Swelling" Review of the 1/1/16 to 3/1/16 MARs (medication administration records) documented, "ALLERGIES. Acetaminophen." The following medication orders were documented, "Tylenol Oral Tablet 325 MG (milligram) 2 Tablet PEG** TUBE PRN (as needed) Every 4 Hours PRN (pain - Mild, Temperature > 100). Acetaminophen Rectal Suppository 650 MG 1 Suppository PER RECTUM PRN Every 4 hours PRN (Temperature)." On 1/1/16, 1/27/16 and 2/9/16 (no times included) it was documented that the Tylenol had been administered to Resident #1. Review of the nurse's notes on 1/1/16, 1/27/15 and 2/9/16 did not evidence documentation that the resident had an allergic reaction to the Tylenol. A review of a verbal order dated and signed on 3/8/16 documented, "Clarification -- No Tylenol allergy ok to give tylenol." An interview was conducted on 3/9/16 at 1:10 p.m. with LPN (licensed practical nurse) #1, unit manager. LPN #1 was asked what process the	F 281	B. Nursing standards of professional documentation were reviewed with nursing staff. 3/23/16-3/28/16. 4. The DON/Designee will audit 10 records per month of residents to ensure allergy warnings are clarified with the physician prior to administration. Any negative findings will be corrected immediately and reported to the facilities monthly QAPI meeting. 5. Corrective Action will be completed on or before 3/27/16.	

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staff followed if a resident had an allergy and was ordered that medication. LPN #1 stated, "If have an allergy, the pharmacy calls us before sending the drug and we clarify it with the doctor."

An interview was conducted on 3/9/16 at 3:25 p.m. with LPN #2. LPN #2 was asked what process the staff followed if a resident had an allergy and was ordered that medication. LPN #2 stated, "The pharmacy puts the orders in and the nurses approve the orders and all the allergies are put in and (name of software program) should have triggered a warning."

An interview was conducted on 3/10/16 at 10:25 a.m. with RN (registered nurse) #3. When asked the process staff follow if a resident had an allergy and was ordered that medication, RN #3 stated, "Notify the physician. Normally the physician asks us to ask the family." When asked what prompted the verbal order on 3/8/16 to clarify the Tylenol allergy, RN #3 stated that the resident had been to an outpatient procedure and the staff there called the facility to clarify whether the resident was allergic to Tylenol. RN #3 stated, "It (the Tylenol allergy) should have been clarified prior to that (administering the medication)."

An interview was conducted on 3/10/16 at 11:10 a.m., with ASM (administrative staff member) #2, the director of nursing. ASM #2 was asked what process the staff followed when a resident had an allergy to a medication and was ordered that medication. ASM #2 stated, "That should be clarified." A request was made for the clarification orders. ASM #2 returned at 2:35 p.m. and stated "We don't have it documented that it was clarified."

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F 281	Continued From page 16 An interview was conducted on 3/10/16 at 1:35 p.m. with LPN (licensed practical nurse) #6. When asked why an accurate listing of a resident's allergies was important, LPN #6 stated, "It could be a med (medication) error." When asked what process staff follows when a resident is noted to have an allergy to a medication and that medication was ordered, LPN #6 stated, "You have to call the doctor and get something else." An interview was conducted on 3/10/16 at 2:40 p.m. with OSM (other staff member) #8, the pharmacist. When asked what process the pharmacy follows if a resident has an allergy to a medication and the physician orders that medication, OSM #8 stated, "The process would be one of two things. The pharmacist will call and speak to the nurse to determine if the MD (medical doctor) has clarified the order. We don't release the medication (until the clarification is made)." When asked if there was a note that Resident #1's allergy to Tylenol had been clarified, OSM #8 stated, "Yes, it was written on 12/18/15 at 10:55 p.m." A request for the note was made and the note was received. The note documented that an order had been received by the doctor clarifying the Tylenol allergy. When asked who removes allergies from the Resident's record after it has been clarified, OSM #8 stated, "We keep all those allergies on the demographics to keep a complete record." When asked how a nurse would know that the resident was not allergic to Tylenol, OSM #8 stated, "In Virginia all orders are reviewed by a pharmacist." Review of the nurse's notes and physician orders for 12/18/15 did not evidence documentation of that clarification.	F 281		

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F 281	Continued From page 17 An interview was conducted on 3/10/16 at 3:10 p.m. with LPN #15, the nurse who provided the verbal clarification order to the pharmacy on 12/18/15. When asked what process staff followed if the resident was allergic to a medication and that medication was ordered, LPN #15 stated, "Call the physician and verify what he wants to do. I usually write a nurse's note." When asked if she had documented the clarification LPN #15 stated, "I might have just forgotten to put something in the nurse's notes." On 3/10/16 at 11:10 a.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. When ASM #2 was asked if the allergy for Tylenol should have been removed, ASM #2 stated, "It's not a complete record if there's an allergy on it, it's not accurate." No further information was received prior to exit. Potter and Perry, Fundamentals of Nursing, 6th edition, p. 843: "A client has the following rights: To have qualified nurses or physicians assess a medication history, including allergies." *Tylox -- Each capsule of TYLOX (oxycodone and acetaminophen capsules USP) contains: Oxycodone Hydrochloride USP 5 mg* Warning - May be habit forming. Acetaminophen USP 500 mg. <https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=85752> **PEG -- A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall. It goes directly into the stomach. <https://www.nlm.nih.gov/medlineplus/ency/article	F 281		

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1b. Review of Resident #1's MDS, a quarterly assessment, with and ARD of 1/2/16 in section O -- Special Treatments, Procedures, and Programs, O0250. Influenza Vaccine documented the resident received the vaccine 12/18/15.

A review of the clinical record did not evidence documentation of consent for the vaccination.

On 3/9/16 at 5:15 p.m. a request for a copy of the vaccination consent was requested.

On 3/10/16 at 9:00 a.m. a copy of the vaccination consent was received. The form documented that verbal consent was obtained on 12/18/15.

On 3/10/16 at 11:00 a.m. ASM (administrative staff member) #2, the director of nursing told this writer, that the nurse had written the consent for the influenza vaccination on 3/10/16.

An interview was conducted on 3/10/16 at 2:00 p.m. with ASM #1, the administrator, and ASM #2, the director of nursing. When made aware of the findings ASM #1 stated, "This is nothing we allow or expect. I apologize for that, it ain't cool." ASM #2 stated, "She called me in tears, she was overwhelmed and she just wrote it. We would never, ever falsify records."

An interview was conducted on 3/10/16 at 2:10 p.m. with RN (registered nurse) #3, the nurse who wrote the consent on 3/10/16. RN #3 stated, "I remember that when you asked for the flu

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F 281	Continued From page 19 consent that the family wanted him to have the flu vaccine. When you requested the consent I searched everywhere. When I couldn't find it I just filled one out and gave it to you." When asked why, RN #3 stated, "I knew I had it, I didn't want to get a deficiency for something that I know what I had." When asked what she would do if one of her staff had done this, RN #3 stated, "I wouldn't be happy with them of course." When asked if falsifying documents was a problem, RN #3 stated, "If it was habitual maybe. I think I would look at every single instance." When asked if her actions were consistent with nursing standards, RN #3 stated, "Absolutely not." Review of the facility's job description under "Values" it was documented in part, "Integrity. Key Behaviors. Exercise good judgement and high ethical standards in decision-making. Represent self and organization fairly and honestly to customers, stressing (name of organization) mission, vision and values." No further information was provided prior to exit.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility document review it was determined that the facility staff failed to provided services for by qualified	F 282		

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F 282	Continued From page 20 professionals for one of 27 residents in the survey sample, Resident #20. The facility staff failed to ensure that only nurses adjusted Resident #20's oxygen rate. The findings include: Resident #20 was admitted to the facility on 10/11/15 with diagnoses that included but were not limited to: atrial fibrillation (an irregularly irregular heart beat), high blood pressure and elevated cholesterol. Resident #20's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/5/16 coded the resident as a 13 out of 15 on the brief interview for mental status, indicating the resident was cognitively intact to make decisions of daily living. The resident needed minimal assistance from staff for activities of daily living. In section O, Special Treatments, Procedures, and Programs, O0100. documented the resident was receiving oxygen therapy. An observation was made on 3/9/16 at 2:50 p.m. of Resident #20. The resident was sitting up in the chair and had oxygen on via nasal cannula* at 3 1/2 liters/minute. Review of the physician's orders signed and dated 1/13/16 documented, "OXYGEN 3 liters/minute..." Review of Resident #1's care plan initiated on 10/22/15 and revised on 11/29/15 documented, "Problem, (name of resident) has potential for cardiac distress. Administer O2 (oxygen) per	F 282	F 282 Services by qualified person 1. The two C.N.A. s and nurse involved with deficient practice was educated that only licensed nursing staff may administer oxygen. 3/10/16 2. Observation of oxygen administration was completed and no issues of non-compliance were noted. 3/20/16-3/25-16. 3. The policy "Medication Administration" was reviewed and no changes are warranted at this time. Nursing and C.N.A. staff were re-educated that only nurses may administer oxygen. 3/20/16-3/15-16 4. DON/Designee will do 5 random observations of oxygen administration on residents weekly to ensure only licensed nursing personnel are administering oxygen. Any negative findings will be corrected immediately and reported to the facilities monthly QAPI meeting. 5. Corrective Action will be completed on or before 3/27/16.	

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F 282	Continued From page 21 order..." An interview was conducted on 3/10/16 at 9:57 a.m. with LPN (licensed practical nurse) #6, the nurse caring for the resident. When asked who checks the oxygen flow rate, LPN #6 stated, "The girls (the certified nursing assistants) check the pulse ox (oximetry) and if they increase it (the oxygen) they tell me." An interview was conducted on 3/10/16 at 10:01 a.m. with CNA (certified nursing assistant) #1, the one caring for the resident. When asked if she was able to adjust a resident's oxygen, CNA #1 stated, "I take the oxygen level and tell the nurse, she tells me if there are any changes." CNA #1 stated that she did adjust resident's oxygen levels. When asked what education she received in administering oxygen, CNA #1 stated, "When I came here I didn't have any experience, they helped me." An interview was conducted on 3/10/16 at 10:05 a.m. with CNA #2. When asked if she was able to adjust a resident's oxygen, CNA #2 stated, "If I check the oxygen (level) and its low I let my nurse know. If the nurse tells me to increase it I go do that." When asked what education she received in administering oxygen CNA #2 stated, "I learned on my first job." An interview was conducted on 3/10/16 at 10:10 a.m. with LPN #4. When asked if the CNAs were able to change the flow rate on oxygen, LPN #4 stated, "No, first of all I want to make sure what the sat (saturation) is before I turn it up. I'm the one documenting it." When asked if oxygen was considered a medication LPN #4 stated, "Yes."	F 282		

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F 282	Continued From page 22 An interview was conducted on 3/10/16 at 10:22 a.m. with LPN #5, the unit manager. When asked who could adjust a resident's oxygen rate, LPN #5 stated, "The nurses do that." When asked if a CNA could adjust the oxygen rate, LPN #5 stated, "No, they are not licensed to do that." When asked if oxygen was considered a medication, LPN #5 stated, "Yes." An interview was conducted on 3/10/16 at 11:10 a.m. with ASM (administrative staff member) #2, the director of nursing. When asked if a CNA can change the oxygen flow rate, ASM #2 stated, "They can't do that, the nurses know that or they should." ASM #2 was made aware of the findings. The facility's policy titled "Medication Administration", documented in part, "I. Medication is defined as any of the following: H. Respiratory Treatment. III. Medication can be administered by the following: A. Registered Nurses (RN)....Licensed Practical Nurses." There was no evidence documented that CNAs could administer medications. Review of the facility's policy titled, "Oxygen Therapy" documented in part, "F. C.N.A. will notify the nurse if the resident needs his oxygen needs adjusted or changed to a tank." On 3/10/16 at 1:20 p.m. ASM #1, the administrator, and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be	F 282		

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F 282	Continued From page 23 treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration. " *nasal cannula consists of two small plastic tubes, or prongs, that are placed in both nostrils. Taken from <http://www.nhlbi.nih.gov/health/health-topics/topics/oxt/howdoes>.	F 282		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to administer oxygen per physician's order for two of 27 residents in the survey sample, Residents # 5	F 328	✓ F 328 Treat for Special Needs 1. The two Nurses involved with deficient practice was re-educated on following physician orders for oxygen administration. 3/10/16 The oxygen level for resident # 5 and # 20 was immediately adjusted to the level ordered by the physician. No adverse effects were noted to either resident.	

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F 328	Continued From page 24 and # 20. 1. The facility staff failed to administer oxygen at the physician's prescribed flow rate of two liters per minute for Resident # 5. 2. The facility staff failed to administer oxygen to Resident #20 at three liters/minute as ordered by the physician. The findings include: 1. Resident # 5 was admitted to the facility on 8/6/14 and most recently readmitted on 10/29/15 with diagnoses that included but were not limited to: pneumonia, hypothyroidism, diabetes, hyperlipidemia, hypertension, depression, gout, congestive heart failure, and gastroesophageal reflux disease. Resident # 5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/27/16, coded Resident # 5 as sometimes understood by others and usually understanding others. Resident # 5 was coded as scoring 1 of a possible 15 on the Brief Interview for Mental Status in Section C, Cognitive Patterns, indicating the resident was cognitively impaired. Section O documented the resident received oxygen therapy during the last 14 days. Review of Resident #5's clinical record revealed physician orders with a start date of 11/10/15 that were most recently signed by the physician on 2/3/16. The physician order documented: "Oxygen 2 liters/minute...PRN (as needed) for Shortness of Breath..."	F 328	2. Observation of oxygen administration was completed and no issues of non-compliance were noted. 3/20/16-3/25-16. 3. The policy "Oxygen Therapy" was reviewed and no changes are warranted at this time. Nursing staff were re-educated on following physician orders for oxygen administration. 3/20/16-3/15-16 4. DON/Designee will do 5 random observations of oxygen administration on residents weekly to ensure physician orders are being followed during administering oxygen. Any negative findings will be corrected immediately and reported to the facilities monthly QAPI meeting. 5. Corrective Action will be completed on or before 3/27/16.	

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F 328	Continued From page 25 Resident # 5's comprehensive care plan initiated on 11/14/15 documented, under "Problem" (Name of Resident # 5) has potential for respiratory distress due to recent Aspiration Pneumonia..." Under "Approach: Administer oxygen as ordered." Approach Start Date: 11/14/15. On 3/9/16 at 1:47 p.m. Resident # 5 was observed sitting up in a chair, on 3/9/16 at 5:00 p.m. lying in bed, on 3/10/16 at 7:35 a.m. lying in bed and on 3/10/16 at 9:10 a.m. lying in bed. During each of these observations Resident # 5 was receiving oxygen via a nasal cannula and the oxygen concentrator was set a 2 and ½ liters per minute as evidenced by the center of the ball in the concentrator flow meter between the 2 and 3 liter marks. An interview and observation was conducted on 3/10/16 at 10:15 a.m. with LPN (licensed practical nurse) # 2 regarding Resident # 5's flow rate meter. LPN # 2 observed Resident # 5's oxygen flow meter and immediately adjusted the flow rate. When asked what she (LPN # 2) had just done LPN # 2 stated, "I just adjusted the flow rate to 2 liters it was at 2 ½ liters." At this time LPN # 2 and the surveyor looked at the flow meter. When asked how she (LPN # 2) knew it was now set at two liters, LPN # 2 stated that the top of the ball in the flow meter was just touching the bottom of the # 2 indicating that the oxygen was set to 2 liters. During an interview on 3/10/16 at 10:20 a.m. with RN (Registered Nurse) # 3, RN # 3 was asked where the ball in an oxygen flow meter would be located if the flow rate was ordered to be 2 liters.	F 328		

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F 328	Continued From page 26 RN # 3 indicated that the ball would be centered on the number two line. On 3/10/16 at 10:30 a.m., ASM (administrative staff member) # 2, the director of nursing, was made aware of the above findings. At this time a request was made for the facility policies on oxygen administration, and the oxygen concentrator manufacturer's user manual. On 3/10/16 at 1:20 p.m., ASM # 1, the administrator, was made aware of the above findings. The oxygen concentrator manufacturer's user manual documented, under "Proper Setting of Oxygen Flowmeter To set the proper flow of supplemental oxygen, turn the flowmeter adjustment knob left or right until the ball inside the flowmeter centers on the flow line number prescribed by your physician." Review of the facility policy, "Oxygen Therapy" documented: "A. Physician order for Oxygen." Review of "RN/LPN Preceptor Orientation Checklist" Under "Respiratory Bullets for Nurses by Steve Hockman" "Condensers: Management of oxygen both concentrator and tank: Turn on tank or concentrator or wall O2; Set the flow meter for the amount of oxygen ordered; Check that the resident is receiving the oxygen; Nurse will monitor the oxygen through adjustment of flow as ordered." No further information was presented prior to exit. According to Fundamentals of Nursing, Perry and	F 328		

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F 328	Continued From page 27 Potter, 6th edition, page 1122, "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." 2. Resident #20 was admitted to the facility on 10/11/15 with diagnoses that included but were not limited to: atrial fibrillation (an irregularly irregular heart beat), high blood pressure and elevated cholesterol. Resident #20's most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 1/5/16 coded the resident as a 13 out of 15 on the brief interview for mental status, indicating the resident was cognitively intact to make decisions of daily living. The resident needed minimal assistance from staff for activities of daily living. Section O, Special Treatments, Procedures, and Programs, O0100. documented, the resident was receiving oxygen therapy. An observation was made on 3/9/16 at 2:50 p.m. of Resident #20. The resident was sitting up in the chair and had oxygen on via nasal cannula* at 3 1/2 (three and a half) liters/minute. An observation was made on 3/10/16 at 7:30 a.m. of the resident. The resident was in bed, the oxygen was on via nasal cannula at four liters/minute.	F 328		

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F 328	Continued From page 28 An observation was made on 3/10/16 at 10:05 a.m. The resident was sitting up in a recliner; the oxygen was on via nasal cannula at 4 liters/minute. The resident was asked if she ever changed her oxygen rate, Resident #20 stated, "No." An observation of the resident's oxygen flow rate was conducted with LPN (licensed practical nurse) #6, the nurse caring for the resident. When asked what the oxygen flow rate was for the resident, LPN #6 stated, "I believe it's two liters." When asked to check the oxygen flow on the oxygen condenser, LPN #6 stated, it looks like it's on four liters." When asked her process for checking a resident's oxygen flow rate, LPN #6 stated, "The girls (the certified nursing assistants) check the pulse ox (oximetry) and if they increase it they let me know." Review of the physician's orders signed and dated 1/13/16 documented, "OXYGEN 3 liters/minute..." Review of the March 2016 medication administration record documented the oxygen was on each day. Review of Resident #1's care plan initiated on 10/22/15 and revised on 11/29/15 documented, "Problem, (name of resident) has potential for cardiac distress. Approach O2 (oxygen) per order..." An interview was conducted on 3/10/16 at 10:10 a.m. with LPN #4. When asked the process for checking the oxygen flow rate, LPN #4 stated, "Anytime I go into the room I try to glance at it, but	F 328		

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F 328	Continued From page 29 definitely once a shift." An interview was conducted on 3/10/16 at 10:22 a.m. with LPN #5, the unit manager. When asked what process staff followed to check the oxygen flow rate, LPN #5 stated, "Usually when we go into see them (the resident) but at least once a shift." Review of the manufacturer's instructions documented on page two, "It is very important to follow the prescribed level of oxygen flow. Do not increase or decrease the flow until you first consult your physician." On 3/10/16 at 1:20 p.m. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration. " **A nasal cannula consists of two small plastic tubes, or prongs, that are placed in both nostrils. Taken from <http://www.nhlbi.nih.gov/health/health-topics/topi	F 328		

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F 328	Continued From page 30 cs/oxt/howdoes>	F 328		
F 371 SS=E	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, staff interview and facility document review, it was determined that the facility staff failed to prepare food in a sanitary manner in one of three facility kitchens. 1. A dietary aide failed to clean thermometers prior to testing food temperatures in the Belleboyd pantry kitchen. 2. A CNA (certified nursing assistant) failed to wear a hair net in the Belleboyd pantry kitchen while food temperatures were being taken. The findings include: 1. A dietary aide failed to clean thermometers prior to testing food temperatures in the Belleboyd pantry kitchen. On 3/8/16 at 5:05 p.m., observation of OSM (other staff member) #4 (dietary aide) taking food	F 371	F 371 Food Procure, Store/Prepare/Serve-Sanitary 1. The dietary staff member was re-educated to follow the procedure for wiping the thermometer prior to taking temperatures on 3/10/16. The C.N.A. was re-educated that all staff in in the food prep and serving area should wear proper hair restraints on 3/10/16. 2. Rounding Observation tool was completed 3/14/16- 3/23/16 in the Belle Boyd Pantry and no deficient practices were noted. 3. The policies entitled "Hair restraints and jewelry" and "Thermometer Guide" was reviewed and no further changes were warranted. Staff were re-educated on these polices. 3/10/16-3/23/16	

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F 371	Continued From page 31 temperatures was conducted in the Belleboyd pantry kitchen. OSM #4 removed the cover from a yellow thermometer and placed the thermometer into a piece of chicken contained in the steam table. OSM #4 did not clean the thermometer prior to placing it into the chicken. After reviewing the temperature reading on the thermometer, OSM #4 stated she was concerned the thermometer was not correctly working. OSM #4 removed the cover from a blue thermometer and placed the thermometer into a piece of chicken contained in the steam table. OSM #4 did not clean the thermometer prior to placing it into the chicken. OSM #4 read the thermometer reading, cleaned the thermometer and continued testing temperatures of all other food in the steam table. OSM #4 cleaned the thermometer in between foods and prior to placing the thermometer into the cover when done. After OSM #4 was finished testing food temperatures, this surveyor asked the facility process for cleaning food thermometers. OSM #4 sought further clarification of this question. This surveyor asked if OSM #4 was supposed to clean the thermometers before taking temperatures, in between foods and after taking temperatures. OSM #4 stated, "Yes." OSM #4 was made aware she did not clean either thermometer at the beginning of the process (prior to obtaining the temperature of the chicken). OSM #4 stated, "You are right." OSM #4 stated she did clean the thermometer after she obtained the temperatures. OSM #4 was asked how she knew the person who used the thermometer prior to her followed the same procedure. OSM #4 stated "That's why it's good to wipe before." On 3/9/16 at 2:26 p.m., an interview was conducted with OSM #3 (the dietary manager).	F 371	4. The Dietary Manager is responsible for maintaining compliance. The Dietary Manager/Designee will complete the "Nutrition Services Audit Tool" weekly to ensure hair nets are worn in the pantry and the thermometer is wiped before taking temperatures. Any negative findings will be corrected immediately and reported to the facilities monthly QAPI meeting. 5. Corrective Action will be completed on or before 3/25/16.	

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F 371	Continued From page 32 OSM #3 stated thermometers are supposed to be cleaned before use and in between each food. OSM #3 was made aware of the above concern. On 3/9/16 at 5:20 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. ASM #1 was asked how many residents were served from the Belleboyd pantry kitchen. ASM #1 stated residents residing on two of five units were served from the Belleboyd pantry kitchen. The facility document titled, "Thermometer Guide" documented in part, "Cleaning Directions: Sanitize thermometer probes using alcohol probe wipes before and after taking temperature measurements..." No further information was presented prior to exit. 2. A CNA (certified nursing assistant) failed to wear a hair net in the Belleboyd pantry kitchen while food temperatures were being taken. On 3/8/16 at 5:05 p.m., observation of OSM (other staff member) #4 (dietary aide) taking food temperatures was conducted in the Belleboyd pantry kitchen. During this observation, CNA #5 entered the kitchen, walked past the steam table containing food and obtained ice from the ice machine. CNA #5 asked this surveyor, "Should I have this on?" and pointed to her head. CNA #5 was not wearing a hair net. On 3/8/16 at 5:18 p.m., an interview was conducted with CNA #5. CNA #5 asked what she was referring to when she was in the Belleboyd pantry kitchen, pointed to her head and asked this surveyor, "Should I have this on?" CNA #5	F 371		

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F 371	Continued From page 33	F 371		

stated she was referring to a hair net. CNA #5 was asked the facility process in regards to CNAs wearing hair nets. CNA #5 stated she must wear a hair net if she serves food and if she goes into the main kitchen. CNA #5 stated she didn't have to wear a hair net if she was just getting ice in one of the pantry kitchens.

On 3/9/16 at 2:26 p.m., an interview was conducted with OSM #3 (dietary manager). OSM #3 stated dietary staff puts hair nets on in the main kitchen and keeps them on all day long. OSM #3 was asked the process for other staff wearing hair nets while in the pantry kitchens. OSM #3 stated there was a sign on the pantry kitchen doors that documented staff have to go around the kitchens, stand at the wall and ask for ice while food is being prepared in the kitchens.

The sign posted on the Belleboyd pantry kitchen door documented, "PLEASE STOP HERE! Due to health and safety requirements, only dietary staff are permitted in this area during meal service. Please go around to the doorway from inside the dining room & ask to speak with a C.N.A or a dietary Staff member if you need assistance..."

On 3/9/16 at 5:20 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above findings. ASM #1 was asked how many residents were served from the Belleboyd pantry kitchen. ASM #1 stated residents residing on two of five units were served from the Belleboyd pantry kitchen.

The facility document titled, "Hair Restraints & Jewelry" documented in part, "EVERYONE MUST RESTRAIN HAIR AND WEAR ONLY

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F 371	Continued From page 34 APPROVED JEWELRY BEFORE ENTERING THE KITCHEN AND HANDLING FOOD..." No further information was provided prior to exit.	F 371		

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 03/08/16 through 03/10/16. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 117 at the time of the survey. The survey sample consisted of 22 current resident reviews (Residents # 1 through # 21 and # 27) and five closed record reviews (Residents # 22 through # 26).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC5-371-220. (B) Cross Reference to F 328 12VAC5-371-250. Resident assessment and care planning cross reference to F278. 12VAC5-371-340. Dietary and food service program cross reference to F371.	F 001		

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

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F 001	Continued From Page 1 12VAC5-371-250 F cross references to F 279 12VAC5-371-200 B.1cross references to F 281 12VAC5-371-220 B cross references to F 328	F 001		