STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	C 02/09/2017

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WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(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 2/7/17 through 2/9/17. Complaints were investigated during this 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 90 certified bed facility was 54 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents 1 through 12, #19 and #20) and 6 closed record reviews (Residents #13 through #18).	F 000		
F 167 SS=D	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 167	The notice of the availability of the preceding three years of survey results available for any individual to review upon request was posted in the survey result book in the front lobby on 2/7/17 by Administrator. Three years of survey results was added to the survey results notebook located in the Administrator's office on 2/7/17 by Administrator. The Social Worker reviewed the posting of the availability of the preceding three years of survey results and the availability upon request of survey results with all alert and oriented residents on 2/28/17.	2/28/17

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Crystal A Bowers — TITLE: Administrator — (X6) DATE: 2/24/17

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

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F 167	Continued From page 1 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to post a notice and have available upon request the preceding three years of the survey results. A notice was not posted to the residents and responsible parties that the results of the previous three years of survey results, with the plan of corrections, were available for review upon request and the facility did not have the results available for review. The findings include: Observation was made of the survey results book in the front lobby on 02/07/17 at 12:15 p.m. The book was located in a wall mounted file holder with a label stating "Survey Results." The cover on the book documented, "Survey By The Virginia Dept (Department) Of Health Facilities Regulation." Further observation of the wall mounted file holder and the binder failed to evidence a notice of the availability of the previous three years of survey results available for any individual to review upon request. The book in the wall mounted file holder contained the survey results and plan of corrections from the annual survey ending on 03/21/16. Further observation of the contents of the book failed to	F 167	The Administrator and Director of Nursing was in-service by the Facility Consultant on 2/22/17 regarding the requirements for survey results posting and accessibility. The Director of Nursing will monitor to ensure the notice of the availability of the preceding three years of survey results available for any individual to review upon request is posted and results are preceding three years of survey results are available weekly x 8 weeks then monthly x 1 month utilizing a Survey Posting QI Audit Tool. The notice will be posted and/or survey results made available for any identified areas of concern during the audit by the DON. The Administrator will initial and review the Survey Posting QI Audit Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Survey Posting QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 167	Continued From page 2 evidence the survey results and plan of corrections for the previous three years. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 2/7/17 at 3:10 p.m. When asked who is responsible for posting the survey results, ASM #1 stated, "I am." When asked which surveys were to be posted for the residents and responsible parties, ASM #1 stated, "The last survey." When asked if she was aware of the new regulations that went into effect on 11/28/16, ASM #1 stated, "I'm not aware of a new regulation about the survey results." On 02/08/17 at 5:10 p.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, ASM # 3, the assistant director of nursing, and ASM # 4, facility consultant, were made aware of the findings. No further information was obtained prior to exit.	F 167		
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 252	The gouge and unpainted A-side wall next to the head of the bed in room #103 was repaired and painted by Maintenance on/or before 3/25/17. The wall on the right side of the room as you enter extending from the A-side to the B-side of the room peeling wall paper in room #104 was repaired by maintenance on/or before 3/25/17. The black marks and unpainted area of B-side on the wall next to the head of the bed in room #109 was repaired and painted by Maintenance on/or before 3/25/17. The black marks on the lower portion of the wall next to the right side of the bed on the A-side of resident in room #112 was repaired by maintenance on/or before 3/25/17. The unfinished plaster patch and unpainted area next to the HOB on the A-side of resident room #113 was repaired and painted by	3/25/17

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physical layout of the facility maximizes resident independence and does not pose a safety risk.

(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.
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 maintain resident rooms in good repair in 11 of 61 resident rooms, (Resident rooms # 103A, # 104A & B, # 109B, # 112A, # 113A, # 114A, # 117A & B, # 200B, # 205A, # 207B, and # 210B).

The findings include:

Observations during the days of the survey, 02/07/17 at 3:50 p.m.; 02/08/17 at 11:50 a.m. and on 02/09/17 at 8:00 a.m., revealed the following:
The A-side wall next to the head of the bed (HOB) was observed to be gouged and unpainted in resident room # 103.
The wall on the right side of the room as you enter, extending from the A-side to the B-side of the room was observed with numerous areas of wall paper peeling off the wall in resident room # 104.
The B-side wall next to the head of the bed (HOB) was observed to have several black marks, with an unpainted area in resident room # 109.
Several black marks were observed on the lower portion of the wall next to the right side of the bed on the A-side of resident room # 112.
A plastered patch area next to the HOB was unfinished and unpainted on the A-side of resident room # 113.

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maintenance on/or before 3/25/17. The gouge and unpainted A-side wall next to the head of the bed in room #114 was repaired and painted by maintenance on/or before 3/25/17. The gouge and unpainted A-side wall next to the head of the bed and area under the window on the B-side in room #117 was repaired and painted by maintenance on/or before 3/25/17. The gouge and unpainted B-side wall next to the head of the bed in room #200 was repaired and painted by maintenance on/or before 3/25/17. The black marks and unpainted area of B-side on the wall next to the head of the bed in room #205 was repaired and painted by maintenance on/or before 3/25/17. The gouge and unpainted B-side wall next to the head of the bed in room #207 was repaired and painted by maintenance on/or before 3/25/17. The gouge and unpainted B-side wall next to the head of the bed in room #210 was repaired and painted by maintenance on/or before 3/25/17.

100% observation of the facility to include all resident's rooms to include rooms #103, #104, #109, #112, #113, #114, #117, #200, #205, #207, and #210 was completed on 2/13/17 by Administrator to ensure all areas and rooms are in good repair. Work orders were completed on 2/23/17 by Administrator for notification to Maintenance for any identified areas of concern. The Maintenance Director will correct all identified areas of concerns from the audit by 3/25/17.

The Maintenance Director was in-service by the Administrator on 2/24/17 regarding ensuring rooms are in good repair. All license nurses, nursing assistants, dietary staff, housekeeping staff, therapy staff, and department managers were in-service by Staff Development Coordinator on/or before 3/25/17 to notify Maintenance of any areas in the facility in need of repair or painting to include resident rooms by completing a work order slip. All newly hired license nurses, nursing assistants, dietary staff, housekeeping

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F 252	Continued From page 4 The A-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area in resident room # 114. The A-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area. Also an area under the window on the B-side was gouged and unpainted in resident room # 117. The B-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area in resident room # 200. The B-side wall next to the head of the bed (HOB) was observed to have several black marks and an unpainted area in resident room # 205. The B-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area in resident room # 207. The B-side wall next to the head of the bed (HOB) was observed with a gouged and unpainted area in resident room # 210. On 02/09/17 at approximately 9:15 a.m. a tour of resident rooms # 103A, # 104A & B, # 109B, # 112A, # 113A, # 114A, # 117A & B, # 200B, # 205A, # 207B, and # 210B was conducted with OSM (other staff member) # 7, director of maintenance. After visually inspecting resident rooms' # 103A, # 104A & B, # 109B, # 112A, # 113A, # 114A, # 117A & B, # 200B, # 205A, # 207B, and # 210B, OSM # 7 acknowledged the resident rooms were in in need of repair. No further information was provided from OSM # 7. On 02/09/17 at 10:15 a.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 4, facility consultant, were made aware of the findings. No further information was obtained prior to exit.	F 252	staff, therapy staff, and department managers will be in-service by the staff facilitator regarding to notify Maintenance of any areas in the facility in need of repair or painting to include resident's rooms by completing a work order slip during orientation. The maintenance director will monitor all areas of the facility to include 100% of all resident rooms, to include rooms #103, #104, #109, #112, #113, #114, #117, #200, #205, #207, and #210 to ensure rooms are in good repair weekly x 8 weeks then monthly x 1 utilizing a Homelike Environment QI Audit tool and complete a work order slip for all identified areas of concerns. The Maintenance Director will immediately address any identified areas of concern during the audit. The Administrator will review the Home like Environment QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The Executive QI committee will meet monthly and review the Homelike Environment QI Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, it was	F 278	A modification of resident #6 MDS for section O0250 was completed on 2/27/17 by MDS fill-in/support person to reflect the Influenza Vaccine. 100% audit was completed of all resident's current MDS's for section O0250 comparing the coding of the MDS to the resident's immunization records to ensure the MDS's are coded accurately for immunizations on/or before 3/5/17 by the MDS fill-in/support person. MDS modifications will be completed for section O0250 for any identified areas of concern during the audit by MDS fill-in/support person on/or before 3/15/17. The MDS Nurse was in-serviced re: accurate coding to include accurately coding immunizations under section O0250 of the MDS on/or before 3/5/17 by the facility consultant. The Administrator will audit 10% of current residents MDS to include resident #6, to ensure accurate coding for immunizations under section O0250 of the MDS utilizing the MDS audit tool weekly x 8	3/15/17

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determined that facility staff failed to maintain an accurate MDS (Minimum data set) assessment for one of 20 residents in the survey sample, Resident #6.

The facility staff failed to properly code Section O0250., "Influenza Vaccine" on Resident #6's annual MDS assessment with an ARD (assessment reference date) of 11/19/16.

The findings include:

Resident #6 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to adult failure to thrive, Alzheimer's disease, dementia, hypertension, atrial fibrillation, anxiety and depression.

Resident #6's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 11/19/16. Resident #6 was coded as being moderately cognitively impaired in the ability to make daily decisions, scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #6 was coded as requiring extensive assistance with one person physical assist with most ADLS (activities of daily living) including transfers, locomotion, dressing, toileting, and personal hygiene; independent with meals, and totally dependent on staff with bathing.

The most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/19/16 coded Resident #6 in Section B0700 "Makes Self Understood" as "Usually understood" and section B0800 "Able To Understand Others" as "Understands - clear

weeks then monthly x 1 month. The MDS nurse will be reeducated by the Administrator and/or DON and a modification will be completed for any identified areas of concern during the audit. The DON will review and initial the MDS audit tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed.

The Executive QI committee will meet monthly and review the MDS audit tools and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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comprehension." Section O0250 "Influenza Vaccination" coded resident # 6 a "0 (zero). No. - Skip to O0250C, if influenza vaccine not received, state reason." Under section O0250C a "-" dash was coded indicating that this area was not assessed.

Review of Resident # 6's clinical record revealed an "Immunization Record". The immunization record documented the influenza vaccination as being refused for 2016-2017. No date was documented under this record of when the vaccination was refused.

Resident #6's consent/release form documented in part, the following: "Flu Vaccination Authorization Flu Vaccines are given annually unless medically contraindicated. I authorize the administration of the flu vaccine based upon educational materials which includes the risks and benefits given by the facility." A check mark was documented under "NO" indicating that the Flu Vaccination was not consented. The POA (Power of Attorney) signed this form on 12-3-14.

On 2/8/17 at 3:05 p.m., an interview was conducted with LPN (licensed practical nurse) #6. When asked what dashes meant on the MDS, LPN #6 stated that dashes meant that the section was not assessed. LPN#6 confirmed that Section O0250C was not assessed. LPN #6 stated that she uses the RAI manual as a reference when completing the MDS.

On 2/8/17 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing), and ASM #4, the facility consultant were made aware of the above concerns. No further information was presented

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prior to exit.

The RAI (Resident Assessment Instrument) manual documented, " O0250: Influenza Vaccine.
Steps for Assessment
1. Review the resident's medical record to determine whether an influenza vaccine was received in the facility for this year's influenza vaccination season. If vaccination status is unknown, proceed to the next step.
2. Ask the resident if he or she received an influenza vaccine outside of the facility for this year's influenza vaccination season. If vaccination status is still unknown, proceed to the next step.
3. If the resident is unable to answer, then ask the same question of the responsible party/legal guardian and/or primary care physician. If influenza vaccination status is still unknown, proceed to the next step.
4. If influenza vaccination status cannot be determined, administer the influenza vaccine to the resident according to standards of clinical practice.
Coding Instructions for O0250A, Did the resident receive the influenza vaccine in this facility for this year's influenza vaccination season?
o Code 0, no: if the resident did NOT receive the influenza vaccine in this facility during this year's influenza vaccination season. Proceed to If influenza vaccine not received, state reason (O0250C).
o Code 1, yes: if the resident did receive the influenza vaccine in this facility during this year's influenza season. Continue to Date influenza vaccine received (O0250B).
Coding Instructions for O0250B, Date influenza vaccine received
o Enter the date that the influenza vaccine was

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received. Do not leave any boxes blank.
- If the month contains only a single digit, fill in the first box of the month with a "0". For example, January 17, 2014 should be entered as 01-17-2014.
- If the day only contains a single digit, then fill the first box of the day with the "0". For example, October 6, 2013 should be entered as 10-06-2013. A full 8 character date is required.
- A full 8 character date is required. If the date is unknown or the information is not available, only a single dash needs to be entered in the first box.

Coding Instructions for O0250C, If influenza vaccine not received, state reason

If the resident has not received the influenza vaccine for this year's influenza vaccination season (i.e., O0250A=0), code the reason from the following list:

o Code 1, Resident not in this facility during this year's influenza vaccination season: resident was not in this facility during this year's influenza vaccination season.

o Code 2, Received outside of this facility: includes influenza vaccinations administered in any other setting (e.g., physician office, health fair, grocery store, hospital, fire station) during this year's influenza vaccination season.

o Code 3, Not eligible-medical contraindication: if influenza vaccine not received due to medical contraindications. Contraindications include, but are not limited to; allergic reaction to eggs or other vaccine component(s) (e.g., thimerosal preservative), previous adverse reaction to influenza vaccine, a physician order not to immunize, moderate to severe illness with or without fever, and/or history of Guillain-Barré Syndrome within 6 weeks of previous influenza vaccination.

o Code 4, Offered and declined: resident or

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(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 278	Continued From page 10 responsible party/legal guardian has been informed of the risks and benefits of receiving the influenza vaccine and chooses not to accept vaccination. o Code 5, Not offered: resident or responsible party/legal guardian not offered the influenza vaccine. o Code 6, Inability to obtain influenza vaccine due to a declared shortage: vaccine is unavailable at this facility due to a declared influenza vaccine shortage. o Code 9, None of the above: if none of the listed reasons describe why the influenza vaccine was not administered. This code is also used if the answer."	F 278		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 280	Resident #6 care plan was reviewed and revised on 2/22/17 to reflect the resident by the DON. Resident #6 no longer has a stage II pressure ulcer. A 100% audit of all care plans was conducted by the Administrative nurses (DON/ADON/SDC/MDS Coordinator/MDS fill-in), including care plans for residents #6 and residents with pressure ulcers to ensure that all areas of the care plan reflect the resident's individual needs on/or before 3/25/17. Any deficient care plans were updated to reflect the resident on/or before 3/25/17 by the responsible interdisciplinary care plan team member.	3/25/17

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F 280	Continued From page 11 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff.	F 280	The interdisciplinary care plan team members (Dietary manager, MDS Coordinator, Social Services Director and Activities Director) have been re-educated on the requirements for completing a comprehensive care plan for each resident and to review and revise the care plan for each resident change as needed by the Administrator on/or before 3/25/17. An audit will be completed of 10% of all resident's care plans to include care plans for resident #6 weekly x 8 weeks then monthly x 1 month by the DON and/or ADON to ensure that the care plans accurately reflects the resident utilizing the QI Care Plan Audit Tool. The interdisciplinary care plan team members will be retrained and the care plan will be revised immediately by the responsible interdisciplinary care plan team member for any identified areas of concern. The Administrator will review and initial the QI Care Plan Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed.	

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F 280	Continued From page 12 (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to revise the comprehensive care plan for one of 20 residents in the survey sample, Resident #6. The facility staff failed to revise Resident #6's care plan after a Stage II [1] pressure ulcer of the sacrum was found on 4/8/16. The findings include: Resident #6 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to adult failure to thrive, Alzheimer's disease, dementia, hypertension, atrial fibrillation, anxiety and depression. Resident #6's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of	F 280	The Executive QI committee will meet monthly and review the QI Care Plan Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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11/19/16. Resident #6 was coded as being moderately cognitively impaired in the ability to make daily decisions, scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #6 was coded as requiring extensive assistance with one person physical assist with most ADLS (activities of daily living) including transfers, locomotion, dressing, toileting, and personal hygiene; independent with meals, and totally dependent on staff with bathing.

Review of Resident #6's nursing notes revealed the following note dated 4/8/16: "Resident noted with a new stage 2 pressure ulcer to sacral area. 2.6 cm (centimeters) X (by) 1.0 cm, 100 % (percent) pink, healthy tissue. Ordered Duoderm [2] dressing changes and Vitamin C and Zinc po (by mouth) X (times) 14 days. RP (Responsible Party) aware. MD (Medical Doctor) aware."

Review of the Wound Ulcer Flowsheet dated 4/8/16, documented the following: "Site: 53) Sacrum Type: Pressure Length: 2.6 cm Width: 1.0cm Stage II."

Review of the physician's telephone orders dated 4/8/16 for Resident #6 documented the following orders: "Apply duoderm to sacral St (stage) 2 ulcer. Change Q (every) 7 days and PRN (as needed). Zinc [3] 220 mg (milligrams) po (by mouth) TID (Three times a day) x 14 days, Vit (Vitamin) C [4] 500 mg po BID (two times a day) x 14 days wound healing."

Review of Resident #6's skin care plan dated 12/3/14, with a reviewed date of 8/29/16, documented skin interventions prior to the development of the Stage II pressure ulcer. The care plan did not address Resident #6's Stage II

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pressure ulcer of the sacrum. There was no evidence that the care plan was reviewed to include interventions implemented after the development of the Stage II sacral pressure ulcer on 4/8/16.

On 2/8/17 at 3:05 p.m., an interview was conducted with LPN (licensed practical nurse) #6, the MDS nurse. When asked who uses the care plan for each resident, LPN #6 stated that everybody can use the care plan. When asked when the care plan was updated, LPN #6 stated that the care plan was updated for any changes in the resident's plan of care such as new falls, etc. When asked if new pressure areas would be on the care plan, LPN #6 stated, "Yes." LPN #6 stated that the location of the ulcer and when it was found should be on the care plan. LPN #6 confirmed that the pressure ulcer identified on 4/8/16, was not documented on Resident #6's care plan. LPN #6 stated, "I wasn't here back in April, but I would have documented the ulcer under skin breakdown." When asked who was responsible for updating the care plan for a new skin area, LPN #6 stated, "The DON (Director of Nursing) or MDS nurse would update it." LPN #6 stated that she was the only MDS nurse currently at the facility.

On 2/9/17 at 10:51 a.m., an interview was conducted with ASM #2, the DON. She stated that she did not start on the floor until July of 2016.

On 2/8/17 at 5:01 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #4, the facility consultant were made aware of the above findings.

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The facility policy titled, "Resident Care Pan," documents in part, the following: "It is the policy of the facility to provide an Interdisciplinary written care plan based on the physician's orders and the assessment of the resident needs. Development of an interdisciplinary plan will occur after completion of a comprehensive assessment by each discipline. The resident will be scheduled for conference within twenty-one days following admission. Review and/or modification of the plan will be done at least quarterly and as needed for residents under the direction of the RN coordinator/designee. the resident care plan will be an ongoing process and will include current problems and/or needs identified from a complete assessment including MDS and CAAs relevant to the resident's response to aging, illness, and his/her health general health status. Any new problem or need of resident which is identified between his/her scheduled care plan review will be addressed on the care plan by the concerned disciplines and brought to the next scheduled care plan meeting to inform disciplines of the addition."

No further information was presented prior to exit.

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

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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.

[1] Stage II Pressure-
Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
Further description:
Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
*Bruising indicates suspected deep tissue injury.
This information was obtained from National Pressure Ulcer Advisory Panel.
http://www.npuap.org/pr2.htm.

[2] Duoderm dressing-DuoDERM® Dressings are modern hydrocolloid dressings for the management of light to moderately exuding wounds. DuoDERM® Dressings are versatile, easy to use and are suitable for managing different stages of wound healing and wound types in a protocol of care.
http://www.convatec.com/en/cvtus-duodrrngus/cvt-portallev1/0/detail/0/1444/1847/duoderm-dressing-range.html

[3] Zinc-"Zinc helps maintain the integrity of skin and mucosal membranes. Patients with chronic leg ulcers have abnormal zinc metabolism and low serum zinc levels, and clinicians frequently treat skin ulcers with zinc supplements." This

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F 280	Continued From page 17 information was obtained from The National Institutes of Health. https://ods.od.nih.gov/factsheets/Zinc-HealthProfessional/ [4] Vitamin C-"Vitamin C is required for the biosynthesis of collagen, L-carnitine, and certain neurotransmitters; vitamin C is also involved in protein metabolism [1, 2]. Collagen is an essential component of connective tissue, which plays a vital role in wound healing." This information was obtained from The National Institutes of Health. https://ods.od.nih.gov/factsheets/VitaminC-HealthProfessional/.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to follow the written plan of care for two of 20 residents in the survey sample, Resident #6, 1. The facility staff failed to follow Resident #6's plan of care to apply heel boots and float her heels while she was in bed. 2. The facility staff failed to serve the	F 282	Resident #6 heel boots and heel floats were applied while resident was in bed as identified on the plan of care on 2/23/17 by the DON. Resident #19 was served the physician-ordered/care planned ground meat diet during supper on 2/8/17 100% audit was conducted by the Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) on/or before 3/25/17 comparing all residents care plans to actual observations of all residents to include resident #6, to ensure services are being provided in accordance to the written care plan to include heel boots and heel floats . The Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) immediately addressed all areas of concern during the audit. 100% audit was conducted by the Dietary Manager on/or before 3/25/17 comparing all residents physician-ordered/care planned diets to actual meals	3/25/17

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physician-ordered ground meat diet at lunch on 2/8/17 for Resident #19.

The findings include:

1. Resident #6 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to adult failure to thrive, Alzheimer's disease, dementia, high blood pressure, atrial fibrillation, anxiety and depression. Resident #6's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 11/19/16. Resident #6 was coded as being moderately cognitively impaired in the ability to make daily decisions, scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #6 was coded as requiring extensive assistance with one person physical assist with most ADLS (activities of daily living) including transfers, locomotion, dressing, toileting, and personal hygiene; independent with meals, and totally dependent on staff with bathing.

On 2/8/17 at 8:00 a.m., Resident #6 was sleeping in bed. Her blanket covered her legs but her heels were resting directly on the bed. No boots were observed in place on her feet.

On 2/8/17 at 8:40 a.m., Resident #6 was sleeping in bed. Her blanket covered her legs but her heels were resting directly on the bed. No boots were observed in place on her feet.

On 2/8/17 at 9:26 a.m., Resident #6 was sleeping in bed. Her blanket covered her legs but her heels were resting directly on the bed. No boots were observed in place on her feet.

observations to include resident #19 to ensure the physician ordered/care planned diet is followed. The Dietary manager immediately addressed all areas of concern during the audit.

100% of license nurses to include LPN #2, LPN #7, and RN #1 and nursing assistants to include CNA #4 were re-educated by Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) on/or before 3/25/17 regarding following the resident's care plan/ care guide to ensure all necessary services for the resident, including heel boots and float heels, are provided as identified. 100% of all license nurses, nursing assistants, and dietary staff to include the cook were in serviced regarding ensuring that residents are provided the physician ordered /care planned diet during meals. All newly hired license nurses and CNAs will be in serviced during orientation regarding following the resident's care plan/ care guide to ensure all necessary services for the resident, including heel boots and float heels, are provided as identified. All newly hired license nurses, CNAs, and dietary staff will be in serviced during orientation regarding ensuring that residents are provided the physician ordered /care planned diet during meals.

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F 282	Continued From page 19 Review of Resident #6's care plan dated 11/28/14 and updated on 8/29/16 documented the following intervention under area "Resident Care Guide: Heel Protection: bunny boots to both feet and float heels as tolerated." Review of Resident #6's current ADL (Activity of Daily Living) tracker log that was posted in her closet, documented in part, the following; "Equipment/Instructions/Precautions...Heel Protection: bunny boots to both feet and float both heels." Review of Resident #6's February 2017 MARs (medication administration record) and TAR (treatment administration record) revealed that heel boots were not on the MARs or TARS. On 2/8/17 at 10:03 a.m., an interview was conducted with CNA (certified nursing assistant) #4, the CNA who worked with Resident #6. When asked how she determined a resident's needs for skin protection, care etc., CNA #4 stated that a care tracker card was in the inside of each resident's closet. When asked if Resident #6 had any special instructions while she was in bed, CNA #4 stated that Resident #6 was supposed to have heel boots on while in bed. When asked if Resident #6 had heel boots on, CNA #4 stated, "I don't know, but I can check." This surveyor followed CNA #4 to Resident #6's room. CNA #4 lifted up Resident #6's blanket. Heel boots were not in place to Resident #6's feet. Resident #6's feet were not elevated or floated. Resident #6's heels were normal in color. No redness was noted. CNA #4 stated, "That is something night duty was supposed to put on. I haven't looked at her yet." When asked if this	F 282	The Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) will complete resident rounds to include resident # 6 using the QI Care Plan/ Care Guide Audit Tool weekly x 8 weeks then monthly x 1 month to ensure residents are provided services to include heel boots and floats in accordance with the written care plan. The Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) will address any identified areas of concern immediately during the audit by ensuring interventions are in place and retraining with the staff member. The Dietary Manager will observe resident meals, to include meals for resident #19, to ensure residents are being provided the physician ordered /care planned diet. The Dietary Manager will address any identified areas of concern immediately by ensuring correct meal provided and retraining with the staff member. The Administrator or DON will review and initial the QI Care Plan/ Care Guide Audit Tools and Meal Observation Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all identified areas of concern were addressed. The Executive QI committee will meet monthly and review the QI Care Plan/ Care Guide Audit Tools and Meal Observation Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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was the first time she had rounded on Resident #6, CNA #4 stated, "Yes this is the first time. She is supposed to have them on. Her boots are not in her closet. I'll go get her a pair of booties." When asked how often CNAs rounded on residents, CNA #4 stated, "Two times a shift."

On 2/8/17 at 3:15 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked who uses the care plan, LPN #2 stated that everyone uses the care plan even CNAs. When asked the purpose of the care plan, LPN #2 stated that it was to tell staff how to care for that particular resident. When asked if a resident had an intervention for heel boots on the care plan, should heel boots be in place, LPN #2 stated, "Yes. If they were not on, I would go and put them on." When asked who was responsible for ensuring skin protective measures were in place, LPN #2 stated that the wound care nurse and CNAs were responsible for ensuring ted hose, boots and other skin protective measures were in place.

On 2/9/17 at 8:15 a.m., further observation of Resident #6's heels was conducted with LPN (licensed practical nurse) #7. Resident #6's heels had no redness and were blanchable to the touch. When asked why Resident #6 needed bunny boots and her heels floated, LPN #6 stated it was to protect her skin.

On 2/9/17 at 8:30 a.m., an interview was conducted with RN (registered nurse) #1, the wound care nurse. When asked who was responsible for ensuring skin protective measures like heel boots were in place, RN #1 stated, "I would check to see if they are still on in the mornings when residents are still in bed. The

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aides usually go in and put heel boots on."

On 2/8/17 at 5:01 p.m., ASM #1, the administrator, ASM #2, the DON (Director of Nursing) and ASM #4, the facility consultant were made aware of the above concerns.

Facility policy titled, "Resident Care Plan" documents in part, the following: "It is the policy of the facility to provide an Interdisciplinary written care plan based on the physician's orders and the assessment of the resident needs. Development of an interdisciplinary plan will occur after completion of a comprehensive assessment by each discipline."

No further information was presented prior to exit.

2. Resident #19 was admitted to the facility on 3/17/14 with diagnoses including, but not limited to: lack of bone density, difficulty swallowing, Schizophrenia (1) and dementia with behaviors. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 12/9/16, Resident #19 was coded as being moderately cognitively impaired for making daily decisions. She was coded as requiring limited physical assistance from one staff member for eating. She was coded as having been ordered a mechanically altered diet by the physician.

A review of Resident #19's clinical record revealed the following physician's order, most recently signed by the physician on 1/7/17: "Diet: Regular, ground meats, thin liquids."

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A review of the registered dietician-approved facility menu for lunch on 2/8/17 revealed, in part, the following: "Reg (Regular) Ground/Mech (Mechanical) Soft: Grd (Ground) Sausage/Pepp (Peppers)/Onions."

On 2/8/17 at 12:45 p.m., observation was made of the tray line for the lunch meal. At this time, OSM (other staff member) #2, the cook, was observed preparing Resident #19's tray. OSM #2 had been observed to serve the last of the ground meat option of sausage, peppers and onions at approximately 12:35 p.m. As OSM #2 prepared Resident #19's tray, she placed a whole piece of boneless, skinless chicken breast on Resident#19's tray. Using the side of the serving spoon, OSM #2 cut the chicken breast into large chunks. OSM #2 served mashed potatoes, cornbread and green peas on the plate, and placed the plate on the lunch tray for Resident #19.

On 2/8/17 at 1:25 p.m., observation was made of Resident #19 in the dining room. She had eaten less than 50% of the food on her tray. Approximately half of the chicken breast remained on the tray. Resident #19 showed no signs of coughing. Observation of the resident's meal ticket revealed, in part, the following: "Texture: Regular, ground meats."

Attempts to interview Resident #19 regarding the lunch tray and meat consistency were unsuccessful.

On 2/8/17 at 1:30 p.m., OSM (other staff member) #2 was interviewed. When asked about the availability of the ground meat option for all residents, OSM #2 stated: "I ran out of the

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ground sausage." When asked if she remembered what she served Resident #19, OSM #2 stated: "The chicken." When asked if she served Resident #19 ground meat as ordered by the physician, OSM #2 stated, "No." She stated that ordinarily, the second shift cook will be there to help prepare what is needed. When asked what she should have done for Resident #19's meat, OSM #2 stated: "I should have put the chicken in the grinder."

On 2/8/17 at 1:35 p.m., OSM #1, the dietary manager, was interviewed. She stated that OSM #2 had not served the physician-ordered therapeutic diet to Resident #19. OSM #1 stated: "I did not know we were out of the ground option." When asked if the facility staff had followed Resident 19's care plan for nutrition, OSM #1 stated: "No. We did not. I know she is care planned for ground meats."

On 2/8/17 at 3:35 p.m., CNA (certified nursing assistant) #1 was interviewed. CNA #1 stated: "If we hand out a tray, we are supposed to make sure what's on the plate matches the meal ticket." She stated the information regarding the physician-ordered diet is on both the meal ticket and the resident guide on the computer.

A review of the comprehensive care plan for Resident #19 dated 12/30/15 and updated on 2/7/17 revealed, in part, the following: "Diet as ordered (Ground).

On 2/8/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, facility consultant, were informed of these concerns.

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F 282	Continued From page 24 A review of the facility policy entitled "Menu Policy" revealed, in part, the following: "The menu is written for the general/regular diets and is modified for the following diets...3) Regular Ground/Mechanical Soft...Mechanical Soft/Regular Ground: The diet consists of foods that are easy to chew; designed for residents with chewing or swallowing difficulties. Meats from the regular menu will be served but will be ground. Raw fruits and vegetable will be served as deemed appropriate." No further information was provided prior to exit. (1) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schizophrenia-booklet/index.shtml.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice,	F 309	Resident #6 was assessed for pain by the floor nurse/LPN on 2/8/17 and will be provided non-pharmacological interventions prior to the administration of pain medications. Resident #6 care plan was updated to reflect non-pharmacological interventions to implement prior to the administration of pain medications by the DON on 2/23/17.	3/25/17

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the comprehensive person-centered care plan, and the residents' goals and preferences.

(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review and clinical record review, it was determined that facility staff failed to provide the necessary care and services to attain or maintain the highest level of wellbeing for one of 20 residents in the survey sample, Resident #6.

The facility staff failed to implement non-pharmacological interventions prior to the administration of pain medication to Resident #6, on several occasions in December 2016 and January 2017.

The findings include:

Resident #6 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to adult failure to thrive, Alzheimer's disease, dementia, hypertension, atrial fibrillation, anxiety and depression. Resident #6's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 11/19/16. Resident #6 was coded as being moderately cognitively impaired in the ability to make daily decisions, scoring 07 out of 15 on the BIMS (brief interview for mental status) exam.

100% of all residents receiving prn pain medications, to include Resident #6, MARs were reviewed to ensure non-pharmacological interventions were implemented with documentation in the medical records prior to the administration of pain medication. The care plan was updated to reflect non-pharmacological interventions to implement prior to the administration of pain medications on/or before 3/25/17 by Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) for all residents who receive prn pain medications.

All license nurses to include LPN #1 and LPN #5 were in serviced on/or before 3/25/17 by Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) to implement non-pharmacological interventions prior to the administration of prn pain medications with documentation in the medical records. Examples of non-pharmacological interventions were reviewed during the in-service. All newly hired licensed nurses will be

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Resident #6 was coded as requiring extensive assistance with one person physical assist with most ADLS (activities of daily living) including transfers, locomotion, dressing, toileting, and personal hygiene; independent with meals, and totally dependent on staff with bathing.

Review of Resident #6's most recently signed POS (physician order sheet) dated 1/31/17 documented the following order, "Ultram Tramadol [1] HCL 50 MG (milligrams) TABS (tablets) 1 by mouth every six hours as needed for pain."

Review of Resident #6's December 2016 and January 2017 MARs (Medication Administration Record) revealed that Resident #6 received Ultram 50 mg on the following dates:

12/5/16, 12/8/16, 12/10/16, 12/11/16, 12/13/16 and 12/24/16, 1/3/17, and 1/6/17.

Review of the December 2016 and January 2017 nursing notes revealed no evidence that non-pharmacological interventions were attempted prior to the administration of Ultram.

Further review of the clinical record failed to show evidence that non-pharmacological interventions were attempted prior to the administration of Ultram.

On 2/8/17 at 2:50 p.m., an interview was conducted with LPN (licensed practical nurse) #1. When asked the process prior to the administration of a prn (as needed) pain medication, LPN #1 stated that nurses should always attempt non-pharmacological interventions prior to the administration of pain

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in serviced during orientation by the staff facilitator to implement non-pharmacological interventions prior to administering prn pain medications with documentation in the medical records. Examples of non-pharmacological interventions will be reviewed during the in-service.

10% of resident's receiving prn pain medications to include resident #6, progress notes and MARs will be reviewed by Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) to ensure non-pharmacological interventions are being provided prior to the administration of pain medications weekly x 8 weeks then monthly x 1 month utilizing a Pain Management QI Tool. The license nurse will be retrained immediately by Administrative Nurses (DON/ADON/SDC/MDS Nurse/MDS fill-in) for any identified areas of concern. The Director of Nursing will review and initial the Pain Management QI Audit Tool weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed.

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F 309	Continued From page 27 medication. On 2/8/17 at 4:00 p.m., an interview was conducted with LPN #5 a nurse who administered Ultram to Resident #6 on three different occasions. LPN #5 was asked about the process staff follows prior to the administration of a prn (as needed) pain medication. LPN #5 stated that she would assess the resident to find out their level of pain by using the 1-10 pain scale and check to see when the last dose of pain medication was administered. LPN #5 stated that she would also follow up on the Resident's pain after the pain medication was administered. When asked if anything would be attempted prior to the administration of pain medication, LPN #5 stated that non-pharmacological interventions such as repositioning would be attempted. When asked where this would be documented, LPN#5 stated that this would be documented in a progress note. When asked if she attempted non-pharmacological interventions prior to administering Ultram to Resident #6, LPN #5 stated, "I can't say I did. She requests her pain medication." When asked if staff should be encouraging residents who request pain medication to try non-pharmacological interventions first, LPN #5 stated, "Yes." On 2/8/17 at 5:01 p.m., ASM (administrative staff member) #1, the Administrator, ASM #2, the DON (Director of Nursing) and ASM #4, the facility consultant were made aware of the above concerns. A policy could not be provided regarding non-pharmacological pain interventions prior to administering prn pain medication. [1] Tramadol/Ultram- analgesic used to treat	F 309	The Executive QI committee will meet monthly and review the Pain Management QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly 3 months.	

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F 309	Continued From page 28 moderate to severe pain. This information was obtained from Davis's Drug Guide for Nurses, 11th edition p. 1197.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, it was determined that facility staff failed to provide treatment and services to prevent or heal pressure ulcers for one of 20 residents in the survey sample, Resident #6. 1a. The facility staff failed to provide weekly wound measurements and staging of a stage two [1] pressure ulcer that was found on Resident #6's sacrum on 4/8/16. 1b. The facility staff failed to implement skin	F 314	Resident #6 heel boots and heel floats were applied while resident was in bed as identified on the plan of care on 2/23/17 by DON. Resident #6 skin was assessed on2/8/17 by Tx Nurse/RN with no observations of pressure sores. 100% audit was completed by facility consultant and DON on 2/22/17 of all residents at high risk for pressure ulcers or with actual pressure ulcers to include resident #6 to ensure preventive measures to prevent pressure sores to include heel boots and heel floats are applied and weekly wound measurements and staging of pressure ulcers are documented. The DON corrected all identified areas of concerns during the audit. 100% of license nurses to include RN #3, RN #1, LPN #2, LPN #6, LPN #7 and nursing assistants to include CNA #4 were re-educated by Administrative Nurses (DON/ADON/SDC/QI/TX nurse and/or MDS coordinator) on/or before 3/25/17 regarding ensuring preventive measure to prevent pressure sores, including heel boots and float heels, are provided per the resident care guide/care plan. The treatment nurse	3/25/17

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preventive measures to prevent pressure sores by not applying heel boots to Resident #6's bilateral feet and by not floating Resident #6's heels while she was in bed.

The findings include:

1. a. Resident #6 was admitted to the facility on 11/27/14 and readmitted on 5/18/16 with diagnoses that included but were not limited to adult failure to thrive, Alzheimer's disease, dementia, hypertension, atrial fibrillation, anxiety and depression. Resident #6's most recent MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 11/19/16. Resident #6 was coded as being moderately cognitively impaired in the ability to make daily decisions, scoring 07 out of 15 on the BIMS (brief interview for mental status) exam. Resident #6 was coded as requiring extensive assistance with one person physical assist with most ADLS (activities of daily living) including transfers, locomotion, dressing, toileting, and personal hygiene; independent with meals, and totally dependent on staff with bathing.

Review of Resident #6's nursing notes revealed the following note dated 4/8/16: "Resident noted with a new stage 2 pressure ulcer to sacral area. 2.6 cm (centimeters) X (by) 1.0 cm, 100 % (percent) pink, healthy tissue. Ordered Duoderm [2] dressing changes and Vitamin C and Zinc po (by mouth) X (times) 14 days. RP (Responsible Party) aware. MD (Medical Doctor) aware."

Review of the Wound Ulcer Flowsheet dated 4/8/16, documented the following: "Site: 53) Sacrum Type: Pressure Length: 2.6 cm Width: 1.0cm Stage II."

was in serviced by facility consultant on regarding wound measurements, requirements for documentation of pressure sores, weekly assessment, staging and care planning of pressure ulcers. All newly hired license nurses and nursing assistants will be in serviced during orientation by the Staff Facilitator regarding ensuring preventive measures to prevent pressure sores, including heel boots and float heels, are provided per the resident care guide/care plan.

The Administrative Nurses (DON/ADON/SDC/QI and/or MDS coordinator) will complete resident rounds on residents at high risk for pressure ulcers and with actual pressure ulcers utilizing the Preventative Interventions QI Tool weekly x 8 weeks then monthly x 1 month to ensure residents are provided intervention to prevent pressure sores to include heel boots and floats in accordance with the written care plan. The Administrative Nurses (DON/ADON/SDC/QI and/or MDS coordinator) will address any identified areas of concern immediately during the audit by ensuring interventions are in place and retraining with the staff member. An audit of wound documentation will be conducted for all residents with

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Review of the physician's telephone orders dated 4/8/16 for Resident #6 documented the following orders: "Apply duoderm to sacral St (stage) 2 ulcer. Change Q (every) 7 days and PRN (as needed). Zinc [3] 220 mg (milligrams) po (by mouth) TID (Three times a day) x 14 days, Vit (Vitamin) C [4] 500 mg po BID (two times a day) x 14 days wound healing."

Review of Resident #6's April 2016 through August 2016 TARs (Treatment Administration Records) revealed that Resident #6 was receiving the same treatment "Apply Duoderm to sacrum stage II q (every) 7 days and prn" for four months.

Review of a skin check sheet dated 6/9/16 documented the following: "Skin is clear and intact."

Review of Resident #6's Flowsheet of Non-Ulcer Skin Conditions dated 6/23/16 documented the following: "Site: Sacrum, Description: protectant...Comments Apply Duoderm Q7 days and PRN." No measurements were documented.

Review of Resident #6's Flowsheet of Non-Ulcer skin conditions dated 7/14/16 documented the following: "Type of skin condition: Stage 2...Site 53) Sacrum...Comments Apply Duoderm to sacral stage II every 7 days and PRN." No measurements were documented.

Further Review of Resident #6's nursing notes revealed the following note dated 8/3/16, "Stage II to sacrum healed, treatment d/c'd (discontinued), RP and MD made aware."

No other notes or Wound Ulcer Flowsheets could

pressure ulcers by Administrative Nurses (DON/ADON/SDC/QI/ and/or MDS coordinator) weekly x 8 weeks then monthly x 1 month using a QI Wound Documentation Audit Tool to ensure wound documentation is completed as per protocol to include weekly assessment, wound measurements, staging of pressure ulcers, and care planning for pressure sores. Any concerns will immediately be addressed by the Administrative Nurses (DON/ADON/SDC/QI and/or MDS coordinator) with reeducation of the treatment nurse and completion of the appropriate wound documentation. The DON will review and initial the Preventative Interventions QI Tool and the QI Wound Documentation Audit Tool weekly x 8 weeks then monthly x 1 month to ensure compliance.

The Executive QI committee will meet monthly and review the Preventative Interventions QI Tools and the QI Wound Documentation Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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be found documenting measurements of Resident #6's stage II pressure ulcer.

Review of Resident #6's skin care plan dated 12/3/14 and reviewed 8/29/16, documented skin interventions prior to the development of the Stage II pressure ulcer. The care plan did not address Resident #6's Stage II pressure ulcer of the sacrum.

On 2/8/17 at 2:50 p.m., an interview was conducted with RN (registered nurse) #3. When asked the process if a new wound is identified, RN #3 stated, "The treatment nurse will be alerted that the resident has a new skin area and then the treatment nurse will check the area every day. She will measure the wound once a week and document the wound measurements under the assessment tab in the computer." RN #3 stated that CNAs (certified nursing assistants) or nursing should be checking the skin every time they provide care to the resident, and document when there are new changes.

On 2/8/17 at approximately 3:00 p.m., an interview was conducted with RN #1, the wound care nurse. When asked the process if a new wound is identified, RN #1 stated, "If the CNAs find an area during a skin check, they will key it in the computer system which will then alert me to assess the area. I will do measurements and incorporate a treatment. I check the area daily and measure and stage the wound weekly." RN #1 stated that measurements were documented on a wound ulcer flow sheet. When asked if she was the only nurse to do treatments, RN #1 stated, "Most of the time yes but it depends on how often the wound has to be changed. Some wounds are changed two times a day and I am

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not here on the evening shift. The floor nurses would then change the dressing." RN #1 stated that she started as the wound care nurse in August of 2016. When asked if she could recall Resident #6's sacral wound, RN #1 stated, "I could not tell you." When asked if she could find Resident #6's wound ulcer flow sheets, RN #1 stated, "I can look."

On 2/8/17 at 5:01 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator and ASM #2, the DON (Director of Nursing). ASM #3 stated that she thought that Resident #6 had the wound when the resident was sent out to the hospital on 5/17/16 and she came back to the facility on 5/18/16 with the wound documented as healed. That information was requested by this writer.

On 2/9/17 at 8:15 a.m., observation of Resident #6's sacral area was conducted with LPN (licensed practical nurse) #7. Resident #6 had no skin issues noted to her sacral area.

On 2/9/17 at 8:30 a.m., further interview was conducted with RN #1, the wound care nurse. When asked why it was important to measure and stage wounds, RN #1 stated that she measures and stages wounds to track healing progress. RN#1 stated that she will change treatments if there is no progress and if the current treatment is not working to heal the ulcer. When asked if she had found measurements for Resident #6's pressure, RN #1 stated that she could not find any additional information. When asked how nursing would know if Resident #6's treatment was effective if weekly wound measurements or staging was not documented, RN #1 stated, "At that time I couldn't tell you if

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treatments were working or effective."

On 2/9/17 at 10:51 a.m., further interview was conducted with ASM #3, the DON. ASM #3 was asked when wounds should be measured and staged. ASM #3 stated that wounds should be measured and staged weekly. ASM #3 stated that measurements would be documented on a wound flow sheet. ASM #3 also stated that herself, the administrator, treatment nurse, and ADON (Assistant Director of Nursing) will have weekly skin meetings to discuss new treatments or if current treatments are successful at healing wounds. When asked if she discussed Resident #6's wounds in the skin meetings, ASM #3 stated, "No because I wasn't here. I didn't get to the floor until the first of July." When asked if she could find documentation that Resident #6 went to the hospital on 5/17/16 with a wound and came back without a wound on 5/18/16, ASM #3 stated, "I just printed the nursing notes documenting that she went out to the hospital and came back."

The nursing notes documenting that Resident #6 went out to the hospital on 5/17/16 and arrived back to the facility on 5/18/16, did not address her wound.

On 2/8/17 at 5:01 p.m., ASM #1, the administrator, ASM #2, the Director of Nursing, and ASM #4, the facility consultant were made aware of the above concerns.

Facility policy titled, "Pressure Ulcer Documentation," documents the following: "It is the facility policy that pressure ulcers will be assessed. Pressure Ulcer Flow Sheets and progress notes on ulcers will be maintained in each resident's medical record In addition, upon

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admission or readmission of any resident, the facility will photograph any existing ulcers."

Facility policy titled, "Wound/Ulcer Treatment" documents, in part the following: "A pressure is a localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and friction...Stage II- Partial thickness skin loss involving epidermis, dermis or both, presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister, an abrasion, or a shallow center."

No further information was presented prior to exit.

According to the U.S. Department of Health and Human Services Public Health Service, Agency for Health Care Policy and Research, Clinical Practice Guidelines, Treatment of Pressure Ulcers, Number 15 an AHCPR Publication No. 95-0652 page 24: The Clinical Practice Guidelines Treatment of Pressure Ulcers revealed in part the following information regarding pressure sore treatment: "7. Assessment of pressure sore healing. Progress toward healing should be evaluated weekly. If signs of ulcer deterioration are observed sooner (e.g. during daily dressing changes), steps to reverse them should be taken immediately. 9. Reassessment of Treatment Plan and evaluation of Adherence. If the ulcer is not healing, the clinician must reassess the treatment plan and determine whether it is being followed. In particular the clinician should assess whether tissue load management is adequate and should evaluate the extent of adherence to cleansing and dressing ... Pressure ulcers should be

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uniformly described to facilitate communication amongst staff and to ensure adequate monitoring of the progress toward healing."

[1] Stage II Pressure-
Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister.
Further description:
Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.
*Bruising indicates suspected deep tissue injury.
This information was obtained from National Pressure Ulcer Advisory Panel.
http://www.npuap.org/pr2.htm.

[2] Duoderm dressing-DuoDERM® Dressings are modern hydrocolloid dressings for the management of light to moderately exuding wounds. DuoDERM® Dressings are versatile, easy to use and are suitable for managing different stages of wound healing and wound types in a protocol of care.
http://www.convatec.com/en/cvtus-duodrrngus/cvt-portallev1/0/detail/0/1444/1847/duoderm-dressing-range.html

[3] Zinc-"Zinc helps maintain the integrity of skin and mucosal membranes. Patients with chronic leg ulcers have abnormal zinc metabolism and low serum zinc levels, and clinicians frequently treat skin ulcers with zinc supplements." This information was obtained from The National Institutes of Health.
https://ods.od.nih.gov/factsheets/Zinc-HealthProf

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[4] Vitamin C-"Vitamin C is required for the biosynthesis of collagen, L-carnitine, and certain neurotransmitters; vitamin C is also involved in protein metabolism [1,2]. Collagen is an essential component of connective tissue, which plays a vital role in wound healing." This information was obtained from The National Institutes of Health. https://ods.od.nih.gov/factsheets/VitaminC-HealthProfessional/.

1b. The facility staff failed to implement skin preventive measures to prevent pressure areas by not applying heel boots or floating heels to Resident #6's bilateral feet.

On 2/8/17 at 8:00 a.m., Resident #6 was sleeping in bed. Her blanket covered her legs but her heels were resting directly on the mattress. No boots were observed in place on her feet.

On 2/8/17 at 8:40 a.m., Resident #6 was sleeping in bed. Her blanket covered her legs but her heels were resting directly on the mattress. No boots were observed in place on her feet.

On 2/8/17 at 9:26 a.m., Resident #6 was sleeping in bed. Her blanket covered her legs but her heels were resting directly on the mattress. No boots were observed in place on her feet.

Review of Resident #6's care plan dated 11/28/14 and updated 8/29/16 documented the following intervention under area "Resident Care Guide:

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Heel Protection: bunny boots to both feet and float heels as tolerated."

Review of Resident #6's current ADL (Activity of Daily Living) tracker log that was posted in her closet, documented in part, the following; "Equipment/Instructions/Precautions...Heel Protection: bunny boots to both feet and float both heels."

Review of Resident #6's February 2017 MARs (medication administration record) and TAR (treatment administration record) revealed that heel boots were not on the MARs or TARS.

On 2/8/17 at 10:03 a.m., an interview was conducted with CNA (certified nursing assistant) #4, the CNA who worked with Resident #6. When asked how she determined a resident's needs for skin protection, care etc., CNA #4 stated that a care tracker card was in the inside of each resident's closet. When asked if Resident #6 had any special instructions while she was in bed, CNA #4 stated that Resident #6 was supposed to have heel boots on while in bed. When asked if Resident #6 had heel boots on, CNA #4 stated, "I don't know, but I can check." This surveyor followed CNA #4 to Resident #6's room. CNA #4 lifted up Resident #6's blanket. Heel boots were not in place to Resident #6's feet. Resident #6's feet were not elevated or floated. Resident #6's heels were normal in color. No redness was noted. CNA #4 stated, "That is something night duty was supposed to put on. I haven't looked at her yet." When asked if this was the first time she had rounded on Resident #6, CNA #4 stated, "Yes this is the first time. She is supposed to have them on. Her boots are not in her closet. I'll go get her a pair of booties."

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When asked how often CNAs rounded on residents, CNA #4 stated, "Two times a shift."

On 2/8/17 at 3:15 p.m., an interview was conducted with LPN (licensed practical nurse) #2. When asked who uses the care plan, LPN #2 stated that everyone uses the care plan even CNAs. When asked the purpose of the care plan, LPN #2 stated that it was to tell staff how to care for that particular resident. When asked if a resident had an intervention for heel boots on the care plan if heel boots should be in place, LPN #2 stated, "Yes. If they were not on, I would go and put them on." When asked who was responsible for ensuring skin protective measures were in place, LPN #2 stated that the wound care nurse and CNAs were responsible for ensuring ted hose, boots and other skin protective measures were in place.

On 2/9/17 at 8:15 a.m., further observation of Resident #6's heels was conducted with LPN (licensed practical nurse) #7. Resident #6's heels had no redness and were blanchable to the touch. When asked why Resident #6 needed bunny boots and her heels floated, LPN #6 stated it was to protect her skin.

On 2/9/17 at 8:30 a.m., an interview was conducted with RN (registered nurse) #1, the wound care nurse. When asked who was responsible for ensuring skin protective measures like heel boots were in place, RN #1 stated, "I would check to see if they are still on in the mornings when residents are still in bed. The aides usually go in and put heel boots on."

On 2/8/17 at 5:01 p.m., ASM #1, the administrator, ASM #2, the DON (Director of

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F 314	Continued From page 39 Nursing) and ASM #4, the facility consultant were made aware of the above concerns.	F 314		
F 363 SS=D	483.60(c)(1)-(7) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED (c) Menus and nutritional adequacy. Menus must- (c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; (c)(2) Be prepared in advance; (c)(3) Be followed; (c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; (c)(5) Be updated periodically; (c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and (c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. 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 follow the menu for one of 20 residents in the survey sample, Resident #19.	F 363	Resident #19 was served the published menu and physician ordered diet for supper on 2/8/17. An audit of 100% of residents was completed on 2/22/17-2/23/17 during lunch and supper by the Facility Consultant and Administrator to ensure the published menu was followed and all residents received the physician ordered diet. The Administrator and Facility Consultant ensured that the proper diet was provided for the resident for any identified areas of concern. 100% of dietary staff to include the cook were trained on or before 2/10/17 by the Administrator on following the published menu, production control to ensure preparation of adequate quantity of foods, and ensuring residents are served diets as ordered. 100% of dietary staff will be trained on or before 3/10/17 by the Dietary Consultant and/or Dietary Manager on having to make substitutions and the proper process to follow.	3/10/17

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The facility staff failed to serve the published menu of sausage, peppers and onions and steak fries at lunch on 2/8/17 to Resident #19. They served Resident #19 chicken, mashed potatoes, and peas.

The findings include:

Resident #19 was admitted to the facility on 3/17/14 with diagnoses including, but not limited to: lack of bone density, difficulty swallowing, Schizophrenia (1) and dementia with behaviors. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 12/9/16, Resident #19 was coded as being moderately cognitively impaired for making daily decisions. She was coded as requiring limited physical assistance from one staff member for eating. She was coded as having been ordered a mechanically altered diet by the physician.

A review of Resident #19's clinical record revealed the following physician's order, most recently signed by the physician on 1/7/17: "Diet: Regular, ground meats, thin liquids."

A review of the registered dietician-approved facility menu for lunch on 2/8/17 revealed, in part, the following: "Reg (Regular) Ground/Mech (Mechanical) Soft: Grd (Ground) Sausage/Pepp (Peppers)/Onions, Steak Fries."

On 2/8/17 at 12:45 p.m., observation was made of the tray line for the lunch meal. At this time, OSM (other staff member) #2, the cook, was observed preparing Resident #19's tray. OSM #2 had been observed to serve the last of the ground meat option of sausage, peppers and onions at

All newly hired dietary staff will be trained on following the published menu, production control to ensure preparation of adequate quantity of foods, and ensuring residents are served diets as ordered, having to make substitutions and the proper process to follow during orientation by the Dietary Manager.

The dietary manager will conduct audits of 10% of resident's trays on the tray line to include resident #19 for all three meals to ensure that residents are served the published menu items and physician ordered diet weekly x 8 weeks, then monthly x 1 month utilizing a Dietary QI Audit Tool. The Dietary Manager will retrain the appropriate dietary staff during the audit for any identified areas of concern. The Administrator will review and initial the Dietary QI Audit Tools weekly x 8 weeks then monthly x 1 month for compliance and to ensure all areas of concern have been addressed.

The Executive QI committee will meet monthly and review the Dietary QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.

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approximately 12:35 p.m. As OSM #2 prepared Resident #19's tray, she placed a whole piece of boneless, skinless chicken breast on Resident #19's tray. Using the side of the serving spoon, OSM #2 cut the chicken breast into large chunks. OSM #2 served mashed potatoes, cornbread and green peas on the plate, and placed the plate on the lunch tray for Resident #19.

On 2/8/17 at 1:25 p.m., observation was made of Resident #19 in the dining room. She had eaten less than 50% of the food on her tray. Observation of the resident's meal ticket revealed, in part, the following: "Texture: Regular, ground meats."

Attempts to interview Resident #19 regarding the lunch tray were unsuccessful.

On 2/8/17 at 1:30 p.m., OSM #2 was interviewed. When asked about the availability of the ground meat option for all residents, OSM #2 stated: "I ran out of the ground sausage." When asked if she remembered what she served Resident #19, OSM #2 stated: "The chicken." She stated that ordinarily, the second shift cook will be there to help prepare what is needed if there is not enough of a particular food item. When asked the process to be followed if the facility needs to substitute a meal item, OSM #2 stated: "We will go out and ask the residents if they would like a substitute." She stated that no one from the staff did this for Resident #19.

On 2/8/17 at 1:35 p.m., OSM #1, the dietary manager, was interviewed. OSM #1 stated: "I did not know we were out of the ground option." She stated they did not follow their usual process of asking the residents about a substitute

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F 363	Continued From page 42 offering. A review of the comprehensive care plan for Resident #19 dated 12/30/15 and updated 2/7/17 revealed, in part, the following: "Diet as ordered (Ground). On 2/8/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, facility consultant, were informed of these concerns. A review of the facility policy entitled "Menu Policy" revealed no information related to the process to be followed if the facility runs out of a published menu item. No further information was provided prior to exit. Complaint Deficiency (1) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schizophrenia-booklet/index.shtml.	F 363		
F 364 SS=B	483.60(d)(1)(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP (d) Food and drink Each resident receives and the facility provides- (d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; (d)(2) Food and drink that is palatable, attractive,	F 364	All resident that had eaten less than 50% of the pizza, pureed meat, pureed peas, mashed potatoes, regular peas, and pasta were offered a substitute by the certified nursing assistants and Director of nursing on 2/8/17.	3/15/17

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and at a safe and appetizing temperature;
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to serve food at an appetizing temperature.

The facility staff failed to serve pizza, pureed meat, pureed peas, mashed potatoes, regular peas, and pasta at an appetizing temperature during lunch on 2/8/17.

The findings include:

On 2/8/17 at 11:55 a.m., observation was made as OSM (other staff member) #2, the cook, took temperatures of lunch foods in the holding steam table pans. The temperatures were (all in degrees Fahrenheit): pizza 98; pureed meat 155; pureed peas 167; mashed potatoes 171; regular peas 184; and pasta 153.

On 2/8/17 at 1:10 p.m., after the last resident tray was served from the tray line, the surveyor requested a test tray. At 1:15 p.m., it was determined that all residents had been served. OSM #1, the dietary manager, and ASM (administrative staff member) #1, the administrator, accompanied the surveyor to test the food on the test tray for temperature and palatability. OSM #1 took the temperatures, which were (all in degrees Fahrenheit): pizza 74; pureed meat 67; pureed peas 72; mashed potatoes 73; regular peas 69; and pasta 73. Two surveyors tasted these items and agreed that they were not at an appetizing temperature. ASM #1 also tasted these items and stated: "It's not

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100% of all alert and oriented residents were interviewed on or before 3/15/17 by social worker regarding are meals served at an appetizing temperature. A resident concern form will be completed by social worker during the audit for any identified areas of concern.

100% of dietary staff were educated on the appropriate holding temps for foods as well as the desired serving temperatures for foods on or before 3/15/17 by the Dietary Manager and/or Administrator. 100% of License Nurses and CNAs were in serviced on passing resident's trays in a timely manner to ensure food is served at an appetizing temperature. All newly hired dietary staff will be in serviced regarding holding temps for foods as well as the desired serving temperatures for foods during orientation by the dietary manager. All newly hired license nurses and CNAs will be in serviced regarding passing resident's trays in a timely manner to ensure food is served at an appetizing temperature during orientation by the staff facilitator.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 364	Continued From page 44 cold; they are warm." When asked if she would describe this as a hot meal, she stated: "It's warm." On 2/8/17 at 1:20 p.m., OSM #1 was asked what process is in place to provide meals at an appetizing temperature to residents. She stated the facility does not have heated plates or trays. On 2/8/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, facility consultant, were informed of these concerns. A review of the facility policy entitled "Food Temperature" revealed no information related to serving foods at an appetizing temperature to residents. No further information was provided prior to exit.	F 364	The dietary manager will conduct test tray audits using the Tray Assessment QI Tool to ensure that residents are served foods at an appetizing temperature weekly x 8 weeks, then monthly x 1 month. The dietary Manager will retrain dietary staff and/or the Director of nursing will retrain the license nurses or certified nursing assistants for any identified areas of concern during the audit. The Administrator will review and initial the Tray Assessment QI Tool for compliance and to ensure all areas of concern have been addressed. The Executive QI committee will meet monthly and review the Tray Assessment QI Tool and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	
F 367 SS=D	COMPLAINT DEFICIENCY 483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility	F 367	Resident #19 was served the physician-ordered/care planned ground meat diet during supper on 2/8/17. The cook is no longer employed at Wayland.	3/25/17

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	495226	A. BUILDING _____ B. WING _____	C 02/09/2017

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F 367	Continued From page 45 document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to serve a physician-ordered therapeutic diet to one of 20 residents in the survey sample, Resident #19. The facility staff failed to serve ground meat as ordered by the physician at lunch on 2/8/17 to Resident #19. The findings include: Resident #19 was admitted to the facility on 3/17/14 with diagnoses including, but not limited to: lack of bone density, difficulty swallowing, Schizophrenia (1) and dementia with behaviors. On the most recent MDS (minimum data set), a significant change assessment with an assessment reference date of 12/9/16, Resident #19 was coded as being moderately cognitively impaired for making daily decisions. She was coded as requiring limited physical assistance from one staff member for eating. She was coded as having been ordered a mechanically altered diet by the physician. A review of Resident #19's clinical record revealed the following physician's order, most recently signed by the physician on 1/7/17: "Diet: Regular, ground meats, thin liquids." A review of the registered dietician-approved facility menu for lunch on 2/8/17 revealed, in part, the following: "Reg (Regular) Ground/Mech (Mechanical) Soft: Grd (Ground) Sausage/Pepp (Peppers)/Onions." On 2/8/17 at 12:45 p.m., observation was made of the tray line for the lunch meal. At this time,	F 367	100% audit was conducted by the Dietary Manager on/or before 3/25/17 comparing all residents physician-ordered/care planned diets to actual meals observations to include resident #19 to ensure the physician ordered/care planned diet is followed. The Dietary manager immediately addressed all areas of concern during the audit. 100% of all dietary staff were in serviced by the Dietary Manager or Administrator on or before 3/25/17 regarding ensuring that residents are provided the physician ordered /care planned diet during meals. All newly hired dietary staff will be in serviced during orientation regarding ensuring that residents are provided the physician ordered /care planned diet during meals. The Dietary Manager will observe resident meals, to include meals for resident #19, to ensure residents are being provided the physician ordered /care planned diet. The Dietary Manager will address any identified areas of concern immediately by ensuring correct meal provided and retraining with the staff member. The Administrator or DON will review and initial the QI Care Plan/ Care Guide Audit Tools and Meal Observation Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all identified areas of concern were addressed.	

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F 367	Continued From page 46	F 367	The Executive QI committee will meet monthly and review the Meal Observation Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

OSM (other staff member) #2, the cook, was observed preparing Resident #19's tray. OSM #2 had been observed to serve the last of the ground meat option of sausage, peppers and onions at approximately 12:35 p.m. As OSM #2 prepared Resident #19's tray, she placed a whole piece of boneless, skinless chicken breast on Resident#19's tray. Using the side of the serving spoon, OSM #2 cut the chicken breast into large chunks. OSM #2 served mashed potatoes, cornbread and green peas on the plate, and placed the plate on the lunch tray for Resident #19.

On 2/8/17 at 1:25 p.m., observation was made of Resident #19 in the dining room. She had eaten less than 50% of the food on her tray. Approximately half of the chicken breast remained on the tray. Resident #19 showed no signs of coughing. Observation of the resident's meal ticket revealed, in part, the following: "Texture: Regular, ground meats."

Attempts to interview Resident #19 regarding the lunch tray and meat consistency were unsuccessful.

Attempts to interview Resident #19 regarding the lunch tray were unsuccessful.

On 2/8/17 at 1:30 p.m., OSM #2 was interviewed. When asked about the availability of the ground meat option for all residents, OSM #2 stated: "I ran out of the ground sausage." When asked if she remembered what she served Resident #19, OSM #2 stated: "The chicken." She stated that ordinarily, the second shift cook will be there to help prepare what is needed if there is not enough of a particular food item. When asked

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F 367	Continued From page 47	F 367		

the process to be followed if the facility needs to substitute a meal item, OSM #2 stated: "We will go out and ask the residents if they would like a substitute." She stated that no one from the staff did this for Resident #19.

On 2/8/17 at 1:35 p.m., OSM #1, the dietary manager, was interviewed. OSM #1 stated: "I did not know we were out of the ground option." She stated they did not follow their usual process of asking the residents about a substitute offering.

On 2/8/17 at 3:35 p.m., CNA (certified nursing assistant) #1 was interviewed. CNA #1stated: "If we hand out a tray, we are supposed to make sure what's on the plate matches the meal ticket." She stated the information regarding the physician-ordered diet is on both the meal ticket and the resident guide on the computer.

A review of the comprehensive care plan for Resident #19 dated 12/30/15 and updated 2/7/17 revealed, in part, the following: "Diet as ordered (Ground).

On 2/8/17 at 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, facility consultant, were informed of these concerns.

A review of the facility policy entitled "Menu Policy" revealed, in part, the following: "The menu is written for the general/regular diets and is modified for the following diets...3) Regular Ground/Mechanical Soft...Mechanical Soft/Regular Ground: The diet consists of foods that are easy to chew; designed for residents with chewing or swallowing difficulties. Meats from

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F 367	Continued From page 48 the regular menu will be served but will be ground. Raw fruits and vegetable will be served as deemed appropriate." No further information was provided prior to exit. Complaint Deficiency (1) "Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website https://www.nimh.nih.gov/health/publications/schizophrenia-booklet/index.shtml.	F 367		
F 441 SS=B	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 441	A cover was placed on the clean linen in the linen closet on the A wing of the facility on 2/24/17 by the housekeeping/laundry supervisor. 100% audit was conducted of all linen closest to ensure linens are stored in a sanitary manner to include not directly beneath areas of staining on the ceiling on/or before 3/5/17 by the Administrator. The Administrator immediately corrected any identified areas of concern during the audit. 100% of license nurses and certified nursing assistants were in serviced on/or before 3/25/17 by	3/25/17

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F 441	Continued From page 49 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441	Administrative Nurses (DON/ADON/SDC/MDS Nurse) to ensure linens are stored in a sanitary manner to include not directly beneath areas of staining on the ceiling. All newly hired license nurses and certified nursing assistants will be in serviced to ensure linens are stored in a sanitary manner to include not directly beneath areas of staining on the ceiling during orientation by the Staff Facilitator. The Housekeeping/Laundry supervisor will audit all linen rooms to include on the A wing to ensure linens are stored in a sanitary manner to include not directly beneath areas of staining on the ceiling weekly x 8 weeks then monthly x 1 month utilizing a Linen Monitoring QI Audit Tool. The Housekeeping supervisor and/or Administrative Nurses (DON/ADON/SDC/MDS Nurse) will retrain the license nurse or certified nursing assistant during the audit for any identified areas of concern. The DON will review and initial the Linen Monitoring QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed.	

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F 441	Continued From page 50 (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. 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 implement infection control practices for the storage of resident linens in one of three linen closets. The facility staff failed to store linens in a sanitary manner. Clean linens in the linen closet on the A wing of the facility were observed stored directly beneath an area on the ceiling containing brown stains. The findings include: Observations of the linen closet located on the A-wing of the facility during the days of the survey, on 02/08/17 at 4:25 p.m. and on 02/09/17 at 8:00 a.m., revealed clean linens (pillows, blankets and sheets) were stacked on shelves and uncovered inside the linen closet. Further observation of the linen closet revealed an area on the ceiling containing brown stains above the linen stacked on the shelves. An observation of the linen closet located on the A-wing of the facility was conducted on 02/09/17 at 9:35 a.m. with OSM (other staff member) # 7, director of maintenance and OSM # 9, director of housekeeping. When asked who was responsible for the linens OSM # 9 stated she was. After observing the stained ceiling above the uncovered clean linen's in the linen closet OSM # 9 stated, "The linens could be stored somewhere else or they could be covered."	F 441	The Executive QI committee will meet monthly and review the Linen Monitoring QI Audit Tools and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 441	Continued From page 51 The facility's policy "Standard for Linen Department" documented in part, "Clean linen and clothing are stored in clean, dry, dust-free areas easily accessible to the nurses' stations." On 02/09/17 at 10:15 a.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 4, facility consultant, were made aware of the findings. No further information was obtained prior to exit.	F 441		
F 465 SS=D	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and complaint investigation, it was determined that the facility staff failed to maintain resident shower stalls in a clean manner in one of two whirlpool rooms. The facility staff failed to clean two shower stalls in the resident's whirlpool room on the B-wing of the facility.	F 465	In the resident's whirlpool room located on the B-wing, new grout/caulk was applied to the two shower stalls to the areas where the black substance was located by Maintenance on/or before 3/15/17. 100% observation of all shower stalls in the facility was completed by Housekeeping Supervisor and Administrator on/or before 3/10/17 to ensure shower stalls are maintained in a clean manner and without black substances. Work orders were completed by Administrator on/or before 3/10/17 for notification to housekeeping and/or maintenance for any identified areas of concern. Housekeeping and/or Maintenance addressed all areas of concerns from the audit by 3/25/17. 100% of Housekeeping Services was in-service by the Administrator on or before 3/10/17 to check and clean shower stalls daily and to notify maintenance if areas of discoloration are noted	3/25/17

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The findings include:

Observations of the resident's whirlpool room located on the B-wing of the facility during the days of the survey, on 02/08/17 at 4:30 p.m. and on 02/09/17 at 8:00 a.m., revealed caulk/grout covered in a black substance in the right and left corners of both shower stalls to the height of approximately 18 inches.

An observation of the resident's whirlpool room located on the B-wing of the facility was conducted on 02/09/17 at 9:35 a.m. with OSM (other staff member) # 7, director of maintenance and OSM # 9, director of housekeeping. When asked who was responsible for cleaning the shower stalls, OSM # 9 stated it was housekeeping. When asked how often the shower stalls were cleaned, OSM # 9 stated, "Every day." When asked about the black substance on the caulk/grout in the shower stalls, OSM # 9 stated that the housekeeping staff use brushes for cleaning the tiles and the caulk/grout. OSM # 9 also stated that if the housekeeping staff was unable to get the shower stalls clean they should have been report to her. OSM # 9 stated she was unaware of the dirty shower stalls. Further examination of the caulk/grout in the two shower stalls was conducted by OSM # 7 and OSM # 9. OSM # 7 stated that it appeared the caulk/grout was discolored and couldn't be cleaned but could be scrapped out and reapplied with new grout or caulk. OSM # 9 stated that if she had known about it she would have consulted the maintenance department.

The facility's policy "Procedure For Cleaning A Shower Stall" documented in part, "5. Scrub with

and unable to be cleaned. All newly hired housekeeping staff will be in serviced by Housekeeping Supervisor during orientation to check and clean shower stalls daily and to notify maintenance if areas of discoloration are noted and unable to be cleaned.

The DON and/or ADON will monitor 100% of all shower stalls to include on B-wing for cleanliness to include without black substances weekly x 8 weeks then monthly x 1 utilizing a Shower Stall QI Audit tool. The DON and/or ADON will immediately retrain the housekeeping staff or Maintenance director for any identified areas of concerns during the audit. The Administrator will review the Shower Stall QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed.

The Executive QI committee will meet monthly and review the Shower Stall QI Audit Tools and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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F 465	Continued From page 53 utility and scouring pad; scrap stubborn scales with putty knife. 6. Rinse with hot water and wipe with clean cloth. 7. Inspect for appearance and odor." On 02/09/17 at 10:15 a.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 4, facility consultant, were made aware of the findings. No further information was obtained prior to exit.	F 465		
F 468 SS=D	Complaint deficiency 483.90(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS (h)(3) Equip corridors with firmly secured handrails on each side; and 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 maintain handrails in good repair in one of three units. The facility staff failed to secure hallway handrails to the wall on the B-wing of the facility. The findings include: On 02/08/17 at 11:50 a.m., observations of the hallway handrail between resident rooms # 204 and # 205, and the handrail between resident room # 206 and the soiled linen room located on the B-wing of the facility were conducted and revealed both handrails were poorly secured to the wall. The handrail between resident rooms # 204 and # 205 was observed to be pulling away	F 468	F 468-Secured Handrails The handrail between rooms #204 and #205, #206 and the soiled linen room on the B wing were properly secured by Maintenance on/or before 3/10/17. 100% audit was completed by the Administrator of all hand rails in the facility to ensure handrails were properly secured and in good repair on/or before 3/15/17. The maintenance director immediately repaired the handrails for any identified areas of concern during the audit. The Maintenance Director will be in serviced by the Administrator on/or before 3/5/17 regarding checking handrails weekly to ensure handrails are secure and maintained in good repair and to	3/15/17

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F 468	Continued From page 54 from the wall and the handrail between resident room # 206 and the soiled linen room was loose from the wall mount. An observation of the hallway handrail between resident rooms # 204 and # 205, and the handrail between resident room # 206 and the soiled linen room located on the B-wing of the facility was conducted on 02/09/17 at 9:35 a.m. with OSM (other staff member) # 7, director of maintenance. After observing the handrails OSM # 7 acknowledged the handrails were loose and in need of repair. On 02/09/17 at 10:15 a.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 4, facility consultant, were made aware of the findings. No further information was obtained prior to exit.	F 468	immediately correct any concerns. 100% of all License nurses, CNAs, Dietary, housekeeping, therapy staff, and department managers was in-service by Administrative Nurses (DON/ADON/SDC/MDS Nurse) on reporting and filling out work orders for equipment in need of repair to include handrails. All newly hired License nurses, CNAs, Dietary, housekeeping, therapy staff, and department managers will be in serviced regarding on reporting and filling out work orders for equipment in need of repair to include handrails during orientation by the staff facilitator. The housekeeping supervisor will audit 100% of all facility handrails to include the wall on the B-wing weekly x 8 weeks, then monthly x 1 month to ensure handrails are	
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520	properly secured and in good repair utilizing a Hand Rail QI Audit Tool. A work order will be completed, the Maintenance Director will be retrained and the handrail will be immediately repaired for any identified areas of concern during the audit by the Administrator. The Administrator will review and initial the Handrail QI Audit Tools weekly x 8 weeks then monthly x 1 month for completion and to ensure all identified areas of concern were addressed. The Executive QI committee will meet monthly and review the Handrail QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.	

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F 520	Continued From page 55 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that facility staff failed to ensure quality assurance members all met on a quarterly basis. The facility staff failed to ensure that the physician attended a QA (quality assurance) meeting in October of 2016. The findings include: On 2/9/17 at 11:11 a.m., the QA (quality assurance) program was reviewed.	F 520	F520 A Quality Assurance meeting will be held on/or before 3/15/17 with the Attendance of Administrator, Medical Director, Quality Improvement Coordinator, Social Worker, Director of Nursing, Pharmacist, Medical Records Director, Dietary Manager, Housekeeping Supervisor to discuss current citations and the QA process. 100% of all previous QA meetings in the past year were review by Administrator on/or before 3/15/17 to ensure required quality assurance members were in attendance to include the medical director. The Administrator will review the information from the quarterly QA meeting with a current update of the area with any required member found not be in attendance by 3/25/17. The Administrator, DON and QI Nurse were educated by corporate consultant on the QA process to include Meeting with the Quality Assurance members on a quarterly basis, Requirements for attendance of the Quality Assurance Members to include the Medical Director with signatures on the QA meeting minutes, identifying issues that warrant development, establish a system to monitor the corrections, implement changes when the expected outcome is not achieved, and sustaining an effective QA program, on/or before 3/5/17. The Administrator will ensure the facility is maintaining an effect QA program with required committee members in attendance to include the medical director with documentation of signatures on the meeting minute form by reviewing and initialing the Executive committee Quarterly meeting minutes Quarterly x2. The Administrator will immediately retrain the QI nurse for any identified areas of concern. The results of the Quarterly Quality Assurance meeting minutes will be presented during the Executive Committee Quarterly Meeting by the Administrator x 3 Quarters for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	3/25/17

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Review of the QA meeting minutes revealed that a QA meeting was conducted on 10/19/16.

Review of the signature sheets for the 10/19/16 QA meeting failed to document a signature from the physician.

On 2/9/17 at 11:11 a.m., an interview was conducted with RN (registered nurse) #3, the QA nurse. When asked how often the physician should attend QA meetings, RN #3 stated, "Quarterly." When asked if the physician attended the 10/19/16 QA meeting, "RN #3 stated, "I wasn't the QA nurse until October." When asked if she could recall if the physician attended the 10/19/16 meeting, RN #3 stated, "I don't think so."

On 2/9/17 at 11:25 a.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. When asked who attends quarterly QA meetings, ASM #1 stated, "All department managers, myself, the pharmacist, DON, and the medical director (a physician). When asked if the medical director was required to meet quarterly for QA meetings, ASM #1 stated yes. When asked if the medical director attended that 10/19/16 QA meeting, ASM #1 stated, "I can't recall one way or the other. I will find out." A policy on QA meetings was requested by this writer.

On 2/9/17 at 11:30 p.m., a document was presented by ASM #1. The document was an email from the former medical director (the physician who would have attended the 10/19/16 QA meeting). The following was documented, "Attn: (attention) (Name of Administrator), I apologize I was unable to attend the 10/19/16 QA

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meeting in person, but I have reviewed the business and reports and agree with all the recommendations present..." This note was signed by the medical director on 10/26/16.

On 2/9/17 at 11:30 a.m., ASM #1, the administrator was made aware of the above concerns. A policy on QA was not presented as requested. No further information was presented prior to exit.

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F 000	Initial Comments An unannounced biannual licensure survey was conducted 2/7/17 through 2/9/17. Complaints were investigated during this survey. Corrections are required for 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 90 certified bed facility was 54 at the time of the survey. The survey sample consisted of 14 current resident reviews (Residents 1 through 12, #19 and #20) and 6 closed record reviews (Residents #13 through #18).	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: Management and administration. 12VAC5-371-110 B2 cross reference to F167 Infection control. 12VAC5-371-180 C7 cross reference to F441 Maintenance and housekeeping. 12VAC5-371-370A cross reference F465 Policies & procedures. 12VAC5-371-140 Based on staff interview and facility document review, it was determined that the facility staff failed to complete pre hire checks, for four of 25 employee records reviewed. The findings include:	F 001	Neither of the therapist are employed at Wayland any longer. The license verification from the Virginia Department of Health Professionals for LPN #7 was completed on 10/07/16 by the payroll bookkeeper. An audit of all current employees files to include therapy and nursing was completed by the payroll bookkeeper on/or before 3/5/17 to ensure all criminal background checks were obtained within 30 days of hire and licensure verifications obtained upon hire are in the employee files. Any identified concerns of missing items will be obtained and placed in the employee record by the payroll bookkeeper on/or before 3/25/17. The hiring managers and rehab director was educated on 2/28/17 by the Administrator regarding state requirements for criminal background checks to be obtained within 30 days of hire and licensure verification to be obtained prior to hire date of new employees.	3/25/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Crystal A Barnes — TITLE: Administrator — (X6) DATE: 2/24/17

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On February 8, 2017 at approximately 2:00 p.m., the employee records for newly hired employees within the past two years were reviewed. Review of the employee records failed to produce evidence that two of the 25 employees hired within the past two years had a Virginia State Police criminal background check within 30 days of hire and license verifications were not completed prior to hire for two of 25 employees hired within the past two years. The facility policy and procedure that was provided on entrance of the survey for hiring new employees and prevention of abuse and neglect was referenced.

The employees identified were:

OSM (other staff member) # 4, occupational therapist registered had a hire date of 02/22/16. The Virginia State Police criminal background on file was dated 10/26/15.
OSM (other staff member) # 5, physical therapist had a hire date of 04/10/16. The Virginia State Police criminal background on file was dated 01/13/16.
OSM (other staff member) # 6, physical therapist assistant had a hire date of 09/28/15. The Virginia license verification from the Department of Health Professionals on file was dated 01/29/16.
LPN (licensed practical nurse) # 7 had a hire date of 02/19/15. The license verification from the Virginia Department of Health Professionals on file was dated 10/07/16.

On 02/8/17 at approximately 3:35 p.m. an interview was conducted with OSM (other staff member) # 8, director accounts payable regarding the license verification from the Virginia Department of Health Professionals for LPN # 7. OSM # 8 stated that the license verification dated 10/07/16 was the only one she had and was

An audit will be conducted by the Payroll Bookkeeper using the New Hire QI Audit Tool prior to new hire orientation for all staff to include therapy staff and license nurses, to proof of licensure verification is present in the employee file and criminal background check is received within 30 days of hire weekly x 8 weeks then monthly x 1 month. The Administrator will immediately retrain the hiring manager and/or therapy director and obtain any missing information for any identified areas of concern during the audit. The Administrator will review and initial the New Hire QI Audit Tool weekly x 8 weeks then monthly x 1 month for completion and to ensure all identified areas of concern were addressed.

The Executive QI committee will meet monthly and review the New Hire QI Audit Tools and address any issues, concerns and/or trends and to make changes as needed, to include continued frequency of monitoring x 3 months.

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unable to locate the license verification for LPN # 7 at the time of hire.

On 02/9/17 at approximately 10:15 a.m. an interview was conducted with OSM (other staff member) # 3, director of rehabilitation department of (Name of Rehabilitation Company). When asked about the relationship of the rehabilitation department and the facility, OSM # 3 stated the (Name of Rehabilitation Company) was contracted with the facility and all the therapist were subcontracted with (Name of Rehabilitation Company). When asked if she was responsible for maintaining employee records and making sure they met the pre hire requirements, OSM # 3 stated, "Employee contract records are kept at the corporate level. We are independent of the facility and we follow our own employee record policy." When asked about a current Virginia State Police criminal background check for OSM # 4 and OSM # 5 and the license verification from the Virginia Department of Health Professionals for OSM # 6, OSM # 3 stated the rehabilitation companies were unable to provide them.

The facility policy "Abuse, Neglect or Misappropriation of Resident Property Policy" documented, "Screening of Employees. Potential employees will be screened by the facility for abuse, neglect or misappropriation of property. This screening process will include the requesting of information from previous and/or current employers and checking with the appropriate licensing boards and/or registries."

Review of the state regulation 12VAC5-371-140 documents "E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including: a. Verification of current professional license, registration, or certificate or completion of

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a required approved training course; b. Criminal record check."

Virginia Nursing Home Regulation 12VAC5-371-150 states that a facility must comply with the requirements of §32.1-126.01: Employment for compensation of persons convicted of certain offenses prohibited; criminal record checks required; suspension or revocation of license. "A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange."

State law (§§ 32.1-126.01 and 32.1-162.9:1 Employment for compensation of persons convicted of certain offenses prohibited; criminal records check required; suspension or revocation of license.) requires that each nursing facility, home care or home health organization, and hospice obtain a criminal record background check on new hires within 30 days of employment. The law also requires that these background checks be obtained using the Central Criminal Records Exchange from the Virginia Department of State Police. See Appendix 2 for a copy of each law.

On 02/09/17 at 10:15 a.m. ASM (administrative staff member) # 1, the administrator, ASM # 2, the director of nursing, and ASM # 4, facility consultant, were made aware of the findings.

No further information was obtained prior to exit.

12VAC5-371-340. Dietary and food service program.
Cross reference to F-363, F364, and F-367

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12VAC5-371-250. cross reference to F278, F309, F314

12VAC5-371-220. cross reference to F280, F309

12VAC5-371-200. cross reference to F282

12VAC5-371-170 cross reference to F520