STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495280	A. BUILDING _____ B. WING _____	C 02/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER AT LAKE RIDGE	12185 CLIPPER DRIVE LAKE RIDGE, VA 22192

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted on 1/30/2017 through 2/1/2017. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey to follow. The census in this 60 certified bed facility was 48 at the time of the survey. The survey sample consisted of 11 current resident reviews (Residents 1-11), and 4 closed record reviews (Residents 12-15)	F 000		
F 274 SS=D	COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE CFR(s): 483.20(b)(2)(ii) (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to implement a significant change assessment for one resident(Resident #6) in the survey sample of 15 residents.	F 274	1. Correction: Resident #6 MDS assessments for the 8-3-16 Quarterly assessment and 11-2-2016 Comprehensive Assessment were reviewed by the interdisciplinary team. The MDS Coordinator made corrections	2/17/17

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

Electronically Signed | 02/17/2017

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F 274	Continued From page 1 Resident #6 had significant declines in bowel and bladder incontinence. The Resident also exhibited improvement in toileting and hygiene. The findings included: Resident #6 was admitted 10-4-13. Diagnoses included but were not limited to; Dementia, anxiety, depression, dissociation, and conversion disorder. Review of the resident's clinical record revealed a quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 8-3-16, and the most recent assessment with an ARD of 11-2-16, which was a full annual assessment. The two consecutive assessments were compared for continuity, and the findings are below. The 8-3-16 quarterly assessment coded the resident as frequently incontinent of bowel, and bladder. This assessment also coded the Resident as being totally dependent on staff for hygiene, and toileting. The 11-2-16 annual assessment coded the resident with declines of; Total dependence now, on 1 staff member to be pushed in a wheel chair for ambulation, and always being incontinent of bowel, and bladder. This assessment also coded the Resident with improvements of needing extensive assistance of staff for hygiene, and toileting, which meant the Resident was now actively involved in these activities, instead of being totally dependent. The resident's clinical record was reviewed. Nursing notes revealed that the Resident had	F 274	and submitted the corrected MDS to CMS on 02/01/2017. In addition the 11-02-2016 Annual Comprehensive assessment was modified to a Significant Change Assessment and Transmitted to CMS. Completed 02-16-17 2. All residents have the potential to be affected by the alleged deficient practice. The alert charting for residents potentially triggering a change in condition has been reviewed by the Interdisciplinary team for potential Significant Change Assessment MDS and accuracy in coding. Completed 02/16/2017 3. Systemic Changes: Review of the 2016 version of the RAI manual Chapter 2 for guidance on Significant Change determination by the MDS Coordinator and DON with the Interdisciplinary team was completed on 02-03-2016. Continued Quarterly review of the RAI process with the IDT team will be provided by the MDS Coordinator or designee. 4.Monitoring: The Interdisciplinary team will audit a random sample of 3 MDS monthly x 3 Months to monitor for accuracy in coding and make a determination whether a significant change was required or not. All findings will be presented to the QAPI monthly for review/recommendations. 5.Date of compliance 02/17/2017	

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F 274	Continued From page 2 been placed on Hospice on 3-6-15, which had been discontinued, and now was considered comfort care only. This indicated that no labs, hospitalization, vital signs, weights, nor special diets would be obtained or ordered for this Resident. An interview was conducted on 2-1-17 at 9:50 am, with the MDS Coordinator. When asked about the results of the two assessments she stated, "I have made a correction, and submitted it to CMS (Centers for Medicare and Medicaid services)." The Director of Nursing, and Administrator were made aware of the findings at the end of day debrief on 1-31-17, and 2-1-17.	F 274		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		2/17/17

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F 371	Continued From page 3 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to store, prepare, and serve food in a sanitary manner. The findings included; Eight issues were identified in the kitchen on initial tour 1-30-17 at 2:30 p.m. The tour was completed with a Sodexho representative, a cook, and the Dining Services Director. Those issues included the following: 1) The first walk in refrigerator contained a clear plastic hanging curtain which resembled vertical blinds inside the refrigerator opening, and inside of the metal exterior door. This curtain was encrusted at the top of the curtain approximately 5-6 inches with dust, mildew, and a brown substance. The sprinkler head inside the refrigerator, on the ceiling, and over the stored food, was encrusted with the same substances as the inside curtain, and the substances hung down from the sprinkler head approximately 2-3 inches in a chandelier effect. 2) In the second walk in refrigerator a plastic tub of open raw fish in water was found on a 3 shelf, wheeled open plastic cart. The fish were on the middle shelf, with cooked bell peppers, and	F 371	The facility will store, prepare, and serve food in a sanitary manner. All issues identified on the initial tour with the Dining Services Director (DSD) were corrected on 1/30/2017 and 1/31/2017. After the initial walk through on 1/30/2017, a comprehensive kitchen inspection was conducted by the Director of Dining Services and the Dietitian. On 1/31/2017, another comprehensive inspection was completed and no deficiencies were found. The following solutions will be implemented to ensure the corrections are sustained. Training on Storage-Cross Contamination Risks were conducted on 01/30/2017 again 02/02/2017. Additional staff in-service training on sanitation, food temps, cleaning of cooking utensils is scheduled for 02/17/17. Continued Training on Cross Contamination and other dietary regulations is provided during the year with no less than one (1) every month. The Dining Services Director (DSD) and/or his designee, and the Chef will conduct periodically random inspections	

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F 371	Continued From page 4 cooked asparagus, directly under them on the bottom shelf, subject to splashing from the fish as the cart was moved. 3) The main ice machine drain was directly in the floor drain, subject to plumbing backup into the ice machine system. 4) The ice cream freezer was found to be encrusted inside and outside with sticky dried on ice cream, a brown substance, and an unknown black, brown, and tan debris. The inside of the freezer was covered in frost crystals with food debris frozen into it, approximately 1/4 inch thick. The 12 ice cream cardboard buckets (approximately 3 gallons each), were open with no tops on them, allowing the ice and debris to fall into the ice cream. 5) The ice cream scoop devices were observed, and consisted of a handle attached to a half round, 2-3 inch deep bowl for forming balls of ice cream. The scoops were resting in an open metal container secured to the wall beside the ice cream freezer with a water line flushing the metal container continuously. In the open container the water was approximately 1 inch deep, and did not cover the scoop bowls with the water. The 3 scoops were found to have a white milky liquid substance in the bowl portion of the scoops which appeared to be ice cream, and there were dead insects in the scoop bowls floating in the milky liquid substance. 6) On top of the main dish washing machine there was found food debris and dead insects. 7) At the 3 compartment sink, used for food defrosting, cook ware sanitizing, and air drying, a	F 371	of the kitchen and equipment. The Dietitian will make at least one sanitation inspection of the kitchen every month and report her findings to the DSD, the Chef, and the QUAPI monthly meeting. The DSD will report findings and corrective actions at the monthly QAPI meeting and Quarterly Quality Assurance (QQA) meeting. The Safety Committee Chairperson has appointed two (2) different teams from the Safety Committee to make at least two (2) inspections during the year. The Safety Committee Chairperson will report the findings and the plan of correction submitted by the DSD. The Director of Health Services will conduct an inspection every month and report the findings to the DSD, the monthly QAPI meeting and the Quarterly Quality Assurance Committee.	

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F 371	Continued From page 5 live cock roach was seen climbing across the wall behind the sinks. 8) On the clean cookware shelving unit, where clean cooking pans were stacked after washing until needed for food preparation, and cooking, a large shallow baking pan was found stacked between others of it's kind. The baking pan was encrusted with baked on food, and plastic wrap across the entire end of the pan, which had not been removed prior to washing the pan after the last use, and was stacked as clean for reuse. The Administrator, Dining Services Director, and the Executive Chef were notified of the kitchen issues on 1-30-17 during and after tour, and again at end of day debrief on 1-31-17, and on 2-1-17. Further information was provided by the facility, that the pest control company had been in to treat the kitchen on 2-1-16, and all other issues had been resolved by the end of survey on 2-1-17.	F 371		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 514		2/17/17

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F 514	Continued From page 6 (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed for one resident (Resident #13) of 15 residents in the survey sample to maintain an accurate clinical record. On 5 occasions, the facility staff documented in the Interdisciplinary Notes that Resident #13 was receiving oxygen at 2 liters per minute (lpm) however the physician's order was for 3 lpm and the nurses were signing on Treatment Administration Record (TAR) that 3 lpm was in use. The findings included: Resident #13 was admitted to the facility on	F 514	1. Corrective action for the Resident found to be affected by the identified deficient practice: Resident # 13 no longer resides in facility. 2. Residents with oxygen ordered have the potential to be affected by the same identified deficient practice. Residents with orders for oxygen have been audited for accuracy in documentation of the Physician order, Treatment Administration Record and Interdisciplinary notes. Completed 02/15/17 3. Systemic Changes:	

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F 514	Continued From page 7 8/8/16 and was discharged home on 9/7/16. Resident #13's diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure with hypoxia, anemia and status post left hip fracture with ORIF (open reduction internal fixation). Being Resident #13 was no longer in the facility a closed record review was conducted. The most recent Minimum Data Set (MDS) assessment was an admission assessment with an Assessment Reference Date (ARD) of 8/15/16. The MDS coded Resident #13 with severe cognitive impairment, was able to make self understood and able to understand others; extensive assistance from staff was required for bed mobility, transfers, dressing, toileting and personal hygiene; was dependent on staff for bathing and supervision for eating. Resident #13's discharge MDS with an ARD of 9/7/16 coded Resident #13's functional status as coded above. On 1/31/17 at 3:10 p.m. Resident #13's clinical record was reviewed. The review revealed a physician's order dated 8/8/16 which read, "O2 (oxygen) at 3L/min via nasal cannula ATC (around the clock)..." "Diagnosis:...Chronic obstructive pulmonary disease...Chronic respiratory failure with hypoxia." Review of the Treatment Administration Record (TAR) revealed the physician's order was transcribed as ordered and initialed as administered daily in the months of August and September 2016. Review of the Interdisciplinary Notes for the months of August and September 2016 revealed	F 514	Licensed Nursing staff will be re-educated on accepted professional standards and practices of complete and accurate documentation in the clinical record by the SDC or designee. Completed 02/17/16. Continued education on complete and accurate documentation in the clinical record will provided at the quarterly Licensed Nursing Meeting by the DON or designee. 4. Residents with orders for oxygen will be audited for documentation accuracy of the Physician order, Treatment Administration Record and Interdisciplinary notes weekly x 4 weeks, then monthly x 3 by the SDC or designee. All findings from the audit process will be presented to QAPI monthly for review/recommendations. 5. Date of compliance: 02/17/2017	

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F 514	Continued From page 8 the following inaccurate documentation of oxygen use: 8/16/16 at 6:51 a.m. "...On continuous oxygen at 2 l via nc (nasal cannula)..." 8/18/16 at 7:22 a.m. "...On continuous O2 at 2 l/mn (liters/minute) via nc..." 8/19/16 at 7:17 a.m. "...On O2 at 2 l/mn via nc..." 8/23/16 at 12:24 a.m. "...on oxygen at 2/L..." 8/31/16 at 7:37 a.m. "...oxygen at 2 l/mn via nc..." On 2/1/17 at 11:40 a.m. the Administrator and Director of Nursing were informed of the oxygen documented in the Interdisciplinary Notes at 2 liters per minute rather than the ordered and documented 3 lpm on the TAR. No further information was provided by the facility staff.	F 514		