STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0247	A. BUILDING: _____ B. WING _____	05/17/2018

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THORNTON HALL NURSING AND REHABILITATION C	827 NORVIEW AVENUE NORFOLK, VA 23509

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection and Medicare/Medicaid standard survey was conducted 5/15/18 through 5/17/18. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. One complaint was investigated during the survey. The census in this 60 bed certified facility was 51 at the time of the survey. The survey sample consisted of 16 current resident reviews (Resident #1, #4, #5, #8, #9, #14, #16, #19, #20, #22, #24, #31, #33, #36, #42, and #102) and 2 closed records (Resident #50a and 50b).	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: 12VAC5-371-180 (A) Infection Control. Cross reference to F880. 12VAC5-340 (A) Food Service Program. Cross reference to F814. 12VAC5-371-220 (A, C) Nursing Services. Cross reference to F689. 12 VAC 5-371-250 (A) & (D). Resident Assessment and Care Planning. Cross Reference to F641. 12 VAC 5-371-220 (D). Nursing Services. Cross Reference to F687.	F 001	12VAC5-371-180 (A) Infection Control. Cross reference to F880. 1. Resident #4 remains at baseline. Nurse #11 was re-educated to the glucometer cleaning policy. 2. All residents who receive glucose finger sticks have the potential to be affected. 3. A review of the facility□s Equipment Cleaning policy (which includes glucometers) was reviewed. No revisions are needed. Glucometer specific manufacturer cleaning guidelines were also reviewed to ensure available cleaning supplies were in concert with said guidelines. No variances were noted. All	6/25/18

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

Electronically Signed | 06/08/18

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F 001	Continued From page 1 12 VAC 5-371-220 (C). Quality of Care. Cross Reference to F698. 12 VAC-5-371-220 (A). Nursing Services. Cross Reference to F757. 12 VAC 5-371-300 (L). Pharmacy Services. Cross Reference to F761.	F 001	licensed nursing staff will be re educated to the glucometer cleaning before and after each use and will be re assessed using a glucometer competency check. Glucometer competencies are part of licensed nurse orientation. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The UM or DON will conduct weekly glucometer checks with nurses assigned to perform the same x one (1) months then monthly x two (2) months; confirming compliance with the cleaning policy and manufacturer guidelines; b) The DON will conduct the Environmental Rounds and Safety Audit monthly x two (2) months then quarterly x six (6) months which requires the observation of the glucometer and related documentation for cleaning; ensuring compliance with policy and expectations. Variances will be addressed promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter. 12VAC5-340 (A) Food Service Program. Cross reference to F814. 1. The open dumpster door was closed. 2. No other dumpsters are located on the property. 3. A review of the facility's policy Dispose of Garbage and Refuse has been conducted ensuring clarity. No revisions	

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F 001	Continued From page 2	F 001	are needed. The facility has activated a twice daily check of the dumpster with documentation. All housekeeping and dietary staff will be re-educated to the policy and expectation. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The dumpster will be checked twice daily by the dietary department; confirming garbage containment and a closed dumpster door x eight (8) weeks then weekly thereafter x six (6) months. These dumpster checks shall be documented; b) The Food Service Manager will conduct a refuse audit monthly x two (2) months then quarterly x one (1) year which includes the monitoring of refuse management. Variances will be addressed promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter. 12VAC5-371-220 (A, C) Nursing Services. Cross reference to F689. This citation is Past Non-Compliance (PNC), so entry of a Plan of Correction is not required. This Citation has been acknowledged. 12 VAC 5-371-250 (A) & (D). Resident Assessment and Care Planning. Cross Reference to F641. F641 1. Resident #16 remains at baseline. The Minimum Data Set (MDS) with an	

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F 001	Continued From page 3	F 001	Assessment Reference Date (ARD) of 2-16-18 was modified to reflect the Anti-anxiety agent usage during the seven (7) day look back period in accordance with the Resident Assessment Instrument (RAI) manual. 2. The facility has conducted a review of all current residents whose plan of care includes any psychoactive medications (including anti-anxiety, hypnotics, anti-depressants, and anti-psychotics). The review compared the resident□s MAR and coding to section N0410A-D during the resident□s most current MDS; ensuring the accurate coding of section N0410A-D. No variances were identified. 3. The facility has the most current copy of the RAI manual and the MDS coordinator was able to verbally re-demonstrate her understanding of the coding requirements for section N0410A-D. The facility has reviewed its□ policy on Resident Assessment acknowledging the expectation of accuracy. The MDS nurse has been re educated to section N0410 RAI manual coding description by the Director of Nursing (DON). 4. The LHNA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) The MDS nurse shall maintain a log reflecting current residents□ usage of psychoactive medications comparing his/her MAR□s and MDS section	

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F 001	Continued From page 4	F 001	N0410A-D coding for one (1) month. This log will be reviewed by the DON for accuracy. Variances will be modified in accordance with the RAI manual. This log and responsive action will be reviewed by the QAA committee x one (1) month; b) Should no variances be identified, the MDS nurse shall continue to track and compare current resident□s MAR□s and related MDS coding for section N0410A-D for up to 30% of the residents receiving psychoactive medications quarterly x six (6) months. This log will be reviewed by the DON for accuracy. Identified variances will be modified in accordance with the RAI manual. This log shall be reviewed by the QAA committee who shall determine the frequency of continued ongoing monitoring. 12 VAC 5-371-220 (D). Nursing Services. Cross Reference to F687. 1. Resident #31 had his toenails assessed and trimmed by the podiatrist on 5-16-18. 2. The facility conducted a review of all current residents; ensuring his/her fingernails and toenails to be clean and trimmed. Variances were promptly addressed by either trained staff members or the podiatrist. 3. The facility reviewed its□ policy on Care of Fingernails and Toes ensuring clarity. No revisions were needed. The facility reviewed its□ Shower Sheet form to confirm the inclusion of fingernails and toenails. The facility conducts routine skin	

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F 001	Continued From page 5	F 001	checks on current residents and has added fingernail and toenail checks to the skin checks process. All nursing staff, full time (FT), part time (PT) and per diem (PD) will be re educated to the facility policy on Care of Fingernails and Toes, shower sheets, and the expectation of checking a resident□s fingernails and toenails during routine skin checks. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The Unit Manager (UM) or DON will review the resident Showers Sheets weekly x four (4) weeks ensuring completion which includes the status of one□s fingernails and toenails; b) The UM or DON will spot check up to 20% of current residents confirming that that which was recorded on the Shower Sheets is an accurate reflection of the resident□s toenail or fingernail condition. Should findings vary from that documented by staff, the UM or DON will review up to 100% of the resident□s fingernails and toenails confirming them to be clean and trimmed; b) Staff nurses will conduct bi-weekly skin checks x two (2) months which includes fingernail and toenail checks; confirming them to be clean and trimmed. The UM or DON will spot check up to 20% of current residents confirming that that which was recorded on the skin check sheet is an accurate reflection of the resident□s toenail or fingernail condition. Should findings vary from that documented by staff, the UM or DON will review up to	

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F 001	Continued From page 6	F 001	100% of the resident□s fingernails and toenails confirming them to be clean and trimmed Variances will be promptly addressed. The QAA committee will determine the frequency of continued ongoing monitoring thereafter. 12 VAC 5-371-220 (C). Quality of Care. Cross Reference to F698. 1. Resident #33 remains at baseline. The DON promptly contacted the assigned dialysis center reinforcing the ongoing need for communication about the resident while at the dialysis center. The DON promptly met with the licensed nursing staff on 5-23-18 alerting them to the expectation of consistent dialysis communication between the facility and the dialysis center. The facility reviewed its□ Dialysis Communication Sheet confirming clarity. This form has been enhanced. 2. All residents receiving hemodialysis have the potential to be affected. The facility conducted an audit of all current resident□s receiving hemodialysis; ensuring that all residents have a Dialysis Communication Book, that all are sent to the dialysis center with a facility generated Dialysis Communication Sheet and that the same is returned with updated documentation. Variances identified have been promptly addressed and will be forwarded to QAA committee for review. 3. The facility has reviewed it□s process of generating the Dialysis Communication	

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F 001	Continued From page 7	F 001	sheets/books for residents receiving hemodialysis and made the following revisions: a) All licensed nurses have been re educated to the Dialysis Communication Sheet and Books for all resident□s receiving hemodialysis; b) DON has contacted all dialysis centers; outlining the expectation of interactive communication on all residents receiving hemodialysis using the facility□s Dialysis Communication sheet; c) Residents scheduled for hemodialysis shall be placed on the 24-hour report on the day of hemodialysis; cueing the nurses to document the use of the Dialysis Communication Sheet and it□s return. Should the resident return to the facility without the facility generated Dialysis Communication Sheet, the shift nurse will notify nursing administration (DON or UM) who in turn contacts the dialysis center. All licensed nurses shall be educated to the above process. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows a) The UM or DON will review up to 50% of the Dialysis Communication Sheets/Dialysis Books weekly x four (4) weeks for residents receiving hemodialysis; confirming the compliance with the facility□s process; b) All residents receiving dialysis will be reviewed during At Risk meetings held routinely (e.g. weekly). During the At Risk meetings, the Dialysis Communication Sheets/Dialysis Books for the residents receiving dialysis	

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F 001	Continued From page 8	F 001	will be reviewed; ensuring compliance with the process; c) The facility will conduct Chart Audits for up to 30% of resident□s receiving dialysis monthly x two (2) months and then quarterly x six (6) months; confirming the presence of inter-communication between the facility and the dialysis center. All variances will be addressed promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter. 12 VAC-5-371-220 (A). Nursing Services. Cross Reference to F757. 1. Resident #33 remains at baseline. The following non-pharmacological interventions have been routinely attempted for Resident #33: enjoys watching TV, movies, keeping up with the news, talking on the phone and napping. Licensed nurses have been re-educated to the importance of documenting attempted non-pharmacological interventions to reduce anxiety prior the administration of an as needed PRN medication in the progress notes. Resident #33□s PRN Xanax has been discontinued. 2. The facility has conducted a review of current residents receiving as needed PRN psychoactive medications; ensuring non-pharmacological interventions are attempted, documented and care planned prior to the administration of PRN psychoactive medications. Documentation and/or administration variances were addressed promptly. Care Plans were enhanced as needed.	

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F 001	Continued From page 9	F 001	3. The facility has reviewed its processes related to offered and documented non-pharmacological interventions for residents prior to the administration of prescribed PRN anti-anxiety agents. The facility has also reviewed its monitoring process of the use of PRN psychoactive medications. Enhancements to both processes included a) documentation of all attempted non-pharmacological interventions in the nursing notes prior to the administration of PRN psychoactive medications; b) monitoring by UM or DON of all residents on PRN psychoactive medications ensuring non-pharmacological interventions are documented and care planned and that PRN psychoactive medications are re-evaluated by the prescriber for continued benefit within fourteen (14) days of activation. All licensed nurses shall be re educated to the above process. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) The UM or DON will review up to 50% of all residents MARs and progress notes for whom PRN psychoactive medications are ordered and administered weekly x four (4) weeks then monthly x three (3) months; confirming the documentation of attempted non-pharmacological interventions prior to the use of the PRN psychoactive medications; b) The UM or DON will review up to 50% of all residents	

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F 001	Continued From page 10	F 001	who are prescribed PRN psychoactive medications ensuring that prescribers have re-evaluated the continued benefit of PRN psychoactive medications within fourteen (14) days of activation; c) During the At Risk meetings, residents receiving PRN psychoactive medications will be reviewed for both the use of non-pharmacological interventions and the fourteen (14) day re-evaluation process. Variances will be address promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter. 12 VAC 5-371-300 (L). Pharmacy Services. Cross Reference to F761. 1. All opened, undated or undated but stored at room temperature Lantus Flex pens were discarded. Licensed nurses were promptly re-educated on 5-23-18 to the importance of dating flex pens upon removal from the refrigerator for med cart storage, upon opening flex pens; along with a twenty-eight (28)-day expiration date of the same. 2. All insulin dependent residents have the potential to be affected. All medication carts and medication refrigerators were assessed confirming that all open insulins were dated upon opening and/or all room stored insulins were dated upon removal from the refrigerator; all with an expiration date not to exceed 28 days from opening or removal from the refrigerator. No variances were identified. 3. The facility has reviewed its□ policy	

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F 001	Continued From page 11	F 001	on Medication Storage which addresses insulin storage and dating upon opening and/or removal of insulin (e.g. flex pens) from the refrigerator. No revisions are needed. All licensed nurses will be re educated to the policy and expectation. Medication Storage (which addresses insulin storage) is included in new nurse orientation. 4. The LNHA is responsible for the POC implementation. The QAA Coordinator and committee members as noted below will be responsible for the ongoing monitoring of this process as follows: a) the assigned staff nurse, UM and/or DON will check insulin storage weekly x four (4) weeks then monthly x three (3) months; confirming accurate storage, dating of insulins once open or removed from the refrigerator and discarding of insulins after 28 days from removal from the refrigerator and/or once opened for use; b) The Medication and Diversion Audit will be conducted by the UM or DON monthly x two (2) months and then quarterly x one (1) year which includes the monitoring of insulin storage and dating. Variances will be address promptly. The QAA committee will determine the frequency of continued ongoing monitoring thereafter.	