STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495112	A. BUILDING ______ B. WING ______	10/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VA BAP HOSP DIV CEN	3300 RIVERMONT AVE LYNCHBURG, VA 24503

(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 10/25/16 through 10/26/16. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 166 certified bed facility was 106 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents # 1 through 19) and three closed record reviews (Residents # 20 through 22).	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		12/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE: — (X6) DATE: 11/08/2016

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 157	Continued From page 1 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to ensure family notification of a transfer for one of 22 residents in the survey sample, Resident # 5. Resident # 5 was transferred to a long term care location from a long term bed hospital type setting (under the same provider number), without notification of the family member. Findings include: Resident # 5 was originally admitted (to the long term care hospital setting) on 10/08/15. Diagnoses for Resident # 5 included, but were not limited to: dementia, malignant neoplasm of the rectum, anemia, diabetes mellitus, cardiomyopathy, stage 3 kidney disease, and palliative care. The most recent MDS (Minimum Data Set) assessment was a quarterly assessment with an assessment reference date of 10/11/16, which assessed the resident as having long and short term memory impairment with severe impairment in daily decision making skills. The resident was	F 157	1. Social Worker confirmed that the legal representative for Resident #5 was aware of the transfer and current placement of resident on 10/26/2016. 2. A 100% audit of all residents being transferred out of facility to another facility within the past 30 days will be conducted to ensure proper notification. 3. Education will be provided to social work staff by the Director of Nursing or designee to ensure that proper notification for transfers is implemented. 4. A 100% audit of all resident transfers to another facility will be conducted weekly for 4 weeks. A 10% random audit will be conducted on a monthly basis for 3 months. If areas of concern are identified they will be investigated and corrected immediately.The results will be reported to the QAPI committee to ensure ongoing compliance.	

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F 157	Continued From page 2	F 157		

also assessed as requiring extensive assistance from staff for most all ADL's (activities of daily living).

During clinical record review on 10/25/16, it was documented in the progress notes that Resident # 5 was transferred to the long term care facility from the long term care hospital setting (two separate locations) on 03/11/16.

A progress note dated 03/13/16 documented, "...brother arrived and concerned he was not told his sister had been transferred here..."

On 10/26/16 at approximately 9:00 a.m., the DON (director of nursing) was made aware and asked for assistance to determine if the resident's brother was notified of the transfer prior to the transfer.

On 10/25/16 at approximately 10:45 a.m., SW (social worker) # 1 and SW # 2 arrived with documentation regarding the above concerns.

SW # 1 stated that the resident's brother was not the guardian and that an outside volunteer was the resident's guardian. The SW was made aware that there was not a concern regarding guardianship, the concern was whether the brother was notified of the transfer. SW # 1 voiced that they (the SW's) would call and leave a message for the brother regarding different things and that he would not call back. SW # 1 then presented documentation that the brother was called in February and notified. The documentation was reviewed and the SW was made aware that the documentation did not mention transfer of the resident, it was speaking of guardianship notification, not transfer to a

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F 157	Continued From page 3 different location of the resident. SW # 2 then spoke up and stated, that it was hospice who was supposed to have notified the resident's brother. SW # 2 was asked why that was. SW # 2 stated that they (SW and hospice) had a verbal agreement. SW # 2 was asked if there was any documentation to ensure that the brother was actually notified. The SW voiced that they did not have any documentation that the brother was notified. SW # 1 stated again that the brother was not the resident's guardian. SW # 1 was asked who would be notified if something happened to Resident # 5. SW # 1 stated, "The brother." The administrator and DON were made aware of the above information regarding the progress note, that Resident # 5's brother was not notified of the resident's transfer from one location to another. No further information or documentation was presented prior to the exit conference on 10/26/16 at 3:30 p.m., to evidence facility staff notified the resident's brother of the transfer prior to the actual transfer.	F 157		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		12/10/16

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure compression stockings (TED) hose were in place as ordered for one of 22 residents in the survey sample, Resident #6. Resident #6 was ordered TED hose on in the morning and off at night. The resident was observed during the morning without the physician's ordered TED hoses. The findings include: Resident #6 was admitted to the facility on 2/23/12, with, but not limited to, the following diagnosis: Dysphagia (difficulty swallowing) vascular dementia, and hypertension (HTN). The most recent Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 9/26/16 was an annual assessment. The resident was assessed as having short and long-term memory impairments and independent in decision-making skills. On 10/26/16 at approximately 7:55 a.m., Resident #6 was observed in his room, sitting in his room in his wheel chair and eating breakfast. Resident #6's legs were observed; the resident was wearing non-skid hospital socks on both of his lower extremities. On 10/26/16 at approximately 8:00 a.m., Resident #6's clinical record was reviewed to include a current, October 2016, Physician's Order Sheet (POS) to include the following: "12/15/15 TED	F 309	1. The physician order for resident #6 was brought to the CNA's attention and the ted hose were immediately applied on 10/25/16. 2. A 100% audit of all orders that specify application of ted hose will be conductedfor the current resident population to ensure that the order was implemented. 3. Education will be provided to the direct care staff by the DON or designee to ensure that the physician order is carried out appropriately. 4. A 100% audit of all orders that specify application of ted hose will be conducted weekly for four weeks. A 10% random audit will be conducted on a monthly basis for 3 months. If areas of concern are identified they will be investigated and corrected immediately. The results will be reported to the QAPI committee to ensure ongoing compliance.	

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F 309	Continued From page 5 Hose to bilateral legs on in AM (morning) off PM (evening/night)." On 10/26/16 at approximately 8:30 a.m., Resident # 6 was observed being assisted to bed by a Certified Nursing Assistant, who will be identified as CNA #1. CNA #1 was interviewed regarding the resident not having on the Physician's ordered TED hoses. CNA #1 stated, I did not see them this morning. Whoever had him last night, I am not sure where they put them. I will get him another pair." CNA #1 went to a storage closet, retrieved a pair of TED hose and applied them to the resident's lower extremities. On 10/26/16 at approximately 2:30 p.m., the administrative staff were made aware of the above findings.	F 309		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by:	F 514		12/10/16

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F 514

Continued From page 6

Based on staff interview, and clinical record review, the facility failed to ensure a complete and accurate clinical record for one of 22 Residents, Resident #2.

Resident #2's verbal order for a Foley catheter was not transcribed onto the physician's orders.

The Findings Include:

Resident #2 was admitted to the facility originally on 8/29/13 with a readmission on 11/27/15 with diagnoses that included urine retention.

The most current full MDS (minimum data set) was a quarterly with an ARD (assessment reference date) of 8/16/16. Resident #2 was assessed as having long and short-term memory loss and severely cognitively impaired.

On 10/26/16 Resident #2's physician orders were reviewed and revealed an active order dated 8/23/16 that read "Foley Care Three Times Daily." The physician's orders did not evidence an actual order for placement of a Foley catheter, size or how much fluid to insert into the bulb to hold the catheter in place.

On 10/26/16 at 9:15 a.m. Resident #2 was observed laying in bed and a Foley catheter was in place.

On 10/26/16 at 9:30 a.m. registered nurse (RN #1) was asked to help locate an order for Resident #2's catheter placement. RN #1 reviewed Resident #2's clinical record and verbalized that she was unable to find an actual order for the catheter.

F 514

1. The verbal physician order for a foley catheter was immediately entered for resident #2 on 10/26/16.
2. A 100% audit of current residents with foley catheters will be conducted to ensure that an order for the foley catheter is present in the EMR.
3. Education will be provided to the nursing staff by the DON or designee to ensure that the physician orders for foley catheters are entered appropriately.
4. A 100% audit of all new admissions with foley catheters will be conducted weekly for 4 weeks to ensure that a physician order is entered in the EMR. A 10% random audit will be conducted on all new admissions with a foley catheter on a monthly basis for 3 months. If areas of concern are identified they will be investigated and corrected immediately. The results will be reported to the QAPI committee to ensure ongoing compliance.

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On 10/26/16 at 9:40 a.m. this surveyor asked for and received a copy of the physician's order set. Upon receiving and reviewing the copy of the physician's order an new order (dated 10/26/16) was reviewed and evidenced the order for a Foley catheter to be placed. The administrator was asked if the order was placed after this had been brought to the attention of the staff by this surveyor. The administrator verbalized yes.

On 10/26/16 at 9:50 a.m. RN #2 (unit manager were Resident #2 resided) was interviewed regarding the order for a Foley catheter for Resident #2. RN #2 reviewed Resident #2's orders and then reviewed Resident #2's nursing notes. RN #2 located a nursing note dated 8/22/16 indicating that Resident #2 was unable to urinate and the physician was notified via telephone and gave an order to place a Foley catheter.

RN #2 verbalized that when a nurse receives a verbal order the nurse is supposed to transcribe the order into the clinical records under physician orders, then when the physician comes in to the facility, the physician will sign off on the order that was transcribed by the nurse. RN #2 verbalized that the nurse that took the verbal order failed to transcribe the order.

No other information was provided prior to exit conference on 10/26/16.