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	495096	A. BUILDING _____ B. WING _____	03/17/2016

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/15/16 through 3/17/16. Significant Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 158 certified bed facility was 143 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Resident #1 through #21) and three closed record reviews (Resident #22 through #24).	F 000	Responses to cited deficiencies do not constitute an admission or agreement by Westminster Canterbury Richmond of the truth of the facts alleged or of the conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and /or State law.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	**Investigate/Report Allegations/Individuals** **1.Corrective actions taken by the facility for residents affected by the practice:** Resident #2 was assessed by an RN as soon as area to right eye was noted. The residents direct caregiver was immediately interviewed and wrote a statement. The Physician and Responsible Party were notified the same day. 02/19/16 The Administrator and Director of Nursing completed an interview with Resident #2's caregiver and a final investigation report will be sent to the Office of Licensure and Certification. 04/08/16	

RECEIVED
APR 11 2016
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Wm. H. Blackwell

TITLE Administrator

(X6) DATE
4/7/16

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

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review, the facility staff failed for one resident (Resident #2) of 24 residents in the survey sample, to thoroughly investigate and report to the State Agency an injury of unknown origin. Resident #2's clinical record had a documented "dark purple discoloration and edema (swelling) to his right peri-orbital/eyelid region" on 2/19/16. The facility staff did not conduct a thorough investigation or notify the State Agency (Office of Licensure and Certification-OLC) of the injury of unknown origin. The findings included: Resident #2 was originally admitted to the facility on 8/31/12 and readmitted on 12/25/14 with the diagnoses of, but not limited to, dementia, anxiety, and cerebrovascular accident (CVA-stroke).	F 225	**2. How will the facility identify other residents having the potential to be affected by the same practice:** The Quality Assurance Nurse reviewed all injuries/skin conditions since 03/01/16 to ensure that all incidents were thoroughly investigated and that no patterns were noted. **3. Measures or systemic changes that will be put into place to ensure that the practice will not recur:** A) The Clinical Educator/ Designee has inserviced Nursing, Housekeeping and Dining personnel on Abuse policy and mandated reporting. B) The Clinical Educator has inserviced Nursing staff on skin assessments, reporting new skin issues/or signs of abuse, incident reporting, and how to investigate and take witness statements from appropriate caregivers/ appropriate individuals.	04/08/16 03/31/16 03/31/16

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F 225	Continued From page 2 The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 1/26/16. The MDS coded Resident #2 with moderately impaired cognition; physical and verbal behaviors towards other; required extensive assistance from staff for all activities of daily living except set up assistance with meals. On 3/16/16 at 9:20 a.m., Resident #2 was observed sitting up in bed with his eyes closed. He did not open his eyes or respond when his name was called. Resident #2's clinical record was reviewed on 3/16/16 at 10:30 a.m. The review revealed a nurses note which read: "At 1206 (12:06 p.m.) resident was sitting at the DR (dining room) table and was noted with dark purple discoloration and edema to his right per-orbital/eyelid region. Resident was able to open the affected eye and no redness was noted. Resident did not report any pain and no s/s (signs/symptoms) of pain was noted...Dr. (name) was made aware of bruising..." The note was dated for 02/19/2016 at 18:46 (6:46 p.m.). There were no Facility Reported Incident (FRI) forms received at the OLC regarding the injury of unknown origin. On 3/16/16 at 2:08 p.m. an interview was conducted with the Unit Manager, Licensed Practical Nurse (LPN-B). When asked why the purple discoloration and edema wasn't reported to the OLC, LPN-B stated the "CNA (certified nursing assistant) felt it was caused by the side rail. She had the side rail up during care." The facility incident report was reviewed and	F 225	**4. How the facility plans to monitor its performance to make sure the solutions are sustained:** A) The Quality Assurance Nurse/ Designee will review all incidents with Nursing Management and ensure proper documentation and investigations have been completed to rule out potential abuse/injuries of unknown origin. 04/01/16 B)The Administrator and Director of Nursing will review and electronically sign all incidents. 04/01/16 C) The Clinical Educator has submitted verification of completed training to the Director of Nursing for review and will report completion to the QA/PI committee for review and further recommendations if needed at the next regularly scheduled meeting. 03/31/16	

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F 225	Continued From page 3	F 225		

contained the following information:

"Incident Date 02/19/2016 Incident Time 12:06:00...
Location Specifics: At DR table beside window
Describe the Incident: Resident was sitting at the DR table and was noted with dark purple discoloration and edema to his right per-orbital/eyelid region. Resident was able to open the affected eye and no redness was noted. Resident was unable to report pain or state how it occurred, but no s/s of pain was noted. CNA reported that the upper side rail on the bed was in the upright position as she turned him during ADL (activities of daily living) care this am and also stated that resident's face may have come in contact with the railing during the turn. CNA also reported that resident voiced no reports or s/s of pain during ADL care. Staff are now reminded to move the railing to the downward position when providing care and tuning resident in the bed..." The incident report did not include any other staff interviews or if Resident #2 was anywhere else in the facility prior to the findings.

The CNA's (CNA-B) statement dated 2/19/16 which was attached to the incident report read: "This morning when I entered room (number), there was no mark or discoloration to his right eye. While I was performing AM care, I did turn and roll him a few times to clean him up. His half rails were up at the time because he uses it to pull on. It is possible that he may have bumped his face on the rail while I was turning him. My charge nurse did inform me later on that morning that he had a mark on his right eye area that was also swollen." No time was written on the statement of when AM care was provided.

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The "INVESTIGATION/FOLLOW-UP" dated 02/22/2016 at 20:57 (10:57 p.m.) and written by LPN-B read:
"Investigation report 2/19/16-CNA stated that while turning resident during AM care in bed, resident may have bumped right side of face on side rail...Resident denied any wrong doing from staff when interviewed by this writer..." The follow up report was was 3 days after the occurrence.

On 3/16/16 at 2:15 p.m. an interview was conducted with the Director of Nursing (Admin-B). When asked when she would report an injury (FRI) to the OLC, Admin-B stated she "Would report a bruise if not able to discern what happened or if a resident stated what happened." She stated "Even though he has some confusion he'd be able to tell what happened." It was discussed with Admin-B that the CNA's statement included it is "possible" that he "may have" bumped his face on the rail and the CNA was notified "later on that morning." It was discussed that there was no length of time indicated on the investigation from when care was provided to when the discoloration and edema was observed and that since a full investigation was not conducted how could the facility be sure nothing happened between when care was provided, to when he was found with the area.

A physician's Progress Note dated 2/19/16 at 2:06 was reviewed. The note included: "Pt. (patient) seen for new swelling and bruising to right periorbital area-no known trauma-was present upon patient awakening this AM." The Assessment/Plan was documented as: "Right periorbital edema and ecchymosis-new-suspect unwitnessed trauma-hold aspirin-follow clinically."

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F 225	Continued From page 5 Facility policy titled "Abuse Prevention Program" was reviewed and contained "Attachment A" which included: "MISCONDUCT AND INJURIES OF UNKNOWN ORIGIN FACILITY INVESTIGATION AND REPORTING REQUIREMENTS" EVENT/INCIDENT Facility learns of an incident of possible misconduct...or injury of unknown origin... ACTION: Facility files an initial written report with the OLC. ACTION: Facility thoroughly investigates incident..." On 3/16/16 at approximately 4:15 p.m. the Administrator was informed of the findings during an end of day meeting with the Administrator and Director of Nursing.	F 225		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility documentation review and clinical record review, the facility staff failed to provide professional standards of quality for one Resident (Resident #10) of 24 residents in the survey sample. The facility nursing staff failed to ensure that the resident was administered the Docusate Sodium 100 milligram medication (pill), which was found on the floor in her room.	F 281	**Services Provided Meet Professional Standards** **1. Corrective actions taken by the facility for residents affected by the practice:** Resident #10 of the survey sample had no negative outcomes from the pill being found on the floor.	

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F 281	Continued From page 6 The findings included: Resident # 10 was admitted to the facility on 8/4/2010. Diagnoses for Resident # 10 included but not limited to Alzheimer's Disease, Hypothyroidism, Idiopathic Normal Pressure Hydrocephalus, Gastroesophageal Reflux Disease, Major Depressive Disorder,Chronic Ischemic Heart Disease, Chronic Pulmonary Obstructive Disease and Hypertension. Resident #10's most recent Minimum Data Set (MDS, an assessment protocol) was an annual assessment with an Assessment Reference Date of 12/10/2015 coded Resident #10 with a BIMS (Brief Interview for Mental Status) score of 12, indicating mild cognitive impairment. Resident # 10 was coded as requiring extensive assistance of one staff member with activities of daily living except required two staff members for toileting, frequently incontinent of bowel and bladder. Resident # 10 was coded as needing only supervision and set up for eating. During initial tour of the facility on 3/15/2016 at 12:40 PM, a reddish colored object was observed on the floor in Resident # 10's room between the recliner and bedside table. The Unit Manager doing tour with the surveyor, LPN A (Licensed Practical Nurse A) picked it up and stated "it looks like Docusate Sodium tablet." The pill looked like a Docusate Sodium 100 milligram soft gel capsule. LPN A put the pill in a tissue and took it to the nurses station. LPN A stated she would research it. Resident # 10 was a resident on the second floor where residents with memory issues reside. The	F 281	**2. How will the facility identify other residents having the potential to be affected by the same practice:** The Unit Manager took the pill to the Director of Nursing for destruction after verification of medication. 03/15/16 100% of all residents rooms were checked for pills on the floor and none were found. 03/15/16 **3. Measures or systemic changes that will be put into place to ensure that the practice will not recur:** 04/08/16 A) The Clinical Educator/Designee will in-service Licensed Nursing Staff on ensuring if a medication is dropped or found on the floor that it is picked up and discarded, and the pharmacy is notified for a replacement. 04/04/16 B) The Unit Managers/ Designee will do walking rounds daily x 5 days, weekly x 2 weeks, then monthly x2 months to ensure there are no items on the resident's floors that could be a safety risk.	

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F 281	Continued From page 7 second floor was equipped with sensors near the elevators for those who wander and use a Wander Guard system. Several residents on that unit were observed to be wearing wanderguards. On 03/15/16 at 2:40 PM, an interview was conducted with LPN A who stated she confirmed that the pill found in Resident # 10's room was a Docusate Sodium 100 milligram soft gel capsule. LPN A stated she spoke with the nurse assigned to give medications to Resident # 10. LPN A stated the other nurse, Registered Nurse E (RN E), told her that she had not seen the pill on the floor in Resident # 10's room and had no idea how long it had been there since she had given the medications to Resident # 10 in the dining room that morning. LPN A stated pills should not be on the floor of residents rooms. LPN A also stated that she didn't know if Resident # 10 had spit the pill out or if it was dropped on the floor by a nurse. LPN A stated she "did not think" Resident # 10 "had a history of spitting pills out though." On 3/15/2016 at 3:15 PM, an interview was conducted with Registered Nurse E (RN E) who stated she administered medications to Resident # 10 that morning in the dining room and the Resident took the pills. RN E stated Resident # 10 was prescribed to get Docusate Sodium twice a day, once in the morning at 9 AM and at 5 PM in the afternoon. RN E stated she was not aware the pill was on the floor in Resident # 10's room and had no idea how long it had been there. Review of the clinical record was conducted on 3/15/2016. Review of the Physicians Orders revealed an order for Docusate Sodium 100 milligrams twice a day.	F 281	C) The Clinical Educator will educate Licensed Nursing Staff on the residents' rights for proper medication administration. D) The Clinical Educator/Designee will educate Certified Nursing Assistants and Housekeeping to report observation of any pills found on the floor to the licensed nurse for investigation and destruction. **4. How the facility plans to monitor its performance to make sure the solutions are sustained:** A) The Quality Assurance Nurse and/or Designee will randomly audit 10 rooms on each unit to ensure there are no medications or safety concerns/items on the resident's floors weekly X 4 weeks then monthly x 2 months and report any abnormalities immediately to the DON. B) Any abnormal findings will be immediately corrected and reported the Unit Manager/ Supervisor for further investigation.	04/08/16 04/08/16 04/08/16 04/08/16

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F 281	Continued From page 8 Review of the March Medication Administration Record (MAR) revealed the record for Docusate Sodium 100 milligram capsule at 9 AM and 5 PM. There was no missing documentation of administration of the medication or of refusal of the medication Docusate Sodium. There was a statement at the bottom of the MAR that "Medication may be administered in the Dining Room." On 3/15/2016 at 5:20 PM, observed Resident # 10 sitting in a wheelchair in the dining room. Resident # 10 consented to an interview. Resident # 10 stated she did not know there was a pill on the floor in her room "but it could have been a stool softener because sometimes they leave the stool softener in my room for me to take later. But sometimes I don't take it because I don't need it." The facility administrator presented a copy of the Medication Administration Policy on 3/15/2016 at approximately 5:30 PM. Review of the Facility's Policy & Procedure titled "Medication Administration, Including Administration Times" revealed number 8 under "Administration Times" stated "Medication should not be left at the bedside, except sublingual nitroglycerin, unless physician order indications to do so and "Self Administration of Medication Assessment" has been completed." Copies of the March MAR and Physicians Orders were requested and presented on 3/16/2016. The facility's policy entitled Medication Administration, including Administration times	F 281	C) Audits will be submitted to the QA/PI committee for review and further recommendations as deemed necessary at the next regularly scheduled meeting. D) The Clinical Educator will submit verification of completed training to the Director of Nursing for review, and report completion to the QA/PI committee for review and further recommendations if needed at the next regularly scheduled meeting.	04/08/16 04/08/16

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read:

On page 1 under MAR documentation:
"10. The nursing staff will initial the time of administration on the /electronic Medication /administration Record (EMAR) when the medication has been administered.

11. Physician will be notified when a resident has refused a medication for two consecutive doses."

On page 2 Under " The Seven Rights "

Administer drugs according to the " Seven Rights. "

20. The Right patient
21. The Right drug
22. The Right dose
23. The Right route
24. The Right time- Always initial drug profile sheet when drug is poured
25. The Right dosage form
26. The Right Documentation "
The DON (director of nursing) stated, the facility basis for nursing standards was "Potter-Perry."

Guidance given from " Potter and Perry, Fundamentals of Nursing, Eighth Edition, page 305" read: "Nurses follow health care providers' orders unless they believe the orders are in error or harm patients. Page 584 read: To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to these rights:

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F 281	Continued From page 10 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation" On 03/16/16 during the end of day debriefing, the facility Administrator and the Director of Nursing were notified of the above findings. No further information was provided.	F 281		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation and clinical record review, the facility staff failed to for one Resident (Resident #5) in a survey sample of 24 residents, to prevent and identify a pressure ulcer prior to the development of a stage 3 pressure ulcer resulting in harm for Resident #5. The facility failed to provide pressure relief interventions to the left elbow despite observations of the resident leaning to her left	F 314	**Treatment/Services to prevent/ heal Pressure Sores** **1. Corrective actions taken by the facility for residents affected by the practice:** Resident #5's Physician was notified on 10/22/15 and examined resident on 10/23/15. — 10/23/15 Resident #5's elbow healed on 11/11/15 and has never had another pressure ulcer. — 11/11/15	

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F 314	Continued From page 11 side and did not identify the pressure ulcer until it had reached a stage 3 ulcer with the presence of slough (dead devitalized tissue), a harm level deficiency. The findings included: Resident #5 was admitted to the facility on 9/178/14 with diagnoses which included, but not limited to, Alzheimer's dementia, stroke with left sided hemiparesis, high blood pressure and difficulty swallowing. Resident #5's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 2/17/16. She was coded with a Brief Interview of Mental Status score of "4" out of a possible 15 indicating severe cognitive impairment. She required total assistance of one staff member for bed mobility and transferring. The resident was coded as having limitations of range of motion both in the upper and lower extremities. The resident was incontinent of bowel and bladder. The resident did not have recent weight loss. On 3/17/16 at 9:25 AM, Resident #5 was observed in the wheelchair with the left hand side of the wheelchair having an upholstered arm rest. With the assistance of CNA (certified nursing assistant) A, the elbow was uncovered by removing the sweater and shirt sleeve and a small scar was evident on the left elbow olecranon (elbow bony prominence). Review of the weekly skin assessments revealed on 10/20/15 revealed "weekly skin assessment	F 314	**2. How will the facility identify other residents having the potential to be affected by the same practice:** 100% of all current residents will have their most recent skin assessment reviewed by the Wound Nurse to ensure that all areas identified have been addressed appropriately. 04/08/16 **3. Measures or systemic changes that will be put into place to ensure that the practice will not recur:** A) The Clinical Educator/Designee will in-service Nursing Personnel on daily and weekly skin assessments, reporting of abnormal findings, and the documentation and prevention of pressure ulcers. 04/08/16 B) The Clinical Educator will in-service Nursing Personnel on the importance of proper body alignment with the use of adaptive equipment and/or use of pillows to align body and separate skin surfaces per the facility's Pressure Ulcer- Prevention & Assessment Policy.	

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F 314	Continued From page 12 completed no new skin impairments noted." CNA (certified nursing assistant)assessments done on 10/21/15 noted no skin impairment. Review of the care plan dated 10/22/15 revealed the following interventions (after the pressure ulcer developed) were noted, "Place air mattress for comfort and support. Elbow protectors as tolerated, assess q (every) shift for break in skin integrity." There were no interventions to protect the elbows prior to the development of the ulcer. In addition, an evaluation of a clinically avoidable pressure ulcer indicated interventions in place prior to the development of the pressure ulcer were not checked, including off load of bony prominences, other positioning devices and pressure reducing equipment in chair. Interventions present on the care plan prior to the development of the elbow ulcer included: "Weekly skin checks by nurse. Ask/Encourage/assist to toilet..provide timely incontinent care. Assist /remind to frequently position in bed/chair. She likes to sit with her head in her hand. Encourage her to change her position throughout the day. Float heels in bed as tolerated. Monitor skin during care. Report any changes to the nurse. Encourage adequate meal and fluid intake. Ensure shoes are well fitted. Avoid shearing force, lift do not slide patient. Apply lotion daily. Monitor food and fluid intake. Notify dietician if intake decreases Supplements as ordered. Review of the clinical record revealed a wound care note dated 10/22/15 at 11:37 AM which read: "Wound care for assessment of stage 3 pressure ulcer to left elbow. 50 % slough (dead tissue) tissue, no s/s (signs and symptoms) of infection.	F 314	**4. How the facility plans to monitor its performance to make sure the solutions are sustained:** A) The Wound Nurse/Designee will randomly check 5 residents on each unit to ensure proper positioning in bed weekly x 4 weeks, then monthly x 2 months. She will bring any abnormalities to the Unit Manager and/or Supervisor immediately. B) The Wound Nurse/Designee will randomly check 5 residents on each unit for proper wheelchair positioning weekly x 4 weeks, then monthly x 2 months. She will bring any abnormalities to the Unit Manager and /or Supervisor immediately. C) The DON/ Designee will review 100% of the Wound Nurse's audits. D) Findings of these audits will be reported to the QA/PI committee for review and further recommendation if needed at the next regularly scheduled meeting. E) The Clinical Educator will report any feedback from her in-services to the QA/PI committee for review and further recommendation if needed at the next regularly scheduled meeting.	A) 04/08/16 B) 04/08/16 C) 04/08/16 D) 04/08/16 E) 04/08/16

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New order per MD (physician) elbow protectors as tolerated, air mattress, Santyl (a debriding agent) ointment, dry dressing daily." The wound measured 0.6 cm (centimeters) length by 1.0 width and less than 0.1 cm in depth. The pressure area was healed on 11/11/15.

The NPUAP (National Pressure Ulcer Advisory Panel) defines a stage III pressure ulcer as:

"Full-thickness tissue loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Further description: The depth of a Stage III pressure ulcer varies by anatomic location. The bridge of the nose, ear, occiput, and malleolus do not have subcutaneous tissue, and Stage III ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Stage III pressure ulcers. Bone/tendon is not visible or directly palpable."

Resident #5's Braden score (indicator of pressure ulcer risk) on 9/20/15, prior to the development of the pressure ulcer, was "14". 18 or less is considered at risk for pressure sore development.

On 10/23/15, a physician's note was written by the attending physician (other "O"). The note read: "Left elbow with stage 2/3 pressure ulcer." Under assessment, the note continued, "Left elbow ulcer- appears to be from chronic contact with tray- mayu (sic) have been exacerbated by minor trauma from repositioning- wound care to follow. I feel this wound could not have been avoided given her advanced debility/dementia."

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On 3/16/16 at 2:30 PM, an interview was conducted with RN (registered nurse) B, the facility wound care nurse. She described the wound as having "slough or dead tissue". The wound care nurse stated, "We prefer to catch at a stage I (redness)." She went on to state that the left arm was contracted and that she "cannot move the arm." She later stated during the interview, "It should not have been found at a stage 3."

On 3/17/16 at 10:25 AM, an interview was conducted with the unit manager, RN (A). She stated, "She had a 1/2 lap tray (tray on the left side for the left arm to rest on, made of hard plastic). We thought she had a stroke, she was leaning to the left side." She went on to state that the resident was referred to OT (occupational therapy) due to "leaning to the left side." She went on to add that the resident now has a padded 1/2 lap tray. RN (A) was asked if pressure relief interventions, such as elbow protectors were used while waiting for the new lap tray and the RN (A) stated, "No." The Administrator was asked on 3/27/16 at about 10:30 AM, the same question and the Administrator stated, "No, because the area was not red."

Review of the OT notes dated 10/13/15 read as followed: "Nursing reporting leaning to left side new." OT notes dated 10/20/15 read, "Plan for trial arm though (? trough) vs (versus) half lap tray." Information sent to the OLC (office of licensure and certification) supervisor included a note from OT dated 10/22/15, which was not given to the surveyor during the survey, which

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stated, "Spoke with wound nurse due to wound on elbow. Area not related to wheelchair positioning." However, a new, padded arm rest was placed, and the attending physician wrote in his notes, "Left elbow ulcer- appears to be from chronic contact with tray."

Review of the "Pressure Ulcer Treatment Policy and Procedure", under Treatment Program Guidelines, revealed the following: "The pressure ulcer treatment program should focus on the following strategies: Assessing the resident for skin breakdown, managing tissue loads, early recognition of tissue injury and continuous and consistent assessment."

The policy for prevention and assessment of a pressure ulcer read as followed: "Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure and a decrease of circulation (blood flow) to that area and subsequent destruction of tissue.

According to "www.nursingceu.com <http://www.nursingceu.com>
"The compression of soft tissue interferes with the tissue blood supply, leading to vascular insufficiency, tissue anoxia, and cell death. Pressure ulcers usually occur over bony prominences such as the sacrum, ischium, heel, and trochanter, where there is less tissue to compress. Other factors previously mentioned also contribute to the tissue breakdown. Pressure ulcers can develop within 24 hours of the initial pressure but may take as long as 5 days to present themselves."

According to the article, Decubitus Ulcer

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F 314	Continued From page 16 Information and Stages of Wounds expertpages.com/news/decubitus, "All decubitus ulcers have a course of injury similar to a burn wound. This can be a mild redness of the skin and/or blistering, such as a first-degree burn, to a deep open wound with blackened tissue, as in a third degree burn. This blackened tissue is called eschar. The common areas of decubitus ulcer formation and prevention is a basic nursing principle covered in nursing school curriculum (LVN/LPN or RN) and most nursing assistant programs as well. Prevention consists of changing position every 2 hours or more frequently if needed. This 2-hour time frame is a generally accepted maximum interval that the tissue can tolerate pressure without damage. Prevention also consists of protection and padding to prevent tissue abrasion, and maintaining hydration, nutrition and hygiene. The basic treatment of decubitus ulcers is prevention. Prevention cannot be stressed too strongly. To this end, there are any number of devices designed to protect and prevent the formation of decubitus ulcers. The decision of which device to use is based on the location and severity of the wound. These devices may be a Medicare/Medicaid/Insurance-covered item when medically necessary. Most insurance's will cover any needed device, material, or equipment necessary to prevent and treat decubitus ulcers. Prevention is the most humane and cost effective approach to care. It remains true that decubitus ulcers are generally considered preventable and the development of decubitus ulcers is evidence of some form of neglect [nutrition, hydration, positioning, infection control, etc]. Many paralyzed or terminal individuals with very poor nutrition can remain free of decubitus ulcers." On 3/17/16 at 3:20 PM, interviews were	F 314		

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conducted with the attending physician (other O) and the wound care physician (other P).
According to Other (P) the presence of slough "indicates an unable to stage wound or a stage 3." He also added that if you are watching, the pressure ulcer starts as blanching (turns white when touched) redness to unblanched redness to skin breakdown. When asked what interventions could be used to prevent elbow pressure ulcers, he stated, "Pillows, elbow protectors could be used." The physician did state that wounds could develop within hours.
Other (O), the attending physician, stated, "When I saw it, I thought it was a stage 2-stage 3." He went on to state that if the skin is gone, it is a stage 2, if not seeing tissue, it would be a 3.
On 3/17/16, at approximately 11:15 AM, the DON (director of nursing) and Administrator were notified of a harm level deficiency.

After review of the deficiency findings, the facility was offered a Past Non-Compliance deficiency status if they provided a plan of correction. The facility rejected this even though they had identified and corrected the deficient practice before the surveyors came on site.

"Past noncompliance may be identified during any survey of a nursing home. To cite past noncompliance with a specific survey data tag (F-tag or K-tag), all of the following three criteria must be met:
1. The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag), at the time the situation occurred:
2. The noncompliance occurred after the exit date of the last standard recertification survey and before the survey (standard, complaint, or revisit)

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F 314	Continued From page 18 currently being conducted: and 3. There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s) , as referenced by the specific F-tag or K-tag." The above, quoted information was taken from the "State Operations Manual" at "Task 6-Information Analysis for deficiency Determination."	F 314		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review the facility staff failed to store and serve food in a sanitary manner. A. Dietary staff were observed to use incorrect hand washing technique. B. Nursing staff were observed to enter the kitchen area without wearing hair restraints. The findings included: A. Dietary staff were observed to use incorrect	F 371	**Food Procure, Store/Prepare/Serve** **1. Corrective actions taken by the facility for residents affected by the practice:** A) The Clinical Educator/Designee immediately educated Dietary staff on duty for proper handwashing and they gave a return demonstration. 03/15/16 B) The Dietary department and main kitchen staff were educated on proper handwashing, and not allowing anyone in the kitchen without a hairnet. 03/16/16	

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F 371	Continued From page 19 hand washing technique. On 3/15/16 at 11:53 a.m., Employee J (dietary staff) was observed in the kitchen preparing for lunch on the Chesapeake North hall. At 12:08 p.m. and 12:13 p.m. Employee J was observed to turn the faucet off with her bare hands after washing her hands. At 12:20 p.m., Employee J washed her hands, turning the faucet off with paper towels. On 3/15/16 at 12:32 p.m., Employee K (dietary staff) was observed preparing for lunch in the kitchen on the Shenandoah North hall. At 12:32 p.m. Employee K was observed to turn the faucet off with her bare hands after washing her hands. On 3/15/16 at 1:30 p.m., an interview was held with Employee L (Kitchen Manager). Employee L was informed that Employee J used improper hand washing technique on 2 occasions and performed correctly on one occasion. She was also informed that Employee K used incorrect hand washing technique on one occasion. Employee L(Kitchen Manager) had been in the kitchen with Employee J during part of the observation. Employee L stated that she had whispered to Employee J to be sure she used a paper towel to turn off the faucet when washing hands. The Infection Control nurse was interviewed on 3/16/16 at 2:00 p.m. She was informed that the dietary staff were observed to use improper hand washing technique. She stated that all management are responsible to correct hand washing when it is observed to be performed incorrectly. Section 8b (Hand Hygiene Technique) of the facility policy titled "Hand	F 371	**2. How will the facility identify other residents having the potential to be affected by the same practice:** All residents have the potential to be affected by this practice. A) The Dietary staff in PHC and the main kitchen received in-service training on proper handwashing and use of hairnets before people enter the kitchen area.	03/16/16
			3. Measures or systemic changes that will be put into place to ensure that the practice will not recur: A) The Clinical Educator will educate Nursing Staff, Housekeeping, and Rehab personnel on Infection Control procedures for the kitchen and not entering the kitchen areas without a hairnet in place. B) The Dietary department for PHC will be educated to not allow anyone into the kitchen areas without a hairnet on. C) Hairnets have been made easily accessible to facility staff outside of the kitchen area.	04/08/16 04/08/16 04/08/16

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F 371	Continued From page 20 Hygiene" read "Use clean towel to turn off the faucet." B. Nursing staff were observed to enter the kitchen area without wearing hair restraints. On 3/15/16 at 11:53 a.m., Employee J was asked if this surveyor should be wearing a hair restraint while in the kitchen area. Employee J stated yes. When asked for a hair restraint, Employee J stated that they were available down the hall at the main facility kitchen. At 12:28 p.m., the dietary aide working in the Chesapeake East kitchen was asked for a hair restraint. She stated that they were available down the hall at the main kitchen. On 3/15/16 at 12:28 p.m., Certified Nursing Assistant M (CNA M) entered the Chesapeake East kitchen. She used the sink to wash her hands. She was not wearing a hair restraint. At 12:43 p.m., Certified Nursing Assistant N (CNA N) entered the Shenandoah South kitchen to wash her hands. She was not wearing a hair restraint. In both kitchens, food was out available for service. On 3/15/15 at 1:30 p.m., an interview was held with Employee L (Kitchen Manager). She was informed that staff stated hair restraints were not available for use in Chesapeake East or Chesapeake North kitchens. Employee L stated that hair restraints should be available in all the hall kitchens. She stated that the diet staff in the Chesapeake East kitchen did not know where to find the hair restraints in her kitchen. Employee L (Kitchen Manager) was informed that the certified nursing staff were observed to enter the kitchens without a hair restraint. She was	F 371	**4. How the facility plans to monitor its performance to make sure the solutions are sustained:** A) The Clinical Educator will report feedback from in-service training to the QA/PI committee for review and further recommendations as needed at the next regularly scheduled meeting. B) The Infection Control Nurse and/ or Designee will report any abnormal findings immediately to the Manager of Dining Services. C) The Infection Control Nurse and/ or Designee will randomly audit 2 kitchen areas weekly x 4 weeks, then monthly x 2 months to ensure proper handwashing and placement of hairnets for anyone entering the kitchen area. The Infection Control Nurse will report the findings of her audits to the QA/PI committee at the next regularly scheduled meeting. D) The Clinical Educator will do 2 random handwashing audits for dietary personnel in PHC weekly x4 weeks then monthly x2 months.	04/08/16 04/08/16 04/08/16 04/08/16

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F 371	Continued From page 21 asked if anyone was allowed to enter the kitchens without using a hair restraint. She stated that the certified nursing staff should have a hair restraint on when entering the kitchen. On 3/16/16 at 4:00 p.m., the Administrator and Director of Nursing were informed of the issues.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441	**Infection Control/ Spread of Infection** **1. Corrective actions taken by the facility for residents affected by the practice:** Parsons Health Center Dietary staff members and Nursing staff will be trained on proper care and handling of ice scoops. Staff will also be properly trained on what to do if an ice scoop falls into the ice. **2. How will the facility identify other residents having the potential to be affected by the same practice:** All residents have the potential to be affected by this practice. Parsons Health Center Dietary staff members and Nursing staff will be trained on proper care and handling of ice scoops. Staff will also be properly trained on what to do if an ice scoop falls into the ice.	04/08/16 04/08/16

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F 441	Continued From page 22	F 441	**3. Measures or systemic changes that will be put into place to ensure that the practice will not recur:**	

hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to maintain an Infection Control Program designed to provide a safe, sanitary environment to help prevent the development disease/infection.

The facility failed to store ice scoops for ice machines in a sanitary manner on the Chesapeake West unit and the Chesapeake North unit and the Shenandoah North unit.

Ice scoops were stored inside the ice machines. Two scoops were observed to be lying on the ice.

The Findings Included:

On 3/15/16 at 11:53 a.m., the ice machine on Chesapeake West was observed. The ice scoop was stored in a holder affixed to the left wall of the inside of the ice machine.

On Chesapeake North, the ice scoop was stored in a holder affixed to the left wall of the inside of the ice machine. Employee J filled a container with ice and put the scoop back in the holder. When the lid to the ice machine was closed, the

A) Ice scoops will be mounted on the wall adjacent to the ice machines in an appropriated covered container on the wall. The ice scoops will be washed and sanitized after each meal period. — 04/08/16

B) The Dining Supervisors/Designee will randomly monitor a kitchen area on each unit for the proper storage, handling, and sanitation of ice scoops weekly x 4 weeks then monthly x2 months. The Dining Director/Designee will be notified of any deficient practice. — 04/08/16

C) Any incident of an ice scoop falling into the ice, the Dietary Supervisor and the Kitchen Manager will be notified and appropriate action will be taken immediately. — 04/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495096	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER-CANTERBURY HOUSE	1600 WESTBROOK AVE RICHMOND, VA 23227

(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 441	Continued From page 23 scoop fell out of the holder and onto the ice. Employee J replaced the scoop in the holder. At 12:32 p.m., the ice scoop was stored in a holder affixed to the left wall of the inside of the ice machine on Shenandoah North. When the lid was closed, the scoop fell onto the ice. On 3/15/15 at 1:30 p.m., an interview was held with Employee L (Kitchen Manager). She was informed that the ice scoop should not be stored in the ice machine due to infection control purposes. She was also informed that the scoop was observed to fall from the internal scoop holder onto the ice on two occasions. She stated that she was not aware that the scoop could fall from the holder onto the ice. On 3/16/16 at 11:09 a.m., Employee L (Kitchen Manager), was asked how many of the ice machines had an internal scoop holder. She stated there were six of that type of ice machine. ServSafe is a food safety certification course offered by the National Restaurant Association. The following information was accessed on 3/17/16 at 2:11 p.m. at the website: <http://www.servsafe.com/manager/food-safety-training-and-certification> "The ServSafe® program provides food safety training, exams and educational materials to foodservice managers." "The program blends the latest FDA Food Code, food safety research and years of food sanitation training experience." Employee L was asked if anyone at the facility was ServSafe certified. She stated that she was certified. The 6th Edition of the ServSafe	F 441	**4. How the facility plans to monitor its performance to make sure the solutions are sustained:** A) The Registered Dietitian/ Designee will report any abnormal audit findings to the QA/PI committee at the next regularly scheduled meeting. B) The monthly audit form that is currently completed will have the proper use, care, handling, and storage of ice scoops added to it. Any abnormal findings will be reported to the QA/PI committee for further recommendations. C) The sanitation of the ice scoops will be added to the temperature and procedural log to ensure that the ice scoops are sanitized after each meal. The Registered Dietitian/Designee will bring any discrepancies to the attention of the QA/PI committee for further recommendations at the next regularly scheduled meeting.	04/08/16 04/08/16 04/08/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495096	A. BUILDING _____ B. WING _____	03/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER-CANTERBURY HOUSE	1600 WESTBROOK AVE RICHMOND, VA 23227

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F 441	Continued From page 24	F 441		

Manager training book was reviewed with Employee L. In Chapter 6, page 6.5, the section titled "Ice" read "Containers and scoops: Use clean and sanitized containers and ice scoops to transfer ice from an ice machine to other containers. Store ice scoops outside of the ice machine in a clean, protected location, as shown in the photo at left." The photo showed a scoop holder affixed to the outside of the ice machine.

On 3/16/16 at 2:00 p.m., the Infection Control nurse was informed that there were six ice machines in use where the scoop was being stored inside of the machine.

On 3/16/16 at 4:00 p.m., the Administrator and Director of Nursing were informed of the issues.