Oldio Oi	v tr giringi							
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDI	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		NP		B. WING		07/04	5/2018	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE			
VIA HEAL	TH CARE CENTER T	HE HERMITAGE IN R	1600 WES	TWOOD AV	/ENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
F 000	Initial Comments			F 000				
	Inspection was con required for complia	ennial State Licensu ducted 7/5/18. Corre ance with the Virginia the Licensure of Nu	ctions are Rules		8			
	time of the survey.	104-bed facility was t The survey sample o ent reviews (Resider	onsisted					
F 001	Non Compliance		į	F 001				
W	The facility was out following state licen	of compliance with t sure requirements:	he				:	
	This RULE: is not r 12VAC 5-371-E 1.a	net as evidenced by:			12VAC5-371-E 1.a.			
	12VAC 5-371-E 1.a. Based on staff Interview, facility document review and employee record review, it was determined the facility staff failed to complete license verification for three of 25 employee record reviews, LPN (licensed practical nurse) #4, LPN #5 and CNA (certified nursing assistant) #1.				Actions to Correct Deficiency     a. LPN #4 - license verify     was found attached to     application that was comprised to the applicant a hand-written application.	fication the online ompleted filling out ation; this	07/05/2018	
The second secon		ed to have document nse verification for th nployment.			document was located elsewhere in the empl personnel file.			
	The findings include	<b>):</b>			b. LPN #5 - License look	kup was	07/05/2018	
	7/6/18. The following LPN # 4 employee is hired on 10/12/16. Twas dated 9/16/16.	rd review was condu g concerns were ide record documented s he employment app A copy of the employ	ntified: she was lication /ee's		c. CNA #1 is no longer of the facility.	working		
	verification of the lic Health Professional		rtment of					
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESEN	TATIVE'S SIGN	ATURE	TITLE		(X6) DATE	
( ~	)		1	11 -	1, -	a1.		

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State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

NP

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

O7/05/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

🕶 .	TH CARE CENTER THE HERMITAGE IN R 1600 WES	STWOOD AV		
(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 001	Continued From Page 1	F 001		
	LPN #5 employee record documented she was hired on 6/14/17. The employment application was dated 5/17/17. A copy of the Department of Health Professionals license look up was dated 4/21/17, almost one month prior to employment. There was no copy of the license in the employee record.		2. Affected Population: All Health Services employees within Hermitage Richmond.	
	CNA # 1 employee record documented she was hired on 9/21/16. The employment application was dated 9/7/16. There was no copy of her license or verification of the license from the Department of Health Professionals.  An interview was conducted with other staff		3. Prevention of Deficiency Recurrence:  a. The Business Office created an "Interview & Hiring Checklist" for all new applicants that is to be completed prior to orientation. This checklist includes license verification.	07/06/2018
	member (OSM) #2, the business office director, on 7/5/18 at 5:22 p.m. When asked why the above failed to have documentation of the license verification, OSM #2 stated she was not here at that time but for the one (LPN#4), thinks that the person felt the copy of the license was all that was needed and had no explanation for LPN #5 and CNA #1.		b. Hiring managers will be re- inserviced on proper procedures for hiring a new employee.  4. Measures Implemented to Maintain Compliance:	07/30/2018 & 08/06/201
	The facility policy, "Employment Hiring Practices" documented in part, "5. Pre-Employment Reference ChecksFor positions requiring a license or certification, verification of current status will be obtained from the state of Virginia and may include inquiries into former states of residence."		a. A monthly "New Hire Audit List" was created.  b. A random audit of new hire charts will be completed by the Administrator on a monthly basis.	07/06/2013 08/01/2018 & ongoing
	The executive director and assistant executive director were made aware of the above concern on 7/5/18 at 6:00 p.m.			
	No further information was provided prior to exit.			
	12VAC5-371-180 C.7. Based on observation, staff interview, facility document review and clinical record review, it was			
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State of	virginia						
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE (DENTIFICATION NU		, ,	PLE CONSTRUCTION	(X3) DATE S COMPL	
		NP		B. WING _		07/0	5/2018
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY,	STATE, ZIP CODE		
VIA HEAL	TH CARE CENTER T	HE HERMITAGE IN R		TWOOD AV			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
F 001	Continued From Pa	ige 2		F 001	12VAC5-371-180 C.7.		
	infection control pra respiratory equipme	lity staff failed to mai actices for the use of ent for two of six resi Residents #1 and #3	dents in		Actions to Correct Deficien     a. Resident #1 - the not cleaned, dated, and stored.	bulizer was	07/05/2018
	<ol> <li>The facility staff failed to store a nebulizer in a sanitary manner for Resident #1.</li> <li>Facility staff failed to store the nebulizer mask and the nasal cannula in a sanitary manner for</li> </ol>				b. Resident #3 - the no and nasal cannula v dated, and properly	vas cleaned,	07/05/2018
	Resident #3		ner for		Affected Population: All resid oxygen and/or nebulizer treatment	_	
ļ	The findings include	e:					
æ	1. Resident #1 was admitted to the facility on 3/12/18 with diagnoses that included but were not limited to: bronchiectasis, asthma, dementia, osteoporosis, Vitamin D deficiency, edema and depression.			3. Prevention of Deficiency Reod  a. Nursing staff will be serviced on infection the policy pertaining storage relevant materials.	e re-in- on control and g to the	08/09/2018	
	assessment, an add assessment referent resident as scoring interview for mental	DS (minimum data s mission assessment nce date of 3/18/18, o a 13 on the BIMS (b I status) score, indica king daily cognitive d	with an coded the rief		b. The "Oxygen Stora policy will be upda nebulizers and rela 4. Measures Implemented to Ma Compliance:	ted to include ted equipment.	07/27/2018
	to extensive assistate of her activities of do the observation was model on the nights mouthpiece was harmonic assistance.	oded as requiring sunce of one staff mer aily living.  ade of Resident #1's  A nebulizer machinitand. The tubing and nging off the back of ot covered or in a pla	nber for all room on e was		a. The night nursing will conduct week checks on resident oxygen and/or net ensure relevant po being followed. A discrepancies will immediately.	ly, random s using ulizers to licies are ny	07/31/2018 & ongoing
	p.m. The nebulizer nightstand and the the machine but wa	on was made on 7/5, machine was noted mouthpiece was atta s not in a plastic baç as observed on the	on the ched to j. An	y	b. A report will be fi Administrator and Nursing on a mon	Director of	08/09/2018 & ongoing

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State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		7.	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NP	_	B. WING _		07/0	5/2018	
	PROVIDER OR SUPPLIER LTH CARE CENTER T	HE HERMITAGE IN R	1600 WES	RESS, CITY, TWOOD AV D, VA 2322	<del>-</del> -			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TI	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 001	practical nurse) #1 asked how a nebuli stored, LPN #1 stat the bracket on the r should be covered, change the tubing." the nebulizer machi Resident #1. After estated, "That has to compromised. It shows the nebulizer and its received.  The executive direct director were made on 7/5/18 at 6:00 p. 10.  No further information 1/2. Resident #3 was 1/28/14 and readmit that included but we high blood pressure. The most recent ME quarterly assessment as requiring assistant living.  Review of the July 2 documented, "02 (ocannula soft plasti	and.  anducted with LPN (liter on 7/5/18 at 2:06 p.m. on achine." When asked the content of the room, LPN #1 was asked the and mouthpiece of the changed as it's bould be in a bag."  attend on the storage are mouth piece. No postor and assistant executive aware of the above	n. When ce is ased ni ed if it e we o look at of N #1 een and use of dicy was ecutive concern at to exit. Ay on diagnoses of disease, neart beat essment ident as metimes as coded f daily	F 001				

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State of Virginia (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED A. BUILDING NP B. WING 07/05/2018

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

VIA HEALTH CARE CENTER THE HERMITAGE IN R 1600 WESTWOOD AVENUE 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) COMPLET DATE		
F 001	Continued From Page 4	F 001				
	(shortness of breath). Start Date - 06/29/2018. DuoNeb (1) Solution 0.5-2.5 MG/ML (milligram/milliliter) inhale orally every 6 hours as needed for SOB (shortness of breath) Start Date - 06/25/2018."	To the state of th				
	Review of the June and July 2018 medication and treatment administration records documented, "02 21 nc at noc for dyspnea. Start Date - 06/29/2018." It was documented that the oxygen was administered every night from 6/29/18 through 7/4/18. "DuoNeb (1) Solution 0.5-2.5 MG/ML (milligram/milliliter) inhale orally every 6 hours as needed for SOB (shortness of breath) Start date - 6/25/2018." It was documented the resident received a nebulizer treatment on 6/26/18.					
	An observation was made on 7/5/18 at 10:50 a.m. of Resident #3's room. There was a nebulizer mask placed on top of the nebulizer machine. The mask was not covered. The nasal cannula was draped over the oxygen concentrator. The nasal cannula was not covered. There were no plastic bags available to cover the nebulizer or nasal cannula noted in the room.		· · · · · · · · · · · · · · · · · · ·			
	An observation was made on 7/5/18 at 1:40 p.m. of Resident #3's room. There was a nebulizer mask placed on top of the nebulizer machine. The mask was not covered. The nasal cannula was draped over the oxygen concentrator. The nasal cannula was not covered. There were no plastic bags available to cover the nebulizer or nasal cannula noted in the room.					
	An observation was made on 7/5/18 at 1:58 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. LPN #2 as shown the nebulizer and nasal cannula. When asked how the nebulizer mask and nasal cannula were to be stored when					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1'''	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		NP		B. WING		07/0	5/2018	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	STREET ADI	DRESS, CITY.	STATE, ZIP CODE	0170	0/2010	
VIA HEAI	LTH CARE CENTER T	HE HERMITAGE IN R	1600 WES	TWOOD A	VENUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
F 001	and it should be da stated, "It's for infect An interview was cowith LPN #3. When and nasal cannular LPN #3 stated, "It hon it." When asked for infection (control ON 7/5/18 at 5:55 pexecutive director adirector were made. Review of the facilit Storage and Use" doxygen therapy to proper storage of oxidocument how to strainly.  No further information 12VAC5-371-200 C Based on staff interview, it was determined a designate by the administrator absence of the direct equivalent of a full-there in for a minimum of five the findings included the provide and the composition of the direct approximately 10:45 director, administrator administrator, admin	stated, "It should have ted." When asked when control."  Inducted on 7/5/18 at asked how a nebulizate stored when not as to have a bag with why, LPN #3 stated, I)."  I.m. ASM #1, the assend ASM #2, the exect aware of the findings by's policy titled, "Oxygocumented, "Policy: Residents and to ensure a nebulizer mask on was provided prior of wiew and facility documented the facility staff of registered nurse, in the tempotor of nursing, so the ime director of nursing e days a week.  Conference on 7/5/16 a.m. the assistant elive staff member (ASthat the interim director of the control of	t 2:45 p.m. ter mask t in use, n a date "That's istant sutive s. gen To provide ure the d not t or nasal r to exit. Iment f failed to n writing porary ere is the ng on duty 8 at xecutive SM) #1,	F 001	12VAC5-371-200 C  1. Actions to Correct Deficiency: A Registered Nurse was ass take over duties for the inter Director of Nursing for the of her vacation.  2. Affected Population: All residents of Hermitage F	rim remainder	07/06/2018	
STATE FORM	Λ		021199		OXK011	If continuation	on sheet 6 of 30	

PRINTED: 07/13/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		1''	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		NP		B. WING	<del> </del>	07/0	5/2018	
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE			
VIA HEAI	TH CARE CENTER	THE HERMITAGE IN R		TWOOD A				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
F 001	The review of the conducted on 7/5/documentation of	e review of the staffing schedules was no cumentation of a registered nurse on duty for e days of the week for the week of 6/30/18 ough 7/5/18.			3. Prevention of Deficiency Re Hermitage Richmond w Registered Nurse to wo capacity of the Director when he/she is out of th	ill designate a k in the of Nursing	07/06/2018 & ongoing	
	staff member (ASI 7/5/18 at 4:50 p.m registered nurse (F director of nursing vacation, ASM #2 but she isn't here a	M) #2, the executive d . When asked if there RN) who is covering fo (DON) while the DON stated, "We have an F all day. She's on call to and has covered for a	irector, on was a or the I is on RN on call		4. Measures Implemented to M Compliance: The Administrator will master schedule during when the Director of N available and report to Director if there are an discrepancies.	monitor the the time ursing is not the Executive	07/06/2018 & ongoing	
	ASM #2.  ASM #1 and ASM above concern on  No further informat  12VAC5-371-220 E  Based on observat document review a determined the fact treatments and me resident's medical residents in the sur Resident #5; and fa order for one of six sample.  1. The facility staff:	ion, staff interview, fac- ind clinical record revi- ility staff failed to adm dications as prescribe plan of care for two of vey sample, Resident ailed to clarify a physic residents in the surve	of the r to exit.  cility ew, it was inister ed in the six ts #1 and clan's		12VAC5-371-220 B  1. Actions to Correct Deficience a. Residents #3 & #5 - corrected to give an oxygen flow rate.  b. Resident #1 - Physic notified about the meights and nebuliz	Orders were accurate cian was issing daily	07/05/2018 07/05/2018	
	and failed to provid physician orders fo 2. The facility staff	e nebulizer treatments	s per the esident #					

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State of Virginia

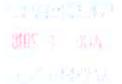
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NP		B, WING_		07/0	5/2018
	PROVIDER OR SUPPLIER LTH CARE CENTER T	HE HERMITAGE IN R	1600 WES	DRESS, CITY, TWOOD AV D, VA 2322			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
F 001	for the oxygen flow The findings include 1. a. Resident #1 w 3/12/18 with diagno limited to: bronchied osteoporosis, Vitam depression.  The most recent MI assessment, an adr assessment referent resident as scoring interview for mental was capable of mak The resident was co to extensive assista of her activities of di The physician order "Daily WT (weight) i The May 2018 MAR record) documented edema." It was sche documented for eve completed.  The June 2018 MAR the morning for eder 6:00 a.m. It was doc 6/27/18, as having I The July 2018 MAR morning for edema.'	d to clarify a physicial rate for Resident #3.  as admitted to the fases that included but tasis, asthma, demension D deficiency, eden DS (minimum data semission assessment, and a 13 on the BIMS (but status) score, indicating daily cognitive decided as requiring sugnice of one staff mension administration administration.  In the morning for Ed (medication administration) with the morning for Ed (medication) with the morning for Ed (me	cility on t were not entia, ma and  et) with an coded the rief ting she ecisions. pervision nber for all umented, ema." stration orning for t was en  / WT in ed for ay, except	F 001	2. Affected Population:     All residents of Hermitage are affected when physician are not clarified and when medications/treatments are per orders.  3. Prevention of Deficiency Reoccuta. Updated policy entitled "Physician Visits and Coreflect handling issues around missed medicated treatments.  b. Re-inservice nursing st importance of notifying physician and POA who medication/treatments given. Nursing staff with reeducated on clarifying physician orders when ambiguous.  4. Measures Implemented to Maint Compliance:     The evening nursing supervibe responsible for randomly monitoring four resident chaweek for notification and classification and class	not given  urrence: d, Orders" to revolving tion/  taff on the g nen are not ill be ng they are  tain  isor will  arts per arification essed and Jursing	07/27/2018 08/09/2018 & ongoing

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State of Virginia (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING \_ NP B. WING 07/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 WESTWOOD AVENUE VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) F 001 Continued From Page 8 F 001 Review of the "Weight Summary" in the computerized medical record documented the weights were not documented on the following days: 5/13/18, 5/14/18, 5/19/18, 5/22/18, 5/23/18, 5/27/18, 5/28/18, 6/1/18, 6/8/18, 6/9/18, 6/10/18, 6/11/18, 6/15/18, 6/20/18, 6/22/18, 6/24/18, 6/25/18, 6/26/18, 6/29/18, 7/2/18, 7/3/18 and 7/4/18. Review of the nurse's notes from 5/1/18 through 7/5/18 failed to evidence documentation of the weights. An interview was conducted with CNA (certified nursing assistant) #1 on 7/5/18 at 1:50 p.m. When asked if a physician has ordered daily weights, who obtains the daily weights, CNA#1 stated, "The CNAs get the weights." When asked where the weight is documented, CNA#1 stated, "It goes in (name of computer program) and I also give it to the nurse on a piece of paper." An interview was conducted with LPN (licensed practical nurse) #1 on 7/5/18 at 2:06 p.m. When asked if the physician has ordered daily weights, who obtains them, LPN #1 stated, "The Life Enhancer (their term for a CNA)." When asked where it is recorded, LPN #1 stated, "In (name of computer program)." When asked if it's not documented in the computer program, would it be anywhere else, LPN #1 stated, "No, that's where we document weights." In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients." The executive director and assistant executive

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State of Virginia (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 07/05/2018 NP STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1600 WESTWOOD AVENUE** VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (X5)(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG **DEFICIENCY**) F 001 F 001 Continued From Page 9 director was made aware of the above findings on 7/5/18 at 6:00 p.m. A request was made for a policy on following physician orders, none was received by exit. No further information was provided prior to exit. b. The physician order dated, 3/16/18 documented, "Albuterol Sulfate Nebulization Solution (used to treat or prevent bronchospasms in patients with asthma, bronchitis, emphysema and other lung diseases) (1) 2.5 MG/3ML (milligrams per milliliter); 3 ML inhale orally via nebulizer two times a day related to bronchiectasis (persistent, abnormal widening of the bronchi, with an associated cough and the spitting up of pus filled mucus) (2). The June 2018 MAR (medication administration record) documented the above medication. The medication was signed off on 6/4/18, 6/5/18 and 6/6/18 at the scheduled 12:00 p.m. dose as "Not given/see nurse's notes". The nurse's note dated 6/4/18 at 1:59 p.m. documented in part, "Neb (nebulizer) machine not working - being repaired. Neb not administered." The nurse's note dated 6/5/18 at 6:57 p.m. documented in part, "Awaiting nebulizer delivery." The nurse's note dated, 6/6/18 at 7:27 p.m. documented in part, "Awaiting nebulizer." There was no documentation of notification to the physician. The comprehensive care plan dated, 3/9/17 and revised on 4/13/18, documented, "Focus: (Resident #1) has potential for altered respiratory status/difficulty breathing related to asthma." The

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_ NP B. WING 07/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VIA HEALTH CARE CENTER THE HERMITAGE IN R 1600 WESTWOOD AVENUE RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From Page 10 F 001 F 001 "Interventions/Tasks" documented in part, "Administer medication/puffers as ordered." An interview was conducted with LPN (licensed practical nurse) #1 on 7/5/18 at 4:55 p.m. When asked what happens if a nurse is unable to give a medication, LPN #1 stated, "First you notate it in the system that it wasn't given. You can borrow it and then replace it when it comes in." When asked if the nurse has to notify the doctor of a missed medication, LPN #1 stated, "Yes, I'll let them know." When asked if the notification has to be documented, LPN #1 stated, "Yes, it should be in the progress notes." The order and the missed nebulizer treatments in June were reviewed with LPN #1. LPN #1 stated that each resident has to have his or her own nebulizer machine. No extra machines are kept at the facility. The executive director and assistant executive director was made aware of the above findings on 7/5/18 at 6:00 p.m. A request was made for a policy on following physician orders, none was received by exit. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT 0008848/?report=details (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 91. 2. Resident #5 was admitted to the facility on 4/12/18, with diagnoses that included but were not limited to: dementia, shortness of breath, difficulty swallowing, and stiffness of joints. The most recent MDS (minimum data set)

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PRINTED: 07/13/2018

**FORM APPROVED** State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_ NP B. WING 07/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WESTWOOD AVENUE VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) F 001 Continued From Page 11 F 001 assessment, an admission assessment, with an assessment reference date of 4/20/18, coded the resident as having short and long term memory problems, as well as severely impaired cognitive skills for daily decision making. The resident was coded as totally dependent on two or more staff members for bed mobility, transfers, dressing, toileting, eating and personal hygiene. In Section O - Special Treatments, the resident was coded as using oxygen during the look back period. During initial rounds on 7/5/18 at 11:00 a.m., Resident #5 was observed reclining in his bed with oxygen on via nasal cannula (a plastic tube with two prong that are inserted just inside the nose) set at between 2.5-3 L/min (liters/minute). A review of Resident #5's clinical record documented the physician's order "Oxygen @ 3L (liters/minute) via nasal cannula continuous every shift for comfort." On 7/5/18 at 1:50 p.m., Resident #5 was observed reclining in his bed with oxygen on via nasal cannula set at between 2.5-3 L/min. A review of the comprehensive care plan dated 4/26/18, documented in part, "Focus: [Resident #5's name] has oxygen therapy r/t (related to) SOB (shortness of breath) and comfort measures." In the Interventions section of this focus it is documented in part, "Give medications as ordered by physician." On 7/5/18 at 2:00 p.m., LPN (licensed practical nurse) #2, was asked to assess Resident #5's current oxygen flow rate. She confirmed it was

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set at 2.5-3 L/min. She also stated that the flow rate should be at 3 L/min. as ordered by physician LPN #2 was asked how to read the flow meter. She stated, "The middle of the ball should be

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State of Virginia (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING \_ B. WING 07/05/2018 NP STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 WESTWOOD AVENUE VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE TAG DEFICIENCY) F 001 Continued From Page 12 F 001 adjusted to the ordered oxygen rate." She then set the oxygen flowmeter to the ordered rate of 3 L/min. The oxygen concentrator's manufacturer's instructions documented, "To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the knob until the ball rises to the line. Now, center the ball on the L/min prescribed." According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration." ASM (administrative staff member) #1, the assistant executive director, and ASM #2, the executive director, were made aware of the above concerns on 7/5/18 at 4:43 p.m. No further information was provided prior to exit. 3. Resident #3 was admitted to the facility on 1/28/14 and readmitted on 6/23/18 with diagnoses that included but were not limited to: lung disease, high blood pressure, dementia and fast heart beat The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 4/28/18 coded the resident as sometimes understanding others and sometimes making self understood. The resident was coded as regulring assistance for all activities of daily

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FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING NP B. WING 07/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WESTWOOD AVENUE VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 001 Continued From Page 13 F 001 living. Review of the July 2018 physician orders documented, "02 (oxygen) 2-4l (liters) nc (nasal cannula - soft plastic prongs that fit in the nose to deliver oxygen) prn (as needed) dyspnea (shortness of breath). Start Date: 06/29/2018." Review of the July 2018 treatment administration record documented, "02 2-41 nc prn dyspnea. Start Date: 06/29/2018." The oxygen was documented as being administered on 7/1/18. There was no flow rate documented. Review of the resident's care plan did not evidence documentation regarding the administration of oxygen. An interview was conducted on 7/5/18 at 1:58 p.m. with LPN (licensed practical nurse) #2, the resident's nurse. When asked to review the oxygen order for Resident #3, LPN #2 stated, "I would clarify it. I would call the doctor and change it. We would do two liters or four liters we don't do ranges." An interview was conducted on 7/5/18 at 2:45 p.m. with LPN #3. When asked what oxygen flow rate would staff administer if the order was for two to four liters, LPN #3 stated, "So, I have to clarify that order just to make sure I know what to give." On 7/5/18 at 5:55 p.m. ASM (administrative staff member) #1, the assistant executive director and ASM #2, the executive director were made aware of the findings.

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Review of the facility's policy titled, "Oxygen Storage and Use" did not evidence documentation regarding clarifying a physician's order for the flow

rate to be administered.

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		NP		B. WING	·	07/0	5/2018
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F 001	According to Funda Potter, 6th edition, preated as a drug. I such as atelectasis drug, the dosage or should be continuous should routinely cheverify that the client oxygen concentration medication administration."  12VAC5-371-220 H Based on staff internand clinical record of facility staff failed to medication, needed available for one of sample, Resident #  The facility staff failed a nebulizer treatment administration for estimated to: bronchiectasis, a osteoporosis, Vitam depression.  The most recent ME assessment, an administration administration for estimated to: bronchiectasis, a osteoporosis, Vitam depression.	ion was provided price imentals of Nursing, page 1122, "Oxygen it has dangerous side or oxygen toxicity. A concentration of oxygen toxicity. A concentration of oxygen monitored. The eck the physician's or is receiving the preson. The six rights of tration also pertain to treat a condition, six residents in the state of the physician of of th	Perry and should be effects, As with any ygen nurse rders to scribed to oxygen on the review lined the when a was not survey cian when for on 3/12/18 of limited ma and et) with an coded the rief ating she	æ	12VAC5-371-220 H  1. Actions to Correct Deficiency: Resident #1 - Physician v notified about the missing nebulizer treatment.  2. Affected Population: All residents of Hermitage are affected when physician are not clarified and when medications/treatments are per orders.	vas g Richmond n orders	07/05/2018

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		1	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	TH CARE CENTER T	HE HERMITAGE IN R		TWOOD A	/ENUE			
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F 001	to extensive assistate of her activities of definition o	oded as requiring superiod of one staff merally living.  I dated, 3/16/18 documents and other and the bronchi, with a not the spitting up of the above medication of the above medicationed off on 6/4/18, 6/5 uled 12:00 p.m. dose	imented, used to not with her lung her two times not, an pus filled istration on. The hi/18 and as "Not m. achine not istered."  m. delivery."  m. delivery."  ion to the spiratory ma." The	F 001	reflect handling around missed treatments.  b. Re-inservice no importance of physician and medication/tregiven. Nursing reeducated on	ventitled, its and Orders" to g issues revolving medication/  ursing staff on the notifying POA when atments are not staff will be clarifying rs when they are  o Maintain g supervisor will andomly ident charts per on and sician orders. Any le be addressed and ector of Nursing	07/27/2018 08/09/2018 & ongoing	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_ NP B. WING 07/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VIA HEALTH CARE CENTER THE HERMITAGE IN R 1600 WESTWOOD AVENUE RICHMOND, VA 23227 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) F 001 Continued From Page 16 F 001 An interview was conducted with LPN (licensed practical nurse) #1 on 7/5/18 at 4:55 p.m. When asked what happens if a nurse is unable to give a medication, LPN #1 stated, "First you notate it in the system that it wasn't given. You can borrow it and then replace it when it comes in." When asked if the nurse has to notify the doctor of a missed medication, LPN #1 stated, "Yes, I'll let them know." When asked if the notification has to be documented, LPN #1 stated, "Yes, it should be in the progress notes." The order and the missed nebulizer treatments in June were reviewed with LPN #1. LPN #1 stated that each resident has to have his or her own nebulizer machine. No extra machines are kept at the facility. The executive director and assistant executive director was made aware of the above findings on 7/5/18 at 6:00 p.m. A request was made for a policy on following physician orders, none was received by exit. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT 0008848/?report=details (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 91. 12VAC5-371-250 A.6. 12VAC5-371-250 A. 6. 1. Actions to Correct Deficiency: Based on staff interview and clinical record review 07/06/2018 The MDS for Resident #2 was it was determined the facility staff failed to corrected to reflect that resident was maintain a complete and accurate assessment for under hospice care. one of six residents in the survey sample, Residents #2. For Resident #2, the facility staff falled to code the resident was receiving hospice care and services

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 001	on the quarterly assignanterly assessment to: heart failure, depand glaucoma.  The most recent MI assessment, a quarassessment referencesident as scoring interview for mental was severely impair decisions. The resident as scoring interview for mental was severely impair decisions. The resident as scoring interview for mental was severely impair decisions. The resident as scoring interview for mental was severely impair decisions. The resident as scoring interview for mental was severely impair decisions. The resident to (name) hor most of her activities. The physician order "Admit to (name) hor physician order activities as reference date of 1/ Section O - Special Programs, the residence date of 4/ O - Special Treatme Programs, the residence date of 4/ O - Special Treatm	age 17 sessment of 1/11/18 ant of 4/5/18.  c: Imitted to the facility included but were no pression, vitamin D do DS (minimum data setterly assessment, wince date of 4/5/18, co a "5" on the BIMS (bill status) score, indicated to make cognitive dent was coded as rele of one staff members of daily living.	and the  on 9/1/14 ot limited eficiency,  et) ith an oded the rief eting she et daily equiring er for  cumented, sment in ures and sok back sment n Section	F 001	2. Affected Population: All Hermitage Rich that are under hospi affected when the N is not completed ac  3. Prevention of Deficiency Re-inservice Medic filling out an accura assessment for resid services.  4. Measures Implemented t Compliance: a. The MDS Coo audit 20 reside assessments pe	mond residents are are MDS assessment curately.  Recurrence: al Leaders on the MDS dents on hospice to Maintain ardinators will ent MDS the month for rections will be desistencies are the reported to the the trising and the	08/09/2018 07/06/2018 & ongoing 07/06/2018 & ongoing	
	period.  An interview was co staff member (ASM) director, on 7/5/18 a completes the MDS	nducted with adminis ) #1, the assistant ex t 2:15 p.m. When as assessments, ASM	strative ecutive ked who #1					
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State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_ NP B. WING 07/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VIA HEALTH CARE CENTER THE HERMITAGE IN R 1600 WESTWOOD AVENUE RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE DEFICIENCY) F 001 Continued From Page 18 F 001 explained that the nurses on the units complete the MDS assessments. An interview was conducted with LPN (licensed practical nurse) #1 on 7/5/18 at 2:24 p.m. When asked if she completed the MDS assessments documented above for Resident #2, LPN #1 stated the other nurse on the unit completed Resident #2's assessments. The other LPN was not available for interview. When asked if hospice care and services should be coded on the MDS assessment, LPN #1 stated, "Absolutely." The executive director and ASM #1 were made aware of the above findings on 7/5/18 at 6:00 p.m. No further information was provided prior to exit. 12VAC5-371-250 F 12VAC5-371-250 F 1. Actions to Correct Deficiency: Based on staff interview, facility document review 07/16/2018 a. Care Plans were reviewed and and clinical record review, it was determined revised for Resident #3 and facility staff failed to review and revise a care plan Resident #4 to reflect falls on the for four of six residents in the survey sample. given dates. Resident #3, #4, #2 and #5. 1. Facility staff failed to review and revise the care b. Care Plan was reviewed and 07/16/2018 revised for Resident #4 to reflect plan following a fall on 4/28/18 for Resident #3. a 5% weight loss. 2. a. Facility staff failed to review and revise the care plan following a fall on 5/7/18, 5/26/18, c. A care plan was developed to 07/16/2018 5/31/18, 6/18/18, 6/22/18 and 6/30/18 for Resident reflect hospice care for Resident #4. #2. 2 b. Facility staff failed to review and revise the d. A comprehensive care plan 07/16/2018 care plan following a five percent weight loss reflecting hospice services was coded on the quarterly 5/14/18 minimum data set developed for Resident #5. for Resident #4. 3. The facility staff failed to develop a care plan to address hospice care that the resident was currently receiving for Resident #2.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1''	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 001	4. The facility staff comprehensive car Resident #5  The findings includ  1. Resident #3 was 1/28/14 and readm that included but whigh blood pressure. The most recent M quarterly assessme reference date) of 4 sometimes underst making self unders as requiring assistativing.  Review of the nurse documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus. (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus. (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus. (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus." (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus." (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus." (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus." (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus." (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus." (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the residence of revised "Focus." (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus." (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the Review of the resid 7/30/16 and revised "Focus." (Name of rewithout injuries." Renot evidence documented that the wheelchair onto the resid 7/30/16 and revised "Focus." (Name of rewithout injuries." (Name of rewithout injuries." (Name of rewithout injuries."	failed to develop a re plan for hospice set e:  admitted to the facilited on 6/23/18 with ere not limited to: lune, dementia and fast DS (minimum data sent, with an ARD (assent, with an ARD (assent) anding others and so tood. The resident wance for all activities de's notes for 4/28/18 are resident had slid o	ity on diagnoses of disease, heart beat et) a sessment sident as coded of daily ut of the ed on ted, y of falls tions did he 4/28/18 at 1:58 p.m. the lents had am ted make when the d, LPN #2, et change, asked to	F 001	2. Affected Population:     All residents of Hermitage  3. Prevention of Deficiency Recurred Re-inservice staff on the import of developing, reviewing, and revising care plans on a daily  4. Measures Implemented to Mainta Compliance:     a. The MDS Coordinators audit 20 resident care possible month for accuracy. Convilled by made if inconsistant are found.  b. Findings will be reported Director of Nursing and Administrator monthly.	ence: fortance d basis.  hin s will blans per brections stencies  ed to the d the	08/09/2018 07/06/2018 & ongoing 07/06/2018 & ongoing

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State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ NP B. WING 07/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 WESTWOOD AVENUE VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE **DEFICIENCY**) F 001 Continued From Page 20 F 001 and/or update following the 4/28/18 fall, LPN #2 stated it was not there. An interview was conducted on 7/5/18 at 2:30 p.m. with LPN #3. When asked why residents had care plans, LPN #3 stated, "So we have a specific plan to follow so if someone else comes in they know what care that resident needs." When asked when the care plan would be updated, LPN #3 stated, "Falls, changes in medications. Any change in the resident's care, we update the care plan." When asked who updated the care plan, LPN #3 stated, "The nurses, the physical therapist, the dietitian." When asked if staff reviewed and/or revised the care plan following a fall, LPN #3 stated, "There should be one for every fall." On 7/5/18 at 5:55 p.m. ASM (administrative staff member) #1, the assistant executive director and ASM #2, the executive director were made aware of the findings. Review of the facility's policy titled, "MDS and Care Planning" documented, "Care Plan: Care Plans will be updated in charts as plans of care changes, (ie: new or changes in medications, falls skin issues etc)." No further information was provided prior to exit. According to Fundamentals of Nursing Lippincott Williams and Wilkins 2007 pages 65-77 documented, "A written care plan serves as a communication tool among health care team members that helps ensure continuity of care...The nursing care plan is a vital source of information about the patient's problems, needs, and goals. It contains detailed instructions for achieving the goals established for the patient and is used to direct care...expect to review, revise and update the care plan regularly, when there are

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State of Virginia (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 07/05/2018 B. WING NP STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1600 WESTWOOD AVENUE** VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 001 Continued From Page 21 F 001 changes in condition, treatments, and with new orders..." (1) (1) Fundamentals of Nursing Lippincott Williams & Wilkins 2007 Lippincott Company Philadelphia pages 65-77. Basic Nursing, Essentials for Practice, 6th edition, (Potter and Perry, 2007, pages 119-127), was a reference for care plans. "A nursing care plan is a written guideline for coordinating nursing care, promoting continuity of care and listing outcome criteria to be used in the evaluation of nursing care. The written care plan communicates nursing care priorities to other health care professionals. The care plan also identifies and coordinates resources used to deliver nursing care. A correctly formulated care plan makes it easy to continue care from one nurse to another. If the patient's status has changed and the nursing diagnosis and related interventions are no longer appropriate, modify the nursing care plan. An out of date or incorrect care plan compromises the quality of nursing care." 2. a. Resident #4 was admitted to the facility on 1/29/18 with diagnoses that included but were not limited to: dementia, high blood pressure and arthritis. Review of the most recent MDS, a quarterly assessment, with an ARD of 5/14/18 coded the resident as sometimes being understood and sometimes understanding. The resident was coded as requiring assistance for all activities of daily living. Review of the May through July 2018 nurse's notes documented the resident had fallen on 5/7/18, 5/26/18, 5/31/18, 6/18/18, 6/22/18 and 6/30/18.

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State of Virginia (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING NP B. WING 07/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER VIA HEALTH CARE CENTER THE HERMITAGE IN R 1600 WESTWOOD AVENUE RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) F 001 Continued From Page 22 F 001 Review of the resident's care plan initiated on 2/2/18 and revised on 5/17/18 documented, "The resident is a high risk for falls r/t (related to) Confusion, Gait/balance problems." Review of the interventions did not evidence that the care plan had been reviewed and/or revised following the 5/7, 5/26, 5/31, 6/18, 6/22 and 6/30/18 falls. An interview was conducted on 7/5/18 at 1:58 p.m. with LPN (licensed practical nurse) #2. When asked why residents had care plans, LPN #2 stated, "So we as team members know how to care for them and make changes as they change. When asked when the care plan would be reviewed and revised, LPN #2, stated, "We update as we need to. A diet change, mood, falls, incidents, anything." An interview was conducted on 7/5/18 at 2:30 p.m. with LPN #3, the resident's nurse. When asked why residents had care plans, LPN #3 stated, "So we have a specific plan to follow so if someone else comes in they know what care that resident needs." When asked when the care plan would be updated, LPN #3 stated, "Falls, changes in medications. Any change in the resident's care, we update the care plan." When asked who updated the care plan, LPN #3 stated, "The nurses, the physical therapist, the dietitian." When asked if staff reviewed and/or revised the care plan following a fall, LPN #3 stated, "There should be one for every fall." When asked to review the fall care plan for review and/or revision following the falls, LPN #3 stated, "They're not there." When asked if they should be, LPN #3 stated, "Yes." On 7/5/18 at 5:55 p.m. ASM #1, the assistant executive director and ASM #2, the executive director were made aware of the findings.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/05/2018	
			07/0					
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE			
VIA HEAL	TH CARE CENTER T	HE HERMITAGE IN R		STWOOD AVE ID, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	ON SHOULD BE COMPLETE HE APPROPRIATE DATE			
F 001	Continued From Page 23			F 001		82		
	No further informat	ion was provided prid	or to exit.					
	b. Review of the 5/4/18 quarterly MDS in section K it was documented the resident's height was 74 inches and the weight was 157 pounds. Under section K0300 titled, "Weight Loss" it was documented that the resident had a five percent or greater weight loss in the past month and the resident was not on a weight reduction regimen.  Review of the weights and vital signs summary record documented the resident's weight on 4/19/18 as 167 pounds and 5/3/18 as 157 pounds. A 5.99% weight loss.  Review of the July 2018 physician's orders documented, "Magic cup two times a day. Start Date -04/28/2018."  Review of the July 2018 medication administration record documented, "Magic cup two times a day. Start Date - 04/28/2018." It was documented as being given twice a day every day.							
	documented, "Focus swallowing problem assessment results documentation that	plan initiated on 2/26 us. (Name of residen n r/t (related to) Swal s." There was no evid t the care plan had booksed regarding the re	t) has a lowing fence of een					
	with LPN #3, the re why residents had we have a specific else comes in they needs." When ask updated, LPN #3 s medications. Any of	onducted on 7/5/18 a esident's nurse. Whe care plans, LPN #3 s plan to follow so if so know what care that ed when the care pla tated, "Falls, change change in the residen e plan." When asked	n asked stated, "So omeone t resident in would be s in t's care,					

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State of Virginia (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ NP B. WING 07/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1600 WESTWOOD AVENUE** VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 001 Continued From Page 24 F 001 updated the care plan, LPN #3 stated, "The nurses, the physical therapist, the dietitian." When asked if staff would revise the care plan if a resident had weight loss, LPN #3 stated, "Yes." When asked about Resident #4's weight loss, LPN #3 stated, "That was a while ago. We are giving him magic cups (a high calorie supplement) everyday." An interview was conducted on 7/5/18 at 5:00 p.m. with OSM (other staff member) #1, the dietitian. When asked who completed section K of the MDS, OSM #1 stated, "I do." When asked what did staff do if a resident lost five per cent or more weight in a month, OSM #1 stated, "We would add supplements and let the doctor know." When asked if the care plan would be updated, OSM #1 stated, "Yes. We would add what supplements we added." When asked to review the care plan for an update, OSM #1 stated, "I didn't sign it (section K in the MDS) so it wasn't updated in the care plan." On 7/5/18 at 5:55 p.m. ASM #1, the assistant executive director and ASM #2, the executive director were made aware of the findings. No further information was provided prior to exit. In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment." 1. DuoNeb -- Ipratropium Bromide and Albuterol Sulfate Inhalation Solution is indicated for the treatment of bronchospasm associated with COPD in patients requiring more than one bronchodilator. This information was obtained

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State of Virginia (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING\_ 07/05/2018 NP B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 WESTWOOD AVENUE VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) in (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 001 Continued From Page 25 F 001 from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cf m?setid=3c64255e-074c-41f8-a344-3686a068502 3. Resident #2 was admitted to the facility on 9/1/14 with diagnoses that included but were not limited to: heart failure, depression, vitamin D deficiency, and glaucoma. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/5/18, coded the resident as scoring a "5" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make cognitive daily decisions. The resident t was coded as requiring extensive assistance of one staff member for most of her activities of daily living. The physician order dated, 10/10/17, documented "Admit to (name) hospice." The review of the comprehensive care plan failed to evidence documentation of Resident #2, receiving hospice care and services. The care plan presented to this writer did not have any dates documented on it. An interview was conducted with LPN (licensed practical nurse) #1, on 7/5/18 at 2:24 p.m. When asked if Resident #2 was currently on hospice care. LPN #1 stated the resident was on hospice care. When asked who updates the care plans, LPN #1 stated, "All nurses." When asked if a resident is on hospice care, should that be addressed on the care plan, LPN #1 stated, "Yes." When the above care plan was reviewed with LPN #1. LPN #1 stated that the other nurse assigned to this unit was assigned to complete Resident #2's care plan. The other nurse was not available for

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FORM APPROVED State of Virginia (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING NP B. WING 07/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1600 WESTWOOD AVENUE VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 001 F 001 Continued From Page 26 interview. The executive director and assistant executive director was made aware of the above findings on 7/5/18 at 6:00 p.m. No further information was provided prior to exit. 4. Resident #5 was admitted to the facility on 4/12/18, with diagnoses that included but were not limited to: dementia, shortness of breath, difficulty swallowing, and stiffness of joints. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 4/20/18, coded the resident as having short and long term memory. problems, as well as severely impaired cognitive skills for daily decision making. The resident was coded as being totally dependent on two or more staff members for bed mobility, transfers, dressing, toileting, eating and personal hygiene. In Section O - Special Treatments, the resident was coded as requiring hospice care during the look back period. A review of the comprehensive care plan dated 4/26/18, failed to evidence any needs, goals or interventions for the provision of hospice services for Resident #5. A review of Resident #5's clinical record documented the physician order, dated 4/13/18, stated "Admit to [name] Hospice."

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[name] Hospice."

A review of the physician's progress note dated 6/12/18 at 4:02 p.m., documented in part, "History of Present Illness: Patient is under the care of

A review of the nursing notes documented in part

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
	NP			B. WING		07/05/2018	
NAME OF P	PROVIDER OR SUPPLIER		Ŀ		STATE, ZIP CODE		
VIA HEAL	TH CARE CENTER T	HE HERMITAGE IN R		STWOOD A\ ID, VA 2322	<del></del>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG			(X5) COMPLETE DATE
F 001	Continued From Page 27			F 001			
	[sic] no changes; 6/hospice; 7/2/18 at 1 On 7/5/18 at 4:15 p nurse) #2, was asked plan. She stated the care team knows he she further stated to change as the residuance plan should be ASM (administrative assistant executive executive director, version of the control of the co	/18 at 18:06: Hospice /26/18 at 18:30: Continue /26/18 at 18:30: Continue /26/18 at 18:45: Hospice /26/18 at 18:30: Continue /2	tinues on nues."  practical acare the sident. could and the  the 2, the		a P		
	concerns on 7/5/18 at 4:43 p.m.  No further information was provided prior to exit.						
	12VAC5-371-340A Based on observation policy review, it was to store food in a safe facility staff failed to within six days, dated dressing container as	· · · · · · · · · · · · · · · · · · ·			1. Actions to Correct Deficiency: All mentioned items were discarded  2. Affected Population: All residents residing at Hermitage Richmond.		07/05/2018
	salt. An observation of the 7/5/18 at 10:30 a.m.				3. Prevention of Deficiency Recu a. Dry storage bins were and put in place for a goods, such as, cornn powdered sugar, salt,	e purchased Il dry neal,	07/09/2018
	In the dry storage room a large bag of cornmeal approximately one-half full was on the shelf with the top of the bag partially opened. A 32 ounce bag of powdered sugar was opened with powdered sugar spilled out of it.				b. Director of Dining Se inserviced staff on pro storage of dry goods.	oper	07/09/2018
	In the refrigerator th	nere was a white plas	itic				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING NP B. WING 07/05/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VIA HEALTH CARE CENTER THE HERMITAGE IN R 1600 WESTWOOD AVENUE RICHMOND, VA 23227 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 001 Continued From Page 28 F 001 4. Measures Implemented to Maintain Compliance: container half full of egg salad. There was no date 07/09/2018 a. A "Dry Storage Inspection Log" noted. Four grapefruit halves were in the refirgerator with an illegible date. has been created to ensure all food items are properly stored, There was a 1 pound box of salt noted on the dated, and discarded. counter. The box was not covered and the pour spout was missing leaving a opening in the box. 07/09/2018 b. This log will be performed by the Director of Dining Services An interview was conducted at this time. When ongoing and Kitchen Manager on a asked how the commeal, powdered sugar and salt weekly basis and submitted to should be maintained, OSM #3 stated they should the Administrator monthly. be securely wrapped. When asked how the staff would know when the egg salad was made, or when to discard the grapefruit halves, OSM #3 stated, "They're supposed to be dated." OSM #3 immediately removed the items from the storage area and refrigerator. On 7/5/28 at 5:55 p.m. ASM #1, the assistant executive director and ASM #2, the executive director were made aware of the findings. Review of the policy titled, "Storage of Frozen and Refrigerated Foods" documented, "Policy. The Dietary Department will adhere to all guidelines and regulation concerning the refrigeration and freezing of foods. Label and date all leftovers and refrigerator immediately. Do not keep potentially hazardous food in the refrigerator over 48 hours." Review of the facility's policy titled, "Storage of Dry Food and Supplies" documented, "Policy. The Dietary Department will store dry food and supplies according to policy guidelines and state regulations. Container guidelines, Reseal open boxes effetely. Bulk crackers, cereal, cookies, pasta, etc. are to be stored in properly labeled. sealed containers or tightly closed food grade plastic bags after opening." No further information was provided prior to exit.

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State of Virginia STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ NP B. WING\_ 07/05/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1600 WESTWOOD AVENUE** VIA HEALTH CARE CENTER THE HERMITAGE IN R RICHMOND, VA 23227 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE tD (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY)

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