State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NP	A. BUILDING _____ 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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 7/5/18. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 104-bed facility was 59 at the time of the survey. The survey sample consisted of six current Resident reviews (Residents #1 - #6).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 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. The facility staff failed to have documented evidence of the license verification for three staff members prior to employment. The findings include: The employee record review was conducted on 7/6/18. The following concerns were identified: LPN # 4 employee record documented she was hired on 10/12/16. The employment application was dated 9/16/16. A copy of the employee's license was documented in the file. There was no verification of the license from the Department of Health Professionals.	F 001	12VAC5-371-E 1.a. 1. Actions to Correct Deficiency: a. LPN #4 - license verification was found attached to the online application that was completed prior to the applicant filling out a hand-written application; this document was located elsewhere in the employee personnel file. b. LPN #5 - License lookup was corrected. c. CNA #1 is no longer working for the facility.	07/05/2018 07/05/2018

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

Assistant Executive Director (Administrator) — 8/15/18

State of Virginia

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F 001	Continued From Page 1 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. 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 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. The facility policy, "Employment Hiring Practices" documented in part, "5. Pre-Employment Reference Checks...For 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." 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	F 001	2. Affected Population: All Health Services employees within Hermitage Richmond. 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. b. Hiring managers will be re-inserviced on proper procedures for hiring a new employee. 4. Measures Implemented to Maintain Compliance: 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.	07/06/2018 07/30/2018 & 08/06/2018 07/06/2018 08/01/2018 & ongoing

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F 001	Continued From Page 2 determined the facility staff failed to maintain infection control practices for the use of respiratory equipment for two of six residents in the survey sample, Residents #1 and #3. 1. The facility staff failed to store a nebulizer in a sanitary manner for Resident #1. 2. Facility staff failed to store the nebulizer mask and the nasal cannula in a sanitary manner for Resident #3 The findings include: 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. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/18/18, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring supervision to extensive assistance of one staff member for all of her activities of daily living. Observation was made of Resident #1's room on 7/5/18 at 11:00 a.m. A nebulizer machine was noted on the nightstand. The tubing and mouthpiece was hanging off the back of the nightstand. It was not covered or in a plastic bag. A second observation was made on 7/5/18 at 1:42 p.m. The nebulizer machine was noted on the nightstand and the mouthpiece was attached to the machine but was not in a plastic bag. An empty plastic bag was observed on the floor	F 001	12VAC5-371-180 C.7. 1. Actions to Correct Deficiency: a. Resident #1 - the nebulizer was cleaned, dated, and properly stored. b. Resident #3 - the nebulizer mask and nasal cannula was cleaned, dated, and properly stored. 2. Affected Population: All residents receiving oxygen and/or nebulizer treatments. 3. Prevention of Deficiency Reoccurrence: a. Nursing staff will be re-in-serviced on infection control and the policy pertaining to the storage relevant materials. b. The "Oxygen Storage and Use" policy will be updated to include nebulizers and related equipment. 4. Measures Implemented to Maintain Compliance: a. The night nursing supervisor will conduct weekly, random checks on residents using oxygen and/or nebulizers to ensure relevant policies are being followed. Any discrepancies will be addressed immediately. b. A report will be filed to the Administrator and Director of Nursing on a monthly basis.	07/05/2018 07/05/2018 08/09/2018 07/27/2018 07/31/2018 & ongoing 08/09/2018 & ongoing

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F 001	Continued From Page 3 behind the nightstand. An interview was conducted with LPN (license practical nurse) #1 on 7/5/18 at 2:06 p.m. When asked how a nebulizer tubing/mouth piece is stored, LPN #1 stated, "It should be encased ni the bracket on the machine." When asked if it should be covered, LPN #1 stated, "Once we change the tubing." LPN #1 was asked to look at the nebulizer machine and mouthpiece of Resident #1. After entering the room, LPN #1 stated, "That has to be changed as it's been compromised. It should be in a bag." A policy was requested on the storage and use of the nebulizer and its mouth piece. No policy was received. 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 obtained prior to exit. 2. 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 requiring assistance for all activities of daily living. Review of the July 2018 physician's orders documented, "02 (oxygen) 2l (liters) nc (nasal cannula -- soft plastic prongs that fit in the nose to deliver oxygen) at noc (night) for dyspnea	F 001		

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F 001	Continued From Page 4 (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." Review of the June and July 2018 medication and treatment administration records documented, "02 2l 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	F 001		

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F 001	Continued From Page 5 not in use, LPN #2 stated, "It should have a bag and it should be dated." When asked why, LPN #2 stated, "It's for infection control." An interview was conducted on 7/5/18 at 2:45 p.m. with LPN #3. When asked how a nebulizer mask and nasal cannula were stored when not in use, LPN #3 stated, "It has to have a bag with a date on it." When asked why, LPN #3 stated, "That's for infection (control)." 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. Review of the facility's policy titled, "Oxygen Storage and Use" documented, "Policy: To provide oxygen therapy to Residents and to ensure the proper storage of oxygen." The policy did not document how to store a nebulizer mask or nasal cannula. No further information was provided prior to exit. 12VAC5-371-200 C Based on staff interview and facility document review, it was determined the facility staff failed to provide a designated registered nurse, in writing by the administrator, to serve in the temporary absence of the director of nursing, so there is the equivalent of a full-time director of nursing on duty for a minimum of five days a week. The findings include: During the entrance conference on 7/5/18 at approximately 10:45 a.m. the assistant executive director, administrative staff member (ASM) #1, informed this writer that the interim director of nursing was on vacation this week.	F 001	12VAC5-371-200 C 1. Actions to Correct Deficiency: A Registered Nurse was assigned to take over duties for the interim Director of Nursing for the remainder of her vacation. 2. Affected Population: All residents of Hermitage Richmond	07/06/2018

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F 001	Continued From Page 6 The review of the staffing schedules was conducted on 7/5/18. There was no documentation of a registered nurse on duty for five days of the week for the week of 6/30/18 through 7/5/18. An interview was conducted with administrative staff member (ASM) #2, the executive director, on 7/5/18 at 4:50 p.m. When asked if there was a registered nurse (RN) who is covering for the director of nursing (DON) while the DON is on vacation, ASM #2 stated, "We have an RN on call but she isn't here all day. She's on call to pronounce deaths and has covered for a few hours where needed." The regulation was reviewed with ASM #1 and ASM #2. ASM #1 and ASM #2 were made aware of the above concern on 7/5/18 at 5:00 p.m. No further information was obtained prior to exit. 12VAC5-371-220 B Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to administer treatments and medications as prescribed in the resident's medical plan of care for two of six residents in the survey sample, Residents #1 and Resident #5; and failed to clarify a physician's order for one of six residents in the survey sample. 1. The facility staff failed to obtain daily weights and failed to provide nebulizer treatments per the physician orders for Resident #1. 2. The facility staff failed to administer Resident # 5's oxygen according to the physician's orders.	F 001	3. Prevention of Deficiency Recurrence: Hermitage Richmond will designate a Registered Nurse to work in the capacity of the Director of Nursing when he/she is out of the building. 4. Measures Implemented to Maintain Compliance: The Administrator will monitor the master schedule during the time when the Director of Nursing is not available and report to the Executive Director if there are any discrepancies. 12VAC5-371-220 B 1. Actions to Correct Deficiency: a. Residents #3 & #5 - Orders were corrected to give an accurate oxygen flow rate. b. Resident #1 - Physician was notified about the missing daily weights and nebulizer treatments.	07/06/2018 & ongoing 07/06/2018 & ongoing 07/05/2018 07/05/2018

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F 001	Continued From Page 7 3. Facility staff failed to clarify a physician's order for the oxygen flow rate for Resident #3. The findings include: 1. a. 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. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/18/18, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring supervision to extensive assistance of one staff member for all of her activities of daily living. The physician order dated, 4/10/18, documented, "Daily WT (weight) in the morning for Edema." The May 2018 MAR (medication administration record) documented, "Daily WT in the morning for edema." It was scheduled for 6:00 a.m. It was documented for every day as having been completed. The June 2018 MAR documented, "Daily WT in the morning for edema." It was scheduled for 6:00 a.m. It was documented for every day, except 6/27/18, as having been completed. The July 2018 MAR documented, "Daily WT in the morning for edema." It was scheduled for 6:00 a.m. It was documented as having been completed on 7/1/18 through 7/5/18.	F 001	2. Affected Population: All residents of Hermitage Richmond are affected when physician orders are not clarified and when medications/treatments are not given per orders. 3. Prevention of Deficiency Reoccurrence: a. Updated policy entitled, "Physician Visits and Orders" to reflect handling issues revolving around missed medication/ treatments. b. Re-inservice nursing staff on the importance of notifying physician and POA when medication/treatments are not given. Nursing staff will be reeducated on clarifying physician orders when they are ambiguous. 4. Measures Implemented to Maintain Compliance: The evening nursing supervisor will be responsible for randomly monitoring four resident charts per week for notification and clarification of physician orders. Any inconsistencies will be addressed and reported to the Director of Nursing and Administrator each month.	07/27/2018 08/09/2018 08/09/2018 & ongoing

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F 001	Continued From Page 8 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	F 001		

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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	F 001		

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F 001	Continued From Page 10 "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/PMHT0008848/?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)	F 001		

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F 001	Continued From Page 11 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 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	F 001		

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	NP	A. BUILDING _____ B. WING _____	07/05/2018

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F 001	Continued From Page 12 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 requiring assistance for all activities of daily	F 001		

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F 001	Continued From Page 13 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 2-4l 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. 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.	F 001		

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F 001	Continued From Page 14 No further information was provided prior to exit. 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." 12VAC5-371-220 H Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to notify the physician when a medication, needed to treat a condition, was not available for one of six residents in the survey sample, Resident #1. The facility staff failed to notify the physician when a nebulizer treatment was not available for administration for esident #1. The findings include: 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. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/18/18, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions.	F 001	12VAC5-371-220 H 1. Actions to Correct Deficiency: Resident #1 - Physician was notified about the missing nebulizer treatment. 2. Affected Population: All residents of Hermitage Richmond are affected when physician orders are not clarified and when medications/treatments are not given per orders.	07/05/2018

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F 001	Continued From Page 15 The resident was coded as requiring supervision to extensive assistance of one staff member for al of her activities of daily living. 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 "Interventions/Tasks" documented in part, "Administer medication/puffers as ordered."	F 001	3. Prevention of Deficiency Recurrence: a. Updated policy entitled, "Physician Visits and Orders" to reflect handling issues revolving around missed medication/ treatments. b. Re-inservice nursing staff on the importance of notifying physician and POA when medication/treatments are not given. Nursing staff will be reeducated on clarifying physician orders when they are ambiguous. 4. Measures Implemented to Maintain Compliance: The evening nursing supervisor will be responsible for randomly monitoring four resident charts per week for notification and clarification of physician orders. Any inconsistencies will be addressed and reported to the Director of Nursing and Administrator each month.	07/27/2018 08/09/2018 08/09/2018 & ongoing

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F 001	Continued From Page 16 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/PMHT0008848/?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. Based on staff interview and clinical record review it was determined the facility staff failed to maintain a complete and accurate assessment for one of six residents in the survey sample, Residents #2. For Resident #2, the facility staff failed to code the resident was receiving hospice care and services	F 001	12VAC5-371-250 A.6. 1. Actions to Correct Deficiency: The MDS for Resident #2 was corrected to reflect that resident was under hospice care.	07/06/2018

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F 001	Continued From Page 17 on the quarterly assessment of 1/11/18 and the quarterly assessment of 4/5/18. The findings include: 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 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 quarterly assessment with an assessment reference date of 1/11/18 was reviewed. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as receiving hospice services during the look back period. The quarterly assessment with an assessment reference date of 4/5/18 was reviewed. In Section O - Special Treatments, Procedures and Programs, the resident was not coded as receiving hospice services during the look back period. An interview was conducted with administrative staff member (ASM) #1, the assistant executive director, on 7/5/18 at 2:15 p.m. When asked who completes the MDS assessments, ASM #1	F 001	2. Affected Population: All Hermitage Richmond residents that are under hospice care are affected when the MDS assessment is not completed accurately. 3. Prevention of Deficiency Recurrence: Re-inservice Medical Leaders on filling out an accurate MDS assessment for residents on hospice services. 4. Measures Implemented to Maintain Compliance: a. The MDS Coordinators will audit 20 resident MDS assessments per month for accuracy. Corrections will be made if inconsistencies are found. b. Findings will be reported to the Director of Nursing and the Administrator monthly.	08/09/2018 07/06/2018 & ongoing 07/06/2018 & ongoing

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F 001	Continued From Page 18 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 Based on staff interview, facility document review and clinical record review, it was determined facility staff failed to review and revise a care plan for four of six residents in the survey sample, Resident #3, #4, #2 and #5. 1. Facility staff failed to review and revise the care plan following a fall on 4/28/18 for Resident #3. 2. a. Facility staff failed to review and revise the care plan following a fall on 5/7/18, 5/26/18, 5/31/18, 6/18/18, 6/22/18 and 6/30/18 for Resident #4. 2 b. Facility staff failed to review and revise the care plan following a five percent weight loss coded on the quarterly 5/14/18 minimum data set 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.	F 001	12VAC5-371-250 F 1. Actions to Correct Deficiency: a. Care Plans were reviewed and revised for Resident #3 and Resident #4 to reflect falls on the given dates. b. Care Plan was reviewed and revised for Resident #4 to reflect a 5% weight loss. c. A care plan was developed to reflect hospice care for Resident #2. d. A comprehensive care plan reflecting hospice services was developed for Resident #5.	07/16/2018 07/16/2018 07/16/2018 07/16/2018

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F 001	Continued From Page 19 4. The facility staff failed to develop a comprehensive care plan for hospice services for Resident #5 The findings include: 1. 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 requiring assistance for all activities of daily living. Review of the nurse's notes for 4/28/18 documented that the resident had slid out of the wheelchair onto the floor. Review of the resident's care plan initiated on 7/30/16 and revised on 2/8/18 documented, "Focus. (Name of resident) has a history of falls without injuries." Review of the interventions did not evidence documentation regarding the 4/28/18 fall. 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 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." When asked to review Resident #3's care plan for a revision	F 001	2. Affected Population: All residents of Hermitage Richmond 3. Prevention of Deficiency Recurrence: Re-inservice staff on the importance of developing, reviewing, and revising care plans on a daily basis. 4. Measures Implemented to Maintain Compliance: a. The MDS Coordinators will audit 20 resident care plans per month for accuracy. Corrections will be made if inconsistencies are found. b. Findings will be reported to the Director of Nursing and the Administrator monthly.	08/09/2018 07/06/2018 & ongoing 07/06/2018 & ongoing

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F 001	Continued From Page 20 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	F 001		

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F 001	Continued From Page 21 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.	F 001		

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F 001	Continued From Page 22 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.	F 001		

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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) COMPLETE DATE
F 001	Continued From Page 23 No further information was provided prior 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. Review of the care plan initiated on 2/26/18 documented, "Focus. (Name of resident) has a swallowing problem r/t (related to) Swallowing assessment results." There was no evidence of documentation that the care plan had been reviewed and/or revised regarding the resident's weight loss. 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	F 001		

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F 001	Continued From Page 24 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	F 001		

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F 001	Continued From Page 25 from: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3c64255e-074c-41f8-a344-3686a0685020. 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	F 001		

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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." 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 [name] Hospice." A review of the nursing notes documented in part	F 001		

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F 001	Continued From Page 27 the following: "6/12/18 at 18:06: Hospice continues [sic] no changes; 6/26/18 at 18:30: Continues on hospice; 7/2/18 at 18:45: Hospice continues." On 7/5/18 at 4:15 p.m., LPN (licensed practical nurse) #2, was asked the purpose of the care plan. She stated the purpose is to ensure the care team knows how to care for the resident. She further stated that the care plan should change as the resident's needs change and the care plan should be updated as needed. 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. 12VAC5-371-340A Based on observation, staff interview and facility policy review, it was determined facility staff failed to store food in a sanitary manner. Facility staff failed to discard six grapefruit halves within six days, date egg salad, date a ranch salad dressing container after it was opened and to securely cover cornmeal, powdered sugar and salt. An observation of the kitchen was conducted on 7/5/18 at 10:30 a.m. with OSM (other staff member) #3, the director of dietary. 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. In the refrigerator there was a white plastic	F 001	12VAC5-371-340 A 1. Actions to Correct Deficiency: All mentioned items were discarded 2. Affected Population: All residents residing at Hermitage Richmond. 3. Prevention of Deficiency Recurrence: a. Dry storage bins were purchased and put in place for all dry goods, such as, cornmeal, powdered sugar, salt, etc. b. Director of Dining Services re-inserviced staff on proper storage of dry goods.	07/05/2018 07/09/2018 07/09/2018

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F 001	Continued From Page 28 container half full of egg salad. There was no date noted. Four grapefruit halves were in the refirgerator with an illegible date. There was a 1 pound box of salt noted on the counter. The box was not covered and the pour spout was missing leaving a opening in the box. An interview was conducted at this time. When asked how the cornmeal, powdered sugar and salt should be maintained, OSM #3 stated they should 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.	F 001	4. Measures Implemented to Maintain Compliance: a. A "Dry Storage Inspection Log" has been created to ensure all food items are properly stored, dated, and discarded. b. This log will be performed by the Director of Dining Services and Kitchen Manager on a weekly basis and submitted to the Administrator monthly.	07/09/2018 07/09/2018 & ongoing

State of Virginia

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