PRINTED: 02/01/2016
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	01/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

(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 Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 01/20/16 through 01/25/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 30 certified bed facility was 30 at the time of the survey. The survey sample consisted of 11 current Resident reviews (Residents #1 through #10, and #12) and 1 closed record review (Resident #11).	F 000	F000 The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. This Plan of Correction is filed as evidence of Our Lady of Perpetual Help's desire to comply with the requirements of participation and to continue to provide high-quality resident care.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Dietary and Food Service Program 12 VAC 5-371-340 (A). Cross-Reference to F-371. Maintenance and Housekeeping 12 VAC 5-371-370 (A). Cross-Reference to F-465. Clinical Records 12 VAC 5-371-360 (A, E 10). Cross-Reference to F-514.	F 001	**Refer to F 371** **Refer to F 465** **Refer to F 514**	2-29-16 2-29-16 2-29-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cindy Niemann	Interim Administrator	2-8-16

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/20/16 through 01/25/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 30 certified bed facility was 30 at the time of the survey. The survey sample consisted of 11 current Resident reviews (Residents #1 through #10, and #12) and 1 closed record review (Resident #11).	F 000	RECEIVED FEB 08 2016 VI H/OLC	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview it was determined facility staff failed to assure the second dry storage area containing supplies for the kitchen and dining room was maintained in a sanitary manner. The findings included:	F 371	F000 The filing of this Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. This Plan of Correction is filed as evidence of Our Lady of Perpetual Help's desire to comply with the requirements of participation and to continue to provide high-quality resident care. **F 371** **Corrective Action:** On 1-25-2016, the storage area floor was mopped. The storage area was also deep cleaned on 2-2-2016. **Identifying other Potential Residents:** All residents have a potential to be affected. **Systemic Changes:** Dietary staff was in-serviced on 2-2-2016. Storage area cleaning was included on daily routine schedule on 2-1-2016. **Monitoring System:** Dietary storage area will be monitored by weekly x 4 weeks by Food Service Director or Designee then monthly x 3 months. Audits will be submitted for review by our Quality Assessment / Quality Improvement team. **Date: 2-29-2016** 2-29-16	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cathy Greenman, LNHA Administrator		2-8-16

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

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F 371	Continued From page 1 During the environmental inspection of the facility on 1/25/16 the dining room was observed. An unmarked door was located on the right side of the room. The unlocked door was opened and revealed a dry storage/supply area. The room did not contain food items but food contact items such as plates, cups and glasses were stored on the shelves. Also in the room were unopened cardboard boxes on wooden pallets with items such as plastic bags. Not all the pallets were full and the area under the pallets was visible. The floor was soiled with loose debris. While the surveyor was in the room, the Dining Room Manager entered and was interviewed. The Dining Room Manager stated cleaning the floor was not assigned to any one individual so it was everyone's job, and she agreed the floor was in need of cleaning and she would take care of the situation.	F 371		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and review of facility policies it was determined the facility ice machine and floors in the nourishment room and activity area were not maintained in a sanitary manner.	F 465		

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F 465	Continued From page 2	F 465	**F 465**	

1. The ice machine was observed with dirt and debris under the machine, areas of a dried rust colored substance around the drain, and the drain did not have a proper "air gap" between the machine drain and the floor drain.

2. There was a build up of dirt around the baseboard in the activity room. This room also contained a kitchen area.

The findings included:

1. During the inspection of the nourishment room the area under the ice machine was observed. The floor had dust and debris but there was also an area of a rust colored dried liquid around the outside and inside of the drain cuff and another area against the back wall. Two surveyors observed the drain and floor. The cuff around the drain was approximately one inch and the ice machine drain pipe went straight down toward the drain but the end of the pipe had an one inch elbow bend that rested on the drain cuff and fed into the drain. One surveyor placed two fingers between the drain floor and the end of the elbow bend representing about an inch.

The purpose of the "air gap" in regard to plumbing is to assure a space between the outlet (drain) and the flood level of a fixture to ensure back flow prevention by siphonage. An example would be the home dishwasher; the air gap prevents the draining water from backing up into the bottom of the dishwasher causing contamination.

The above situation was brought to the Maintenance Director's attention on 1/25/16 around 1 pm. The nourishment room was

Corrective Action:
On 1-25-2016, the ice machine was placed in out of service status. On 1-26-2016, the floor under the refrigerator in the activity room was cleaned. On 2-1-2016, floor area under the TV stand was cleaned. On 2-2-2016, the quarter round molding in the activity room was removed, area around baseboards cleaned, and new quarter round molding was installed.

Identifying other Potential Residents:
All residents have a potential of being affected.

Systemic Changes:
New ice machine was ordered 2-3-2016. A back flow prevention device will be installed on the ice machine drain assembly prior to utilization.
Housekeeping staff was educated on 1-27-2016 on deep cleaning of activity room and new cleaning schedule. A weekly deep cleaning schedule of the Activity room was implemented on 2-1-2016.

Monitoring System:
Weekly monitoring x 4 weeks of the Activity Room for cleanliness then monthly x 3 months.
Results of the audits will be provided for review by our Quality Assessment / Quality Improvement team.

Date: 2-29-2016 2-29-16

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F 465	Continued From page 3	F 465		

checked again about two hours later and the ice machine had been moved and the floor cleaned. The Maintenance Director stated that possibly the outlet from the ice machine had been dislodged when the ice machine was moved for cleaning.

At approximately 4:30 pm on 1/25/16 this was again discussed with the Administrator and the Director of Maintenance the possibility of the dark rust color around the drain cuff and on the bottom of the PVC elbow joint was due to back flow. The Administrator stated the machine was old and would immediately be taken out of service and replaced.

2. During the environmental inspection of the activity room the baseboard around the room were observed to have a build up of dirt at the base board.

The floor between the counter and the refrigerator and between the refrigerator and the wall had dirt and debris.

The entertainment center holding the television had a dried stain on the floor in front of the unit and behind the unit.

On 1/25/16 at approximately 3 pm the surveyor and the Maintenance Director observed the above areas together. The Maintenance Director stated that was not the way the facility wanted to be seen. At 4 pm he provided cleaning schedules; each area is to receive daily cleaning/janitor services but a "floor tech" is to do deep cleaning twice a month in both the activity room and the nourishment room.

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F 465	Continued From page 4 The above information was shared with the Administrator, no additional information was obtained.	F 465		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure that one clinical record was complete and accurate for one resident (Resident #10) of a 12 resident survey sample. During an interview with nursing staff it was reported that Resident #10 had had a test done that confirmed a diagnosis of moderate to severe arterial insufficiency because of a non-healing left heel lesion that Resident #10 had been admitted to the facility on 05/01/15. There was not any documentation or Aortogram results located in the resident's clinical record.	F 514	F 514 **Corrective Action:** On 1-25-2016, the procedure notes for the arteriogram for Resident #10 was received and added to the Resident's medical record. **Identifying other Potential Residents:** 100% audit for all residents for the past year with orders for vascular studies was completed by 1-20-2016 to ensure results/ reports were included in the residents' medical record. **Systemic Changes:** On 1-26-2016, licensed nurses were educated on ensuring that test results are obtained at the time of occurrence. A tracking form was implemented on 1-26-2016 to ensure that results from scheduled vascular studies are received and placed in the medical record. **Monitoring System:** Monitoring to ensure test results are placed in the medical record will occur monthly x 3 months. Results of the audits will be provided for review by our Quality Assessment / Quality Improvement team. **Date: 2-29-2016** 2-29-16	

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F 514	Continued From page 5 The findings include: Resident #10 was originally admitted to the facility 05/01/15 and most recently readmitted on 11/24/15. Diagnoses included but were not limited to Chronic Embolism/Thrombosis of Left Lower Extremity, Hypertension, Stage II Pressure Ulcer on Admission, Arteriosclerotic Heart Disease (narrowing of the arteries due to plaque build up inside the arteries), mild PVD (peripheral vascular disease) and GERD (gastroesophageal reflux disease). Review of the resident's clinical record revealed a Significant Change Comprehensive MDS (minimum data set-an assessment protocol) with an ARD (assessment reference date) of 12/03/15. The resident's BIMS (brief interview for mental status) score was coded as an eight (8 out of a possible score of 15)) which indicated the resident's cognitive skills for safety and daily decision making was moderately impaired. Further review noted the resident was coded as requiring extensive assistance of one to two staff members for bed mobility, dressing, personal hygiene and bathing. The resident was coded as being totally dependent on two or more staff members for transferring to and from different surfaces and for toileting. The resident was coded as being able to feed self and requiring supervision of facility staff. Further, the resident was coded as being frequently incontinent of both bladder and bowel. During the investigative process of reviewing the resident's clinical record it was noted that the resident had multiple issues with maintaining the skin integrity to her left lower extremity.	F 514		

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An interview was conducted on 01/22/16 at approximately 12:45 p.m., with LPN (Licensed Practical Nurse) #21. During the interview LPN #21 was asked if the resident had any additional co-morbidities that would cause the resident to acquire the additional pressure areas to her left lower extremity. LPN #21 reviewed the resident's clinical record and located a document that stated the resident had Peripheral Arterial Disease-mild. LPN #21 then stated that she remembered that the resident had gone for an additional test as she had a history of DVT (deep vein thrombus-a blood clot) in her left lower extremity which also could cause difficulty with healing and further development of stasis ulcers to her left lower extremity. She stated that when she located the report of the procedure and the results she would pass it on for review.

An interview was conducted on 01/25/16 at approximately 8:45 a.m., with LPN #21. She stated: "I had to contact the hospital where Resident #10 (name) had her surgical procedure. Review of the document revealed that on 09/14/15, Resident #10 had an Aortogram (an aortogram involves placement of a catheter in the aorta (primary artery in the body and injection of contrast material while taking x-rays of the aorta). The end diagnosis from results of the test was a diagnosis of moderate-to-severe arterial insufficiency. LPN #21 was then asked where she had located the information and she stated: "I had to contact the hospital to obtain the information. It has now been added to Resident #10's (name) clinical record.

Administration which consisted of the Administrator, the ADON (assistant director of

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F 514	Continued From page 7 nursing) and LPN #21 were informed of the findings on 01/25/16 at approximately 4:45 p.m. No additional information was submitted for review.	F 514		