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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid Standard survey was conducted 02/02/16 through 02/04/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care and the Virginia State Long Term Care requirements. Three complaints were investigated during the survey. The Life Safety Code survey/report will follow.<br><br>The census in this 150 bed certified facility was 141 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #21) and three closed records (Residents #22 through #24). | F 000 | | |
| F 278 SS=D | 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED<br><br>The assessment must accurately reflect the resident's status.<br><br>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>A registered nurse must sign and certify that the assessment is completed.<br><br>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual | F 278 | F 278<br><br>1. Resident # 15's MDS with Assessment Reference Date 12/5/2015 was modified on 2/4/2016 to reflect the presence of a colostomy.<br>2. Any resident who is not accurately coded in section H "Bowel and Bladder" of the MDS has the potential to be affected. A review of current resident's will be conducted to ensure accurate coding of colostomy.<br>3. The MDS coordinators will be re-educated regarding accurate coding of section H "Bowel and Bladder" as per the RAI manual. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/18/2016

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

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| F 278 | Continued From page 1<br>to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.<br><br>Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review, facility documentation, and staff interviews the facility staff failed to ensure an accurate Minimum Data Set (MDS) assessment was completed for 1 of 24 residents in the survey sample, Resident #15.<br><br>The facility staff failed to ensure an accurate Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/05/15 was completed for Resident #15 to include a colostomy.<br><br>Resident #15 was a 60 year old originally admitted to the facility on 6/13/13 and was readmitted on 8/28/15. Resident #15 diagnoses included *Cerebrovascular Accident, *Bipolar Disorder, *Colostomy, and *Hypertension.<br><br>*Cerebral Vascular Accident: an abnormal condition of the brain characterized by occlusion by an embolus, thrombus, or cerebrovascular hemorrhage or vasospasm, resulting in ischemia of the brain tissues normally perfused by the damaged vessels.<br><br>*Bipolar Disorder: a major mental disorder characterized by episodes of mania, depression, or mixed mood. | F 278 | 4. MDS coordinator or designee(s) will conduct an audit of 10 completed MDS assessments weekly x 4 then monthly x 2 for coding Section H of the MDS.<br>5. Results will be reported to the Quality Assurance Committee for further discussion and recommendations.<br>Date of alleged compliance: March 14, 2016. | |

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*Colostomy: a surgical creation of an artificial anus on the abdominal wall by incising the colon and bringing it out to the surface, performed for cancer of the colon, benign obstructive tumors, and severe abdominal wounds.

*Hypertension: a common disorder that is a known cardiovascular disease risk factor, characterized by elevated blood pressure over normal values of 120/80 mm Hg (milligrams of mercury) in an adult.

The above definitions were derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.

The most recent Minimum Data Set (MDS) assessment was a Quarterly assessment with an Assessment Reference Date (ARD) of 12/05/15 with a Brief Interview for Mental Status (BIMS) of a 15 out of a possible 15 which indicates that the resident is cognitively intact and able to make decisions for daily living. Under Section H Bladder and Bowel H0100 Appliances Resident #15 was coded at Z (None of the above). Resident #15 should have been coded at C. (Ostomy including urostomy, ileostomy, and colostomy). Under H0400 Bowel Continence Resident #15 was coded a 2 (Frequently Incontinent). Resident #15 should have been coded at 9 (Not rated, resident had an ostomy).

Resident #15's Comprehensive Care Plan was reviewed. The Comprehensive Care Plan documented in part, read as follows:

Date Initiated: 7/01/2013, Revision on: 9/17/2015 (Name) Resident #15 has potential impairment to

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skin integrity r/t (related to) colostomy.

Resident #15's Order Summary Report active orders as of 1/26/15 documented in part, read as follows:

Colostomy care q shift (every shift)
Order Status: Active
Order Date: 8/29/2014
Start Date: 8/29/2014

An interview was conducted on 2/3/16 at 3:45 p.m. with the facilities Senior Clinical Services Specialist. During the interview the above information was reviewed and the Specialist was asked, "How would you have expected the staff to code Resident #15's colostomy?" The Senior Clinical Services Specialist stated, "If he has a colostomy, that it be coded."

On 2/3/16 at 4:00 p.m. an interview was conducted with the Regional RAI (Resident Assessment Instrument) Coordinator. During the interview the above information was reviewed and the RAI Coordinator was asked, "How would you have expected your MDS Coordinators to Code Resident #15's colostomy?" The RAI Coordinator stated, "I would expect them to have coded the resident according to the RAI Manual."

The facility policy titled "Resident Assessment" approved 1/4/16 documented in part, read as follows:

Policy:
A comprehensive assessment of a resident's needs will be completed per RAI guidelines. The basis for the comprehensive assessment is the use of the Minimum Data Set (MDS) and care

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area assessments (CAA's) that provide a basis of information from which the Comprehensive Care Plan is developed.

Procedure:
2. The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. The results of the assessment are used to develop, review and revise the resident's comprehensive care plan.

3. Information derived from the comprehensive assessment enables the staff plan care that allows the resident to reach his/her highest practicable level of functioning and includes, at a minimum:
a. Medically defined condition and prior medical history.
c. Physical and mental functional status.
d. Sensory and physical impairments.

The Center for Medicare Services RAI Version 3.0 Manual dated October 2015 documented in part, read as follows:

SECTION H: BLADDER AND BOWEL

Intent: The intent of the items in this section is to gather information on the use of bowel and bladder appliances, the use of and response to urinary tolieting programs, urinary and bowel continence, bowel training programs, and bowel patterns. Each resident who is incontinent or at risk of developing incontinence should be identified, assessed, and provided with individualized treatment (medications, non-medical treatments, and/or devices) and services to achieve or maintain as normal

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elimination function as possible.

H0100: Appliances

Item Rationale Health-related Quality of Life

*It is important to know what appliances are in use and the history and rationale for such use. *Ostomies (and periostomal skin) should be free of redness, tenderness, excoriation, and breakdown. Appliances should fit well, be comfortable, and promote resident dignity.

Steps for Assessment

1. Examine the resident to note the presence of any urinary or bowel appliances.

2. Review the medical record, including bladder and bowel records, for documentation of current or past use of urinary or bowel appliances.

Coding Instructions

Check next to each appliance that was used at any time in the past 7 days. Select none of the above if none of the appliances were used in the past 7 days.

*H0100C, ostomy (including urostomy, ileostomy, and colostomy)

Definitions:

COLOSTOMY:

A stoma that has been constructed by connecting a part of the colon onto the anterior abdominal wall.

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| F 278 | Continued From page 6<br><br>On 2/4/15 at 12:15 p.m. a pre-exit interview was conducted with the Administrator, Director of Nursing, Regional RAI (Resident Assessment Instrument) Coordinator and the Senior Clinical Services Specialist where the above information was shared. The Regional RAI (Resident Assessment Instrument) Coordinator provided the surveyor with a Modification Assessment copy dated 2/3/16 of the Quarterly MDS dated 12/5/15 with Resident #15's colostomy coded correctly.<br><br>12 VAC 5-371-250 (A) Please Cross-Reference to F-278 | F 278 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.<br><br>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | F 280 | F 280<br><br>1. Resident # 10's care plan for the care and services of a post-operative incisional site and sutures was updated on 2/15/2016.<br>2. Any resident who is readmitted to the facility has the potential to be affected if care plan is not revised upon readmission. A review of re-admissions during past 14 days will be conducted to ensure that care plans are revised to accurately reflect needs of the resident.<br>3. Licensed nurses will be re-educated on updating of care plans following re-admission to ensure a comprehensive review of care needs. | |

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review the facility staff failed to revise a care plan for 1 of 24 residents in the survey sample, Resident #10.

The facility staff failed to revise Resident #10's care plan for the care and services of a post-operative incisional site and sutures.

The findings included:

Resident #10 was admitted to the facility on 9/11/15 following a hospitalization for a decompressive hemicraniotomy (a surgical procedure where part of the skull is opened) on 8/5/15 for a rupture of a recurrent aneurysm (a dilation of a blood vessel). The resident was discharged to the hospital on 1/6/16 and returned on 1/20/16 following a cranioplasty (plastic surgery of the skull) with 20 sutures. The resident had a tracheostomy (an opening through the neck), a PEG tube (a tube surgically inserted into the abdomen for enteral nutrition) and a Foley catheter (a tube inserted into the bladder to drain urine).

The hospital discharge records dated 1/20/16 accompanying the resident back to the facility read in part, under Hospital Course:...Sutures to be removed at LTF (Long Term Facility) on 1/28/16-if unwilling to do at the facility can arrange to see patient outpatient.

The current MDS (Minimum Data Set) with an assessment reference date of 12/17/15 coded the resident as having long and short term memory

4. DON or designee will conduct daily audits 5 times per week x 4 weeks and then weekly audits x8 weeks of re-admission to ensure the care plans accurately reflect the care needs of the resident.
5. Results will be reported to the Quality Assurance Committee for further discussion and recommendations.

Date of alleged compliance: March 14, 2016.

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deficits with moderately impaired daily decision making skills. The resident resident was dependent on the staff for all activities of daily living.

The Health Status Note dated 1/21/16 at 12:03 am, read, in part:...The admission dx (diagnosis) was S/P (status post) Cranioplasty with 20 stitches...Medication list verified with MD and send {sic} to pharmacy."

The comprehensive plan of care was not revised to include care and services for the management of the post-operative suture site.

The nursing daily Health Status Notes from 1/22/16 through 2/2/16 did not evidence any ongoing monitoring or assessment of the post-operative site.

On 2/2/16 at 3:00 pm, 2/3/16 at 9:45 am and 2:45 pm, the resident was observed in bed. The resident was observed with a tracheostomy attached to oxygen. The resident was non-responsive to verbal stimuli. The PEG tube was in use with Nutren infusing at 50 cc/ hour (cubic centimeter/hour), the Foley catheter was patent and draining urine into the drainage bag. The resident's head was observed to have sutures from the top of her head going down to the back of her head. The incision line was observed with a small amount of crusted drainage/ dry skin at the edges.

On 2/3/16 at 2:50 pm, the licensed practical nurse (LPN #12) assigned to care for Resident #10 on 2/2/16 and 2/3/16 was interviewed. The nurse was asked about the sutures. She stated, "I noticed yesterday after going through the record

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that the sutures were to have been removed...I spoke with the physician yesterday and he gave me (verbal) orders to remove the sutures, I was planning on removing them before I left today." The nurse was asked where were the verbal physician orders to remove the sutures documented, she stated, "I forgot to do that." The nurse stated she obtained the verbal order as she was leaving for the day. LPN #12 was asked if she had communicated this new order to the oncoming shift for follow up, she stated, "No."

An interview was conducted the Director of Nursing on 2/4/16 at 9:45 am. The above findings was shared. She stated the admission nurse should have obtained clarifying orders for suture site care and removal of the sutures. She stated the orders should have been obtained within 24 hours of the resident's admission. When asked if the resident's plan of care should have been revised to include care for the post-operative site she stated, "Yes, when she came back from the hospital, absolutely."

An interview was conducted with the MDS Coordinator on 2/4/16 at 11:15 am. She was asked who was responsible for the revision of the comprehensive care plans. She stated the MDS Coordinators revise care plans following admission, significant change and quarterly MDSs. She stated the admission nurse/ unit nurse are responsible for revision of care plans as needed.

Review of the facility policy titled Comprehensive Care Planning Process (no date) read, in part: 3...Additionally, the care plan is a fluid document that shall be reviewed and updated at any time the resident, family, or representative or member

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| F 280 | Continued From page 10<br>of the ID (interdisciplinary) team determines a need for additional interventions or care areas to be addressed. | F 280 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on a observation, staff interviews, clinical record review, facility document review and during the course of a complaint investigation the facility staff failed to provide the necessary care and services for 2 out of 24 Residents ( Resident #10, and Resident #23) to maintain the highest practicable physical and mental wellbeing.<br><br>1. The facility staff failed to provide care and services for management of Resident #10's post operative incision site and sutures.<br><br>2. The facility staff failed to follow Physician Orders for Resident #23 by not applying a Fentanyl Patch ordered on 12/09/15 and not applied until 12/12/15<br><br>1. The facility staff failed to provide care and | F 309 | F 309<br>1. It is dually noted that the facility did not follow physician orders for Resident # 23 by not applying a Fentanyl Patch ordered on 12/09/2015 until 12/12/2015. Resident #10 received care and services for post-operative incision site and sutures on 2/4/2016.<br>2. Residents have the potential to be affected by physician's orders that are not followed for management of wounds and/or for medication administration.<br>3. Licensed nurses will be re-educated on the process for obtaining and following physician's orders.<br>4. DON or designee will conduct daily audits 5 times per week x4 weeks and then weekly audits x8 weeks of new admissions and re-admissions to ensure that new orders are written and followed as per physician's directions. | |

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| F 309 | Continued From page 11<br>services for the management of a post-operative incision site and sutures for Resident #10.<br><br>Resident #10 was admitted to the facility on 9/11/15 following a hospitalization for a decompressive hemicraniotomy (a surgical procedure where part of the skull is opened) on 8/5/15 for a rupture of a recurrent aneurysm (a dilation of a blood vessel). The resident was discharged to the hospital on 1/6/16 and returned on 1/20/16 following a cranioplasty (plastic surgery of the skull) with 20 sutures. The resident had a tracheostomy (an opening through the neck), a PEG tube (a tube surgically inserted into the abdomen for enteral nutrition) and a Foley catheter (a tube inserted into the bladder to drain urine).<br><br>The hospital discharge records dated 1/20/16 accompanying the resident back to the facility read in part, under Hospital Course:...Sutures to be removed at LTF (Long Term Facility) on 1/28/16-if unwilling to do at the facility can arrange to see patient outpatient.<br><br>The current MDS (Minimum Data Set) with an assessment reference date of 12/17/15 coded the resident as having long and short term memory deficits with moderately impaired daily decision making skills. The resident resident was dependent on the staff for all activities of daily living.<br><br>The Health Status Note dated 1/21/16 at 12:03 am, read, in part:...The admission dx (diagnosis) was S/P (status post) Cranioplasty with 20 stitches...Medication list verified with MD and send {sic} to pharmacy." | F 309 | 5. Results will be reported to the Quality Assurance Committee for further discussion and recommendations.<br>Date of alleged compliance: March 14, 2016. | |

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The History and Physical Examination dated 1/22/16 by the physician read, in part:...She is in coma, not responding appropriately...no open wound..."
The physician did not address the sutures.

The physician orders did not include care and services for the management of the post-operative suture-site.

The comprehensive plan of care was not revised to include care and services for the management of the post-operative suture site.

The nursing daily Health Status Notes from 1/22/16 through 2/2/16 did not evidence any ongoing monitoring or assessment of the post-operative site.

On 2/2/16 at 3:00 pm, 2/3/16 at 9:45 am and 2:45 pm, the resident was observed in bed. The resident was observed with a tracheostomy attached to oxygen. The resident was non-responsive to verbal stimuli. The PEG tube was in use with Nutren infusing at 50 cc/ hour (cubic centimeter/hour), the Foley catheter was patent and draining urine into the drainage bag. The resident's head was observed to have sutures from the top of her head going down to the back of her head. The incision line was observed with a small amount of crusted drainage/ dry skin at the edges.

On 2/3/16 at 2:50 pm, the licensed practical nurse (LPN #12) assigned to care for Resident #10 on 2/2/16 and 2/3/16 was interviewed. The nurse was asked about the sutures. She stated, "I noticed yesterday after going through the record that the sutures were to have been removed...I

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spoke with the physician yesterday and he gave me (verbal) orders to remove the sutures, I was planning on removing them before I left today." The nurse was asked where were the verbal physician orders to remove the sutures documented, she stated, "I forgot to do that." The nurse stated she obtained the verbal order as she was leaving for the day. LPN #12 was asked if she had communicated this new order to the oncoming shift for follow up, she stated, "No."

An interview was conducted the Director of Nursing on 2/4/16 at 9:45 am. The above findings was shared. She stated the admission nurse should have obtained clarifying orders for suture site care and removal of the sutures. She stated the orders should have been obtained within 24 hours of the resident's admission.

No additional information was provided prior to exit.

2. The facility staff failed to follow Physician Orders for Resident #23 by not applying a Fentanyl Patch ordered on 12/09/15 and not applied until 12/12/15.

Resident #23 was admitted to the facility on 12/09/15 from the hospital and admitted back to a hospital on 12/30/15. The Resident's diagnoses per 12/09/15's hospital discharge note and admission to the facility on 12/09/15 included but were not limited to: neuromyopathy (disorder affecting both nerve and muscle tissue at the same time), impaired swallowing function, Encephalopathy Delirium (disorder of brain/with

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tremors), Recurrent Urinary Tract Infections (bacterial infection of bladder), and status post Ivermectin-(medication to treat parasites) for pulmonary Strongerloides (parasite infection in the lungs).

The Admission MDS (Minimum Data Set) with an ARD (assessment reference date) of 12/16/15 coded Resident #23 as requiring extensive assistance with transfers, dressing, and toileting. Resident #23 was coded as being totally dependant on eating as he had a G-tube (tube inserted through the abdomen to the stomach for feeding). Resident #23 had an indwelling catheter (tube into the bladder to drain urine). Resident #23 was coded as Frequently incontinent of bowel. Resident #23's 14 day MDS coded his BIMS (brief interview for mental status) as 13 indicating his mental status to be intact.

Hospital Discharge Summary for 12/09/15 was reviewed and discharge medications listed included but were not limited to the following two medications last given in the hospital: Fentanyl 12 mcg/hour last time was given 12/06/15 11:26 a.m. Place 1 patch onto the skin every 72 hours.

Resident #23 Physician orders upon admission into the facility 12/09/15 included but are not limited to the following as were noted on Facility Order Summary Reports:

12/09/15 Fentanyl Patch 72 Hour 12 MCG (microgram) per Hour Apply one patch transdermally (on skin) every 72 hours for pain and remove per schedule.

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Review of the MAR (Medication Administration Record) 12/01/15 - 12/21/15 indicated the Fentanyl Patch was first placed on Resident #23 on 12/12/15 at 10:39 (10:39 a.m.) and indicated the Fentanyl Patch was removed 12/19/15 at 21:53 (9:53 p.m.) as ordered by Nurse Practitioner #47 to be done 12/19/15.

An interview was conducted on 02/04/16 at approximately 11:00 a.m. with Unit Manager RN #7. When RN #7 Unit Manager was asked to recall her care of Resident #23's admission, she stated the following: "On second day after admission a Team Base Assessment (TBA) meeting was held. Wife and Daughter were present. Items discussed were tube feeding, therapy schedule and tremors." She stated, "Palliative Care was involved due to neuropathic pain and Gabapentin (medication for treatment of nerve pain) was ordered". She stated the complainant's husband called and asked if the Resident had gotten oxycodone as it caused confusion in hospital and she said he is on oxycodone and Fentanyl also a narcotic.

Resident #23 did not receive the Fentanyl until three days after the initial order of 12/09/15 until 12/12/15. Resident #23's orders were not followed for Fentanyl Transdermal Patch.

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| F 371 SS=F | Complaint Deficiency 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must - | F 371 | F 371<br>1. Food service professionals with facial hair started wearing facial hairnets on 2/4/2016. | |

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| F 371 | Continued From page 16<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interviews, and review of the facility's policy, the facility staff failed to ensure food was prepared, distributed and served under sanitary conditions.<br><br>The finding included;<br>During inspection of the kitchen on 2/3/16 at approximately 11:25 a.m. the cook was observed preparing sliced deli-meat for lunch. The cook wore a well-trimmed beard but no beard restraint. The food server for the 100 unit was observed standing beside the cook leaning over to talk. The 100 unit server wore a bushy moustache and no hair restraint.<br><br>The Food Service Manager (FSM) was informed of the observation and the cook was seen throughout the lunch meal on 2/3/16 wearing the facial hair restraint. The 100 unit server was observed serving the entire lunch meal on 2/3/16 with no hair restraint covering the bushy moustache.<br><br>The Registered Dietitian (RD) approached the surveyor on 2/3/16 at approximately 11:40 a.m. stating the staff cook was following the facility's policy because his beard was not greater than ¼ | F 371 | 2. Residents dining in the center have the potential to be affected if food service professionals are not wearing beard covers while preparing and distributing food.<br>3. Staff engaged in preparing and serving food will be educated on the proper use of and need for beard covers and hair nets.<br>4. Administrator or designee will conduct random daily audits of at least 2 food service areas in the center 5 times per week x 4 weeks and then weekly audits x8 weeks to ensure that all food service professionals properly use hairnets and beard guards as needed in the facility.<br>5. Results will be reported to the Quality Assurance Committee for further discussion and recommendations.<br>Date of alleged compliance: March 14, 2016. | |

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| F 371 | Continued From page 17<br>of an inch therefore no hair restraint was required. The RD presented a copy of the facility's policy entitled Dress Code/Uniforms with a revision date of 12/10; 7-13. The policy stated at #7 "Men with facial hair longer than ¼ inch must wear a beard guard. The RD also presented a copy of the U.S. Public Health Service Food Code 2013. It read under the title Hair Restraints; "Food employees shall wear hair restraints such as hats, hair coverings, or nets, beard restraints and clothing that covers body hair, that are designed and worn effectively keep their hair from contacting exposed food." The RD also gave the surveyor a copy of the State Operations Manual (SOM) which read under the title of Hair Restraints/Jewelry/Nail Polish "Dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraints) to prevent their hair from contacting exposed food."<br><br>The above findings were shared with the Administrator, Director of Nursing, MDS Coordinator and the Corporate Specialist at approximately 12:20 p.m. on 2/4/16.<br><br>The RD spoke with the survey team on 2/4/16 at approximately 12:45 p.m. The RD stated the ¼ of an inch policy was adhered to and she did not understand what the problem was because the U.S. Food Code neither SOM had a definitive explanation of the expectations for hair restraints. The RD further stated she wrote the policy allowing ¼ of an inch of exposed hair without use of a hair restraint based on the hair length on her arms. | F 371 | | |
| F 441 SS=E | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS | F 441 | F 441<br>1. The infection control program was reviewed with no trends identified | |

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| F 441 | Continued From page 18<br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by: | F 441 | on 2/4/15. LPN #12 was re-educated on 2/4/2015 regarding CDC guidance for hand washing.<br>2. Residents have the potential to be affected if the center fails to maintain an infection control program that investigates, controls, and prevents the onset and spread of infection.<br>3. Nursing staff will be re-educated on proper hand-washing procedure. The Infection Control Preventionist will be re-educated on the Infection Control program components to include surveillance, investigation, tracking and trending and education as needed to prevent the spread and onset of infections.<br>4. DON or designee will conduct 5 daily audits x4 weeks and then 10 weekly audits x8 weeks to ensure that staff are using proper hand washing technique. Administrator or designee will conduct monthly audits x3 months to ensure that facility is in compliance with components of the infection control program including recognition of trends within the facility. | |

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| F 441 | Continued From page 19<br>Based on observations, staff interviews and review of the facility's policy, the staff failed to establish an effective infection control program which investigates, controls, and prevent the onset and the spread of infections. In addition, the facility staff failed to practice professional standards of handwashing during removal of sutures.<br><br>The findings included:<br>1. An interview was conducted with the Infection Control Nurse on 2/4/16 at approximately 10:30 a.m. to review the facility's Infection Control Program. The surveyor asked the Infection Control Nurse what processes did the infection control program consist of and the Infection Control Nurse stated the facility uses surveillance forms to track all infections in which an antibiotic is prescribed. She stated she reviews the 24 hour report daily for reports of infections, symptoms and ordered antibiotics. The Infection Control Nurse stated after the data is obtained she tracks it on a facility map to identify the unit and room within the facility the infection occurred. This aids in identifying trends.<br><br>The Infection Control Nurse chose to review the infections for November 2015 to demonstrate the facility's infection control processes. The report revealed 20 residents acquired infections and were prescribed antibiotics; four others were prescribed antibiotics but the lab results were negative. On the Shenandoah Unit a resident in room 301 was diagnosed with a urinary tract infection (UTI) an infection of the urinary system, 11/30/15, a resident in room 306 was diagnosed with a UTI 11/23/15 and a resident in room 305 was diagnosed with a UTI on 11/4/15. A resident in room 313 was also diagnosed with a UTI on | F 441 | 5. Results will be reported to the Quality Assurance Committee for further discussion and recommendations.<br>Date of alleged compliance: March 14, 2016. | |

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11/18/15.

The November 2015 infection control report also revealed on the Shenandoah Unit a resident in room 323 was diagnosed with pneumonia on 11/14/15 and the resident in room 322 was diagnosed with pneumonia on 11/21/15.

On the Piedmont Unit the November 2015 infection control report revealed on 11/4/15 a resident in room 116 was diagnosed with a UTI and a resident in room 110 was diagnosed with a UTI on 11/5/15. On 11/9/15 a resident in room 118 was diagnosed with a UTI and on 11/10 15 a resident in room 115 was diagnosed with a UTI and Clostridium Difficile (C-Difficle) a gastrointestinal infection that causes severe diarrhea. A resident in room 114 also was diagnosed with C-Difficle on 11/12/15. A resident in room 101 began receiving antibiotics for a UTI on 11/13/15 and a resident in room 104 was started on antibiotics on 11/17/15 for a UTI. On 11/21/15 a resident in room 103 began antibiotic therapy for a UTI.
The Infection Control Nurse stated all staff is in-serviced during orientation and annually regarding infection control.

The above findings were shared with the Administrator, Director of Nursing, MDS Coordinator and the Corporate Specialist at approximately 12:20 p.m. on 2/4/16.

The facility's staff was unable to determine if the multiple residents with infections who resided in rooms within close proximity constituted a cluster and/or trend. The Director of Nursing stated during the 2/4/16 meeting at 12:20 p.m., that there were no records of investigations or

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outcomes related to infections even though they discussed each in the "at risk" meetings and there was not any education provided to the staff based upon the collected data from the infection control report. The Corporate specialist stated after their mock survey the staff was in-serviced regarding general infection control policies based on what was identified during the mock survey. The areas included non-bagged and non-labeled personal items, dirty suction canisters and bedside commodes, tube feeding pumps with dried feeding on them, staff carrying linen against their body, hand washing issues during the medication pass and food serving with gloves.

The facility's policy entitled Infection Control Program dated 4/2005 and revised 9/20/09 stated the Program will at bullet 5, Perform Process Surveillance to identify and report evidence of infection ... reviewing the data to detect clusters and trends.

The McGeer's criteria for infection control states the purpose for tracking infections is to look for trends and clusters before they become full-blown outbreaks. Once clusters are detected, further investigation is warranted and action is taken to determine the root cause. The McGeer's criteria states this can be done by continuous rounds and observation of staff's infection control practices, review of surveillance data, and in-service/education of staff, residents and families. (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3538836/)

Review of the facilities documentation revealed they collected the data, mapped the infections and discussed the infection in an interdisciplinary

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setting (the at risk meeting) but they did not recognize the number of infections in close proximity, investigate to determine a root cause, and provide necessary action to prevent further onsets or spread of infections in the facility. The Corporate Specialist stated "I understand" .

2. The nurse failed to implement appropriate hand washing before and after removal of sutures for Resident #10.

Resident #10 was admitted to the facility on 9/11/15 following a hospitalization for a decompressive hemicraniotomy (a surgical procedure where part of the skull is opened) on 8/5/15 for a rupture of a recurrent aneurysm (a dilation of a blood vessel). The resident was discharged to the hospital on 1/6/16 and returned on 1/20/16 following a cranioplasty (plastic surgery of the skull) with 20 sutures.

The current MDS (Minimum Data Set) with an assessment reference date of 12/17/15 coded the resident as having long and short term memory deficits with moderately impaired daily decision making skills.

The hospital discharge records dated 1/20/16 accompanying the resident back to the facility read in part, under Hospital Course:...Sutures to be removed at LTF (Long Term Facility) on 1/28/16-if unwilling to do at the facility can arrange to see patient outpatient.

On 2/2/16 at 3:00 pm, 2/3/16 at 9:45 am and 2:45 pm, the resident was observed in bed and non-responsive to verbal stimuli. The resident's

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 441 | Continued From page 23 | F 441 | | |

head was observed to have sutures from the top going down to the back of her head.

On 2/3/16 at 3:00 pm, an observation of the removal of sutures for Resident #10 was conducted. The licensed practical nurse (LPN #12) was observed washing her hands for a count of less than 9 seconds prior to putting on and taking off gloves on two occasions during the removal of the resident's sutures. The nurse was also observed turning off the water faucet using the side of her arm near her wrist, instead of a paper towel.

The observation of inappropriate hand washing was shared with the LPN. When asked how long should one rub their hands with soap when washing them, she stated one to two minutes.

The above findings was shared with the Director of Nursing on 2/4/16 at 9:45 am. The DON provided the surveyor with a copy of the facility policy titled Hand Washing (Effective Techniques), no date.

The facility policy titled Hand Washing (Effective Techniques) read, in part: ...Constant care must be taken to prevent the spread of disease organisms. Frequent and thorough hand washing is of major importance in preventing the spread of organisms...Times When Handwashing Is Very Important: B. Before and after resident contact.

According to CDC (Centers for Disease Control) 2002 guidelines for Hand Hygiene read as follows:
1. Wet hands with water, apply soap, and rub hands together (for at least 15 seconds).
2. Rinse and dry with a disposable towel.

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| | 495179 | A. BUILDING _____ B. WING _____ | C 02/04/2016 |

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| F 441 | Continued From page 24<br>3. Use a towel to turn off the faucet.<br><br>No additional information was provided prior to exit. | F 441 | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>The facility staff failed to ensure the clinical record was complete for 1 of 24 residents in the survey sample, Resident #10.<br><br>The nurse failed to document a physician verbal order in the clinical record for Resident #10.<br><br>The findings included:<br><br>Resident #10 was admitted to the facility on 9/11/15 following a hospitalization for a decompressive hemicraniotomy (a surgical procedure where part of the skull is opened) on 8/5/15 for a rupture of a recurrent aneurysm (a | F 514 | F 514<br>1. The order for resident #10's suture removal was written on 2/4/2016.<br>2. Any resident that receives a physician's verbal order has the potential to be affected.<br>3. Licensed nursing personnel will be re-educated on the process of taking and transcribing verbal orders.<br>4. DON or designee will conduct daily audits 5 times per week x4 weeks and then weekly audits x8 weeks to ensure that verbal orders are written and followed.<br>5. Results will be reported to the Quality Assurance Committee for further discussion and recommendations.<br>Date of alleged compliance: March 14, 2016. | |

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| F 514 | Continued From page 25 | F 514 | | |

dilation of a blood vessel). The resident was discharged to the hospital on 1/6/16 and returned on 1/20/16 following a cranioplasty (plastic surgery of the skull) with 20 sutures.

The hospital discharge records dated 1/20/16 accompanying the resident back to the facility read in part, under Hospital Course:...Sutures to be removed at LTF (Long Term Facility) on 1/28/16-if unwilling to do at the facility can arrange to see patient outpatient.

The current MDS (Minimum Data Set) with an assessment reference date of 12/17/15 coded the resident as having long and short term memory deficits with moderately impaired daily decision making skills. The resident resident was dependent on the staff for all activities of daily living.

On 2/2/16 at 3:00 pm, 2/3/16 at 9:45 am and 2:45 pm, the resident was observed in bed and non-responsive to verbal stimuli. The resident's head was observed to have sutures from the top going down to the back of her head. The incision line was observed with a small amount of crusted drainage/ dry skin at the edges.

On 2/3/16 at 2:50 pm, the licensed practical nurse (LPN #12) assigned to care for Resident #10 on 2/2/16 and 2/3/16 was interviewed. The nurse was asked about the sutures. She stated, "I noticed yesterday after going through the record that the sutures were to have been removed...I spoke with the physician yesterday and he gave me (verbal) orders to remove the sutures, I was planning on removing them before I left today." The nurse was asked where are the verbal physician orders to remove the sutures

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| F 514 | Continued From page 26 | F 514 | | |

documented, she stated, "I forgot to do that." The nurse stated she obtained the verbal order as she was leaving for the day.

The above findings was shared with the Director of Nursing on 2/4/16 at 9:45 am. The DON provided the surveyor with a copy of the facility policy titled Physician Verbal Orders.

The facility policy titled Physician Verbal Orders (no date) read, in part: Verbal orders can be taken by licensed nurse, pharmacist, or physician. All physician's verbal and telephone orders are recorded in the medical record immediately by licensed nurse.

No additional information was provided prior to exit.

State of Virginia

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| F 001 | Non Compliance | F 001 | | |

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:
12 VAC 5-371-370A, Refer fo F256.

12 VAC 5-371-180-C. Infection Control
Cross Reference F 441

12 VAC 5-371-220-C. Nursing Services
Cross Reference F 309

12 VAC 5-371-250-G. Resident Assessment
Cross Reference F 280

12 VAC 5-371-360-F. Clinical Records
Cross Reference F 514

12 VAC 5-371 - 180. INFECTION CONTROL A., B., and C., 1., and 3. Cross reference to F Tag 441
12 VAC 5-371-340 DIETARY AND FOOD SERVICE PROGRAMS A. Cross reference to F Tag 371

12 VAC 5-371-250 (A) Please Cross-Reference to F-278

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