RIVERSIDE

Rehabilitation Center
Hampton

July 6, 2016

Ms. Elaine Cacciatore, LTC Supervisor
Division of Long Term Care
Virginia Department of Health
Office of Licensure and Certification
9960 Maryland Dr., Suite 401
Henrico, VA 23233-1485

FAX: (804) 527-4502

RE: Riverside Convalescent Center – Hampton
Provider Number 495308

Dear Ms. Cacciatore:

Please find attached the Plan of Correction for the deficiencies reflected on the Revised Statement of Deficiencies and Plan of Correction, CMS Form 2567 included with your letter dated June 27, 2016 that were cited during our recent survey, ending June 10, 2016.

If you have any questions regarding our PoC, or anything else, please contact me at (757) 722-9881.

Sincerely,

William M. Jolly
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495308	A. BUILDING _____ B. WING _____	06/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERSIDE REHABILITATION CENTER AT HAMPTON	414 ALGONQUIN RD HAMPTON, VA 23661

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/8/16 through 6/10/16. Four complaints were investigated during the survey. The facility was cited with a deficiency at a Past Non Compliance (PNC); No Plan of Correction is needed for this citation. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code Survey/Report will follow. The census in this 130 certified bed facility was 115 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #20) and 3 closed records (Residents #21 through #23).	F 000		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure for 2 out of 23 residents (Resident #7 and #23), admitted with pressure ulcers, did not develop additional ones unless unavoidable. This was a Past Non-compliance deficiency.	F 314	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 7/6/16

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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1. Resident #7 acquired a pressure ulcer on the top of his left foot as a result of a tight application of Kerlix wrap, the pressure ulcer was identified at a stage II and then advanced to an unstageable pressure ulcer.

2. Resident #23 acquired a pressure ulcer on the top of her foot as a result of a tight application of Kerlix wrap, that was found at a stage II and then advanced to an unstageable pressure ulcer with MRSA infection and sepsis Gangrene.

The findings included:

1. Resident #7 acquired a pressure ulcer on the top of his left foot as a result of a tight application of *Kerlix wrap, that was found at a Stage II and then advanced to an unstageable pressure ulcer.

*KerlixTM Bandage Rolls are made of prewashed, fluff dried 100% woven gauze with unique crinkle-weave pattern for loft and bulk. KerlixTM Bandage Rolls provide fast-wicking action, superior aeration, and excellent absorbency. Finished edges on the product reduce loose ends and lint (http://www.medline.com/product/Kerlix-Gauze-Bandage-Rolls-by-Covidien/Z05-PF42830).

Resident #7 was admitted to the nursing facility on 6/17/13 with diagnoses that included altered mental status, dementia, stroke with left hemiplegia and swallowing problems. The resident was re-admitted to the nursing facility on 1/7/16 following amputation of left great toe due to *Methicillin Resistant Staphylococcus Aureus (MRSA), as well as *Osteomyelitis and returned with *unstageable left medial heel and left inner

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heel pressure ulcers.

*Methicillin-resistant Staphylococcus Aureus (MRSA) infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections (http://www.mayoclinic.org/diseases-conditions/mrsa/basics/definition/CON-200244790.

*Osteomyelitis is an infection in a bone. Infections can reach a bone by traveling through the bloodstream or spreading from nearby tissue (http://www.mayoclinic.org/diseases-conditions/osteomyelitis/basics/definition/con-20025518).

*Unstageable pressure Ulcers
Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown
Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as " the body ' s natural (biological) cover " and should not be removed (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org).

The Minimum Data Set (MDS) assessment dated 3/6/16 coded Resident #7 with short and long term memory and severely impaired in the skills needed for daily decision making. He was assessed to require extensive assistance of two staff for bed mobility, transfers, dressing, toilet use and personal hygiene. He was totally

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dependent on two staff for bathing. The resident was coded at risk for having pressure ulcers and had two unstageable ulcers covered by slough and/or eschar, both present upon admission.

The care plan dated 1/7/16 identified the resident had an community (hospital) acquired/re-admitted with, unstageable left inner heel. The goal set for the resident by the staff was that the area would heal without complications. Some of the approaches the staff would implement to accomplish this goal included avoid placing constricting items on resident's feet. The care plan identified the resident through the Braden Risk Assessment Scale as moderately at risk for pressure ulcer development.

The SBAR (Situation/Background/Assessment/Request) dated 4/20/16 written by Licensed Practical Nurse (LPN) #4 indicated "Upon doing the treatment to the left heel, I noticed a non-blanchable area noted on the top of the resident's left foot caused by Kerlix-measures 2.2 centimeters (cm) by (x) 5.5 cm x 0 cm..."

The R-CARES (facility incident report) report dated 4/20/16 reflected the same information as the SBAR.

The pressure ulcer investigation worksheet dated 4/20/16 indicated licensed nurses and Certified Nursing Assistants (CNA) were interviewed that had worked with Resident #7 over 48 hours. This investigation was signed off as completed on 5/13/16. The investigation confirmed the ulcer on the top of the resident's left foot was caused by direct pressure from Kerlix wrap.

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The Weekly Pressure Ulcer Progress Report documented the pressure ulcer on the top of the left foot accordingly, as noted on the SBAR on 4/20/16. The next assessment of the pressure ulcer dated 4/26/16 assessed the wound to have the same measurements, but wound bed color was now purple and maroon. On 5/3/16, the pressure ulcer was assessed unstageable with 100 % *slough (soft necrotic material) in the wound bed. The most recent documentation dated 6/6/16 assessed the pressure ulcer with slough and irregular wound edges. The most recent skin assessment before 4/20/16 was performed by the licensed nurse on 4/19/16 and did not reveal any new skin breakdown.

*On 6/10/16 at 1:35 p.m., wound care observation was made of the top of the left foot. LPN #4 performed the dressing change. The foot had two dressings on it, one on the top and one on the heel covered with gauze pads and transparent dressings. There was no Kerlix wrap observed on the foot. A stockinette covered the entire foot to contain both dressing sites, with the toe section cut out, thus no pressure was exerted on the top of the foot. Once the dressing was removed from the top of the foot, the pressure ulcer across the top of the foot exhibited thick tan slough in the wound bed. The center portion of the ulcer was closing slightly to create two separate ulcers across the top of the foot. The LPN stated she usually performed the dressing change to the left heel, but was off from work 3 days. According to the LPN, upon her return when she performed the dressing change, the Kerlix wrap was wrapped too tightly and the Kerlix embedded itself in the top of the resident's left foot, which was in her opinion avoidable. She said she removed it, called the physician and implemented treatment

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along with application of a stockinette.

The *Ankle Brachial Index (ABI) performed on 5/24/16 indicated moderate arterial blood flow to both lower extremities. Along with the resident's compromise in blood flow to the left extremity, the resident had a recent toe amputation on the left foot extremity, as well as a large unstageable community acquired left heel pressure ulcer, which placed the resident at risk for subsequent ulcers.

The facility's policy and procedures titled 'Skin Integrity Management and Care: A focus on Lower extremity (LE) Concerns' dated 7/2000 indicated *ABI was a non-invasive assessment of arterial blood flow in the LE by comparing brachial systolic pressure to ankle systolic pressure. This diagnostic test requires a trained assessor, a blood pressure cuff and a Doppler.

An interview was conducted with the Director of Nursing (DON) on 6/9/16 at approximately 3:00 p.m. She stated Resident #7 was the second resident in one week on the same unit that had a facility acquired pressure ulcer from Kerlix wrap; therefore, she and a project team implemented an all inclusive action plan (4/20/16) that included the following:

Issue/Concern-wound assessment/proper treatment and application.
Goals/objectives/expected outcome-nurses will be able to appropriately assess, stage, initiate appropriate treatments, perform proper treatment and document appropriately.
The action(s) planned included- 1). Correction for the identified residents/system; 2). How you will identify other potential residents and correct for

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them if needed (100% skin sweeps completed on 5/13/16); 3). System changes; 4). Monitoring-explain how you will monitor that the plan is successful (return demonstrations 4/26-5/10/16); include QA committee oversight; 5). Add/modify tasks and plan as needed.

The DON, Unit Managers, the Staff Development Coordinators, Assistant Director of Nursing, Corporate Staff Development Coordinator, Corporate Quality Assurance (QA) Nurse, Nurse Practitioner/Physician, Interdisciplinary Team (Registered Dietician, Rehabilitation Manager) and reports to the QA team (included the Administrator) with monitoring and oversight were incorporated into the aforementioned planned actions.

All education and original sign in sheets were reviewed with inservice dates for all licensed nurses of 4/20/16 and 5/6/16. All CNAs were inserviced on 5/26/16 and 5/27/16.

The project completion date was recorded as 5/30/16, after all the CNAs were educated, but the audits continued by the Unit Managers as ongoing. Their QA committee will meet 6/30/16 to review results of compliance of the action plans.

There were no further pressure ulcers identified as avoidable and/or as a direct pressure from Kerlix wrap after the aforementioned action plan's completion date of 5/30/16. Nor were any avoidable pressure ulcers identified during the Standard survey conducted 6/8-10/16, therefore the facility met the necessary criteria for Past Non Compliance (PNC) for regulation F314.

On 6/10/16 at 4:40 p.m., the aforementioned

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issue was shared with the Administrator and re-shared with the DON. No further information was forthcoming prior to survey exit.

The facility's policy and procedures titled 'Skin Integrity Management and Care:A focus on Lower extremity (LE) Concerns' dated 7/2000 indicated a pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominances as a result of pressure or pressure combination with shear. Presence of an ulcer or history of a prior pressure ulcer puts a person at risk for additional pressure ulcers. Early detection of skin areas allows proper treatment immediately that can prevent a red area from opening or promote rapid healing of a superficial wound to prevent deep tissue destruction.

2. Resident #23 acquired a pressure ulcer on the top of her foot as a result of a tight application of Kerlix wrap, identified as a stage II that advanced to an unstageable pressure ulcer with MRSA infection and sepsis Gangrene.

Resident #23 was admitted to the nursing facility on 9/18/12 with diagnoses of Peripheral Vascular Disease (PVD), atherosclerosis, vascular dementia with behaviors, hyperlipidemia, stroke with right hemiplegia, swallowing problems and alcohol and cocaine abuse. The resident expired in the nursing facility on 5/23/16 at 11:03 p.m. The Discharge Death Summary indicated the cause of death was failure to thrive due to stroke, dysphagia and gangrene sepsis due to occlusive vascular disease.

The Minimum Data Set (MDS) assessment dated 4/1/16 coded the resident with a BIMS (Brief Interview for mental Status) score of 7 out of a

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possible score of 15, which indicated the resident was severely impaired in the skills needed for daily decision making. The MDS assessed the resident to require extensive assistance of one staff for bed mobility and bathing, extensive assistance from two staff for dressing, eating, toilet use and personal hygiene. She was coded impaired on one side of lower extremity in range of motion. She used the wheelchair for mobility. She was coded frequently incontinent of bowel and bladder. The resident was assessed with swallowing problems that included holding food in mouth, coughing or chocking during meals and complaints of difficulty or pain when swallowing. She was on a mechanically altered diet and during this assessment period had to receive Intravenous fluids to maintain adequate hydration, but had no weight loss. The resident was assessed to have one or more unhealed pressure ulcers with the most severe tissue type with Eschar (black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges, may be softer or harder than surrounding skin).

The Discharge MDS dated 5/23/16 identified the resident with 3 unstageable pressure ulcers with the largest one measured at 19.5 centimeters (cm) in length and 15.3 cm in width with the inability to determine pressure ulcer depth. The most severe tissue type remained with Eschar. The resident had weight loss assessed at 5% or more in the last month or 10 % or more in the last 6 months. She remained on a mechanically altered diet with swallowing disorders.

The care plan dated 11/17/15 indicated the resident was at risk for pressure ulcers and pressure ulcers would not develop unless unavoidable.

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The care plan and the Weekly Pressure Ulcer progress Reports identified the resident had acquired a right heel Deep Tissue Injury (DTI) pressure ulcer on 2/2/16 that had improved on 5/3/16, opened up as unstageable. A right medial shin DTI and a left posterior heel was identified as acquired on 5/6/16.

The resident was identified with an acquired pressure ulcer to the top of the resident right foot on 4/14/16 as a Stage II 5.0 cm by (x) 5.2 cm. On 4/26/16 slough was observed in the wound bed and on 5/3/16 the area was measured as 7.4 cm by 7.5 cm with slough.

The resident was admitted to the hospital on 5/10/16 through 5/18/16. Upon her return to the nursing facility, all of the aforementioned pressure ulcers had worsened with the one on the top of the right foot now measuring 19.5 cm by 19.5 cm. with odor and necrotic tissue.

The SBAR report dated 4/14/16 indicated a new area was noted on the top of Resident #23's right foot that was red and non-blanchable. It was documented and that the area was caused by direct pressure from Kerlix wrap. The pressure ulcer investigation indicated the resident had existing pressure areas that required Kerlix wrap to the heels and as a result the Kerlix was wrapped too tightly causing a pressure ulcer on the top of the resident's right foot. It was noted the resident had PVD that would complicate healing. The full investigation was completed on 5/13/16 with the licensed nurses and Certified Nursing Assistants interviewed and documentation reviewed. Again documented on 5/13/16 that the area on the top of the foot was

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confirmed to have originated from tight application of Kerlix wrap. The most recent Braden Risk Assessment dated 4/5/16 prior to the development of the pressure ulcer on the top of the foot was dated 4/5/16, and scored the resident at high risk for the development of pressure ulcers. The last skin assessment by the licensed nurse prior to 4/14/16 (when top of foot area identified) was conducted on 4/8/16 with no new pressure ulcers or skin issues identified. The Lower Extremity Wound Differentiation Worksheet indicated that physician classified the area as a pressure ulcer. It was also noted there was a diagnosis of Venous Insufficiency.

The R CARES report (facility's incident report) dated 4/14/16 reflected the same information as the SBAR.

On 6/10/16 at 3:00 p.m., an interview was conducted with the Director of Nursing (DON) and the Unit Manager, Licensed Practical Nurse #5. They stated the resident acquired the pressure ulcer on the top of the foot from the Kerlix that had been applied too tightly and because of the resident's vascular status, she had problems healing that area despite all their interventions/treatments. The Unit Manager stated the pressure ulcer on the top of the foot was avoidable. The DON agreed with her statement. They both stated the area was large, but when she returned from the hospital it had greatly increased in size. They stated the resident returned with a DNR status under hospice care. They stated when the resident returned she was on isolation precautions for MRSA, her comfort was maintained, oxygen in place, morphine and atropine administered, Tylenol for elevated temperatures. They stated the POA (power of

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attorney) had been ill and the other family members visited infrequently.

Resident #23 was seen in a hospital local Emergency Room (ER) on 5/10/16 due to fever and worsening wound, despite treatments, consults, nutritional interventions and speech intervention for swallowing. Feeding tube was declined by Power of Attorney (POA) as signed on 3/ 23/16.

The hospital History and Physical (H&P) the resident was admitted to the hospital 5/11/16. The H&P indicated the resident had "...a large area of the right foot dorsum (top surface portion of the foot) was necrotic appearing and with necrotic tissue and eschar over a large area with surrounding erythema and patient had a fever of 101.4. She also had a bedside ultrasound study by the ER physician, which revealed some vascular occlusion..." A vascular consult was ordered, the resident was admitted to the hospital and ordered IV antibiotics in the ER and on the medical floor. The resident was diagnosed with Sepsis and cellulitis of the right foot dorsum with large necrotic area with eschar and PVD. It was noted that the bedside ultrasound done by the ER physician revealed some vascular occlusion, "...which was likely why the patient's large wound has failed to heal and has worsened..." The H&P indicated that the resident could possibly require an amputation if foot was evaluated to be salvageable.

On 6/10/16 at 10:05 a.m., an interview was conducted with the physician in charge of the resident's care while at the nursing facility. This physician's office was located off site at an

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all-inclusive care program for the elderly and was contracted with this program to provide for the provision of comprehensive health related and social services to senior citizens who met the requirements for enrollment into the program. The program has entered into an agreement with the Centers for Medicare and Medicaid (CMS) in order to provide these services. The physician stated the resident had been coming to the program before she was a resident at the nursing facility and continued to come several times a week. She stated she was made aware of all the resident's wounds and confirmed all of them to have been caused by pressure. She stated the resident had limited lower range of motion, could sometimes be difficult to manage and at times refused skin checks as was reported to her from the nursing facility. She stated all pressure areas were first identified at the nursing facility and she directed care for them. She stated if the resident was with them on a particular day of the week, the program's clinic nurse performed and documented wound care on the resident. She stated the resident was nutritionally stable up until the first part of April 2016 where she was declining to swallow and thus a slow decline began in her physical status. She had been seen by Speech Therapy (ST) and all areas she had up to that time were healing fairly well.

During the interview with the attending physician, she stated the resident acquired the worse wound on the top of the right foot due to pressure from Kerlix wrap which was used to secure the heel ulcer dressings. She stated the resident was an avid smoker as long as she was able and had a long standing diagnosis of PVD and atherosclerosis. The resident was diagnosed with aspiration pneumonia on 5/3/16 and was treated

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with antibiotics and had IV fluids while in the nursing facility for three episodes of dehydration. She stated when the resident was admitted to the hospital 5/11/16, the POA and family had discussed one of the best options of survival may have been start tube feedings and to amputate the right foot to rid the body of possibility of gangrene infiltrating the resident's system. She stated ultimately the decision was made to not start tube feeding, not to amputate the right foot and make the resident comfort care with a Do Not Resuscitate (DNR). The physician stated the family further decided to return the resident to the nursing facility upon her discharge from the hospital under hospice care.

An interview was conducted with the Director of Nursing (DON) on 6/9/16 at approximately 3:00 p.m. She stated she and a project team implemented an all inclusive action plan (4/20/16) that included the following:

Issue/Concern-wound assessment/proper treatment and application.
Goals/objectives/expected outcome-nurses will be able to appropriately assess, stage, initiate appropriate treatments, perform proper treatment and document appropriately.
The action(s) planned included- 1). Correction for the identified residents/system; 2). How you will identify other potential residents and correct for them if needed (100% skin sweeps completed on 5/13/16); 3). System changes; 4). Monitoring-explain how you will monitor that the plan is successful (return demonstrations 4/26-5/10/16); include QA committee oversight; 5). Add/modify tasks and plan as needed.

The DON, Unit Managers, the Staff Development

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Coordinators, Assistant Director of Nursing, Corporate Staff Development Coordinator, Corporate Quality Assurance (QA) Nurse, Nurse Practitioner/Physician, Interdisciplinary Team (Registered Dietician, Rehabilitation Manager) and reports to the QA team (included the Administrator) with monitoring and oversight were incorporated into the aforementioned planned actions.

All education and original sign in sheets were reviewed with inservice dates for all licensed nurses of 4/20/16 and 5/6/16. All CNAs were inserviced on 5/26/16 and 5/27/16.

The project completion date was recorded as 5/30/16, after all the CNAs were educated, but the audits continued by the Unit Managers as ongoing. Their QA committee will meet 6/30/16 to review results of compliance of the action plans.

There were no further pressure ulcers identified as avoidable and/or as a direct pressure from Kerlix wrap after the aforementioned action plan's completion date of 5/30/16. Nor were any avoidable pressure ulcers identified during the Standard survey conducted 6/8-10/16, therefore the facility met the necessary criteria for Past Non Compliance (PNC) for regulation F314.

On 6/10/16 at 4:40 p.m., the aforementioned issue was shared with the Administrator and re-shared with the DON. No further information was forthcoming prior to survey exit.

COMPLAINT DEFICIENCY

F 441 483.65 INFECTION CONTROL, PREVENT — F 441

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F 441 SS=D	Continued From page 15 SPREAD, LINENS	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

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

F441 7/15/16

1. Nurse #2 was re-educated by staff educator on 6/10/16 on standard infection control practices to prevent the spread of infection while providing wound care. Resident #14 has had no signs and symptoms of wound infection.
2. Residents who receive wound care have been identified as having the potential to be affected by the alleged practice.
3. Licensed staff will be re-educated by 7/15/16 by Staff Development Coordinator or designee on standard infection control practices while performing clean dressing procedure, and on infection control policy and cross contamination.
4. DNS or designee will visually audit 6 dressing changes weekly for 4 weeks, then 3 dressing changes for 4 weeks to validate appropriate technique with infection control measures. Licensed nurses will complete competency checklist by 7/15/16 validating proper infection control technique while setting up clean field for dressing change. The results of the audits will be reported monthly at the QA meeting for

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This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed for one resident (Resident #14) of 23 residents in the survey sample to ensure that standard infection control practices were followed to prevent the spread of infection when the wound care nurse Licensed Practical Nurse (LPN) #2 used bare hands to pick up a non sterile dressing used to clean Resident #14's Left ankle wound.

The findings included:

Resident #14 was admitted into the facility on 10/29/13. Diagnoses for Resident #14 included but are not limited to Non Alzheimer's Dementia (any form of dementia other than Alzheimer), Vascular (related to blood vessels) Dementia and Open wound to the Left Ankle.

Resident #14's Quarterly Minimum Data Set (MDS - an assessment protocol) coded Resident #14's Cognitive Skills as Moderately impaired. In addition, the MDS coded Resident #14 as Extensive Assistance with one staff person assistance for Dressing. Resident #14 was coded as Extensive assistance with two staff person assistance for Toilet Use. Resident #14 was coded as Total Dependence with one staff person assistance for Bathing.

Resident #14's Braden Scale for 1/28/16 and 4/26/16 were scored at 18 indicating Mild Risk for predicting pressure sores.

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evaluation of compliance and ongoing monitoring for continuous improvement analysis after implementation.

5. 7/15/16

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Resident #14's Weekly Wound (Non Pressure) Progress Report for Left outer ankle documents on 3/15/16 an Unstageable Ulcer measuring 2.5 cm length, by 3.5 cm width; serosanquineous drainage, without odor, yellow tan exudate of moderate amount. Wound Bed macerated moist, Intact wound edges around wound, worsened wound progress. Wound Progress Comments of this document, documented the following: "3/18/16 This area was a previous wound area. A callous had developed and resident did not display any discomfort until recently, Serosanquineous (drainage of both serum and blood) drainage was expressed from center of site. Xray was taken of left ankle. Recommend bone scan scheduled for 3/23/16 to clarify if osteomyelitis is present."

Resident #14's 4/26/16 Vascular Consult Note of Nurse Practitioner documented the following: "Skin: 2 centimeter (cm) circular, dry ulceration to left lateral malleolus (ankle bone). Assessment: 1. Pressure ulcer to left lateral malleollus. Plan: 1. Recommend heel protectors and floating ankles during rest; 2. Return to office if redness, drainage, or signs of infection occur.

A 4/27/16 Care Plan documented the problem: Resident has a pressure area to left ankle stage II. Objective documented the following: Pressure area will heal without stage progression. Pressure Area will have a decrease in size. The Care Plan Approaches documented the following: Treatment per Treatment Administrator Record, with the following interventions:
1. Wound care per Medical Doctor Orders, see Treatment Administrator record
2. Turning and weight shifts per standards of

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care using wedge and heels up or pillows for positioning
3. Nursing to continue to reinforce education regarding importance of offloading pressure
4. Nursing to measure weekly until resolved
5. Nursing to administer all medications per Medical Doctor Orders
6. Nursing to report to Medical Doctor and document non-compliance with pressure relieving measures.
7. Registered Dietician consult as needed

A 4/28/16 Nurse Practitioner's progress note documented the following: "He was recently seen by (Physician) of vascular for evaluation of this non-healing ulceration. ... Performed ABI (Arterial Brachial Index-) and this is 0.63 indicating some vascular compromise.... Assessment: Pressure Ulcer of Ankle Left - Unstageable assessed as deteriorated - slough covered pressure ulcer to the left malleolus. ABI determined to be 0.63--consider arterial studies if wound continues to be a concern. Suspect this wound is pressure related but not healing due to vascular impairment."

5/23/16 Physical Therapy note documented the following: "This therapy session completed to provide minimum sharps debridement of Left ankle wound to encourage optimal wound environment for healing. This therapist performed manual debridement of non-viable tissue to left malleolus at this session...."

Resident #14's Treatment Administration Record (TAR) documents 6/9/16 treatment order: Left Ankle: Cleanse with Normal Saline, Pat dry, wipe area with small ABD (Abdominal Dressing) two times a day. May Cleanse with iodine until

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Betadine wipe arrive at facility.

An observation was made of Resident #14 on 6/8/16 at approximately 2:55 p.m. He was sitting in hall in his wheel chair. He was well groomed. His feet were in shoes and socks and were observed to be placed on the floor. Resident #14 gave his permission for the surveyor to observe wound care in the morning.

An observation was made of Resident #14's wound care to left ankle on 6/9/16 at approximately 10:20 a.m. Licensed Practical Nurse (LPN) # 2 performed the wound care and LPN #1 assisted. LPN #2 performed the following steps:

1. Explanation of wound care steps
2. Assessment of pain prior to wound care
3. Washed hands
4. Surface cleansed with bleach wipe
5. Dressings placed on table (LPN #2 picked up non sterile dressings with ungloved hands).
6. Hands washed
7. Gloves donned
8. Wound care done per order
9. Hands washed
10. Wound Care surface and supplies cleaned up
11. Hands Washed
12. Surface cleaned with bleach wipe

An interview was conducted with LPN #2 after she completed the wound care on 6/9/16 at approximately 11:00 a.m. LPN #2 stated, "I was nervous. I should have had gloves on when I picked up the 4x4's."

The 5/2013 Policy and Procedure, titled "Cleaning of Wounds/Dressing Change" was reviewed. It

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F 441	Continued From page 20 documented the following: apply a second pair of clean gloves prior to performing wound care. The facility administration was informed of the findings during a briefing on 6/10/16 at approximately -1:45 p.m. The facility did not present any further information. An interview was conducted with the Director of Nursing (DON) #2 on 6/9/16 at approximately 11:45 a.m.. The DON stated, "My expectation would be for the nurse to follow standards of infection control. She should have had gloves on when she picked up dressings used in wound care." *Unstageable pressure Ulcers Unstageable/Unclassified: Full thickness skin or tissue loss - depth unknown Full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar are removed to expose the base of the wound, the true depth cannot be determined; but it will be either a Category/Stage III or IV. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as " the body ' s natural (biological) cover " and should not be removed (National Pressure Ulcer Advisory Panel/NPUAP www.npuap.org).	F 441		
F 518 SS=E	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing	F 518		

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staff; and carry out unannounced staff drills using those procedures.

This REQUIREMENT is not met as evidenced by:
Based on staff interviews and facility document review the facility failed to ensure all staff were competent in emergency procedures.

Three of six staff interviewed for emergency preparedness failed to verbalize competency in emergency procedures.

The findings include:

On 6/10/16 interviews were conducted to assess the staff's competency in emergency procedures. Three supervisory staff and three direct care staff were selected at random, and interviewed separately by this inspector. Three of the six staff interviewed failed to verbalize competency in emergency procedures.

A direct care staff, certified nurse aide (CNA #1), was interviewed on 6/10/16 at 11:10 a.m. She was asked, "What do you do during a natural disaster, such as a tornado, to ensure resident safety?" She stated, "We don't have a basement, I guess we would put all the residents downstairs in the large dayroom/dining room." She then asked this inspector, "If all the resident rooms have windows where would be the best place?"

The large dayroom/ dining room located on the first floor was observed to have large windows.

The second floor unit manager was interviewed on 6/10/16 at 11:30 a.m. She was asked where

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F518 7/15/16

1. 2nd floor unit manager and other staff were re-educated on 6/10/16 by Staff Development Coordinator on emergency procedures. C.N.A #1, #2, and 2nd floor Unit Manager have been re-educated by the centers Maintenance Director on emergency procedures and also have participated in fire drill utilizing correct procedure on 6/28/16.
2. All residents have the potential to be affected.
3. Interdisciplinary staff were trained on 6/20/16, 6/21/16 and 6/22/16 by center Maintenance Director in emergency procedures and are able to verbalize competency in emergency procedures starting 7/15/16. Fire drills will be completed on all shifts by Maintenance Director or designee 3 times per week for 4 weeks, then monthly on all shifts for 3 months.
4. The centers safety champion/Director of Maintenance or designee will verbally interview 6 employees weekly for 4 weeks, then 3 employees weekly for 4 weeks, then 3 monthly for 4 weeks

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the fire extinguishers where located on that unit. She stated they were stored inside a certain room on the unit. When asked where the pull fire alarms were located, she stated, "I believe in the halls...there maybe one by the elevator...I'm not sure, I am going to have to look." When asked, "Where are the emergency power outlets located?" she stated, "I'll have to find that out."

A second direct care staff CNA #2 was interviewed on 6/10/16 at 12:30 p.m. When asked, "If the fire alarm sounds, what do you do?" she stated, "I would go to the emergency door." When asked,"What would you do if you discovered a fire in a resident's room?" she stated, "Call 911 and then let a nurse know." When asked, "What do you do during a natural disaster, such as a tornado, to ensure resident safety?" she stated she would place the residents in the main dining room. When asked, "Is there emergency power and if so, where are the emergency power outlets?", she stated, "Yes...I would hope they had a generator...every outlet is an emergency outlet." When asked if there were red emergency outlets in the building she stated, "No."

Emergency red outlets were observed in hallways and inside resident rooms.

On 6/10/16 at 2:40 p.m., the Fire/Disaster Drill Reports were reviewed. A fire drill was conducted on 6/4/15 at 7:42 p.m., by the evening nursing supervisor. Deficient areas were identified to include; only one staff had bought a fire extinguisher to the location of the fire and the staff used the elevator.

The last quarterly fire drill for the day shift was on

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to validate knowledge of emergency procedures. The center will perform one emergency drill every other week X 12 weeks. . The results of the audits will be reported monthly at the QA meeting for evaluation of compliance and ongoing monitoring for continuous improvement analysis after implementation.

5. 7/15/16

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3/23/16 at 11:10 a.m., conducted by the maintenance director. Under comments read, "Staff is a bit unsure of procedure. Will get with staff educator to schedule inservice within 90 days.

The maintenance director was interviewed on 6/10/15 at 2:40 p.m., he stated fire drills are conducted every shift once a quarter. He was asked to clarify the comment on the fire drill report for 3/23/16 of the staff being "a bit unsure of the procedure". He stated, "We have a lot of new staff members who aren't exactly sure of their role (during a fire). When a drill is happening they are not sure if they are supposed to stay in their area or go to where the fire is located. He stated following each fire drill inservices are provided to the responding staff as to what the correct action/response should have been. He stated the scheduled inservice with the staff educator had not yet been conducted.

A quarterly fire drill for the evening shift was last conducted on 3/31/16 at 2:10 p.m., by the nursing supervisor. Under comments read, " The fire was in the front lobby but nurses on North wing closed there {sic} room doors & never responded to fire in lobby".

A quarterly fire drill for the night shift was last conducted on 3/31/16 at 4:45 a.m., by the nursing supervisor. Under comments read, "The staff that arrived on the scene did not have a fire extinguisher. The nurse came down the elevator. The staff was educated on location of fire extinguishers on their floor and the location of the stairwell. New staff educated to proper protocol for fire."

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RIVERSIDE REHABILITATION CENTER AT HAMPTON	414 ALGONQUIN RD HAMPTON, VA 23661

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 518	Continued From page 24	F 518		

On 6/10/16 at 3:45 p.m., the Staff Educator was interviewed. She was asked when is the next scheduled fire safety inservice. She stated, "I would have to get with (name of Maintenance Director), we try to have them twice a year."

The above findings was shared with the Administrator on 6/10/16 at 4:15 p.m. He stated, "We have had tornado drills." When asked where is the safest place for the residents to be placed during a tornado warning, he stated, "In the community room areas."

On 6/10/16 at 4:30 p.m., the Maintenance Director was asked during a tornado warning where would the residents be placed for safety. He stated, "In the interior areas of the hallways." When asked if it would be appropriate to place the residents in the large dining rooms or the community rooms, he stated, "No."

The Code Red fire safety handout provided by the maintenance director read, in part: Fire Safety- Know the location of the alarm pull boxes, fire extinguishers and emergency fire exits.

The facility document titled General Fire Plan 802.310(i) read, in part: How to report a fire: The employee who discovers a fire shall: a. Ensure the safety of the residents and b. Report the fire.

Each employee discovering a fire must ensure that each of the following actions are immediately taken:
a. Determining Need to Move Resident(s). The safety of residents shall be the first consideration.
b. Pull Alarm. The nearest fire alarm box shall be pulled. Spread the Alarm: The person discovering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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the fire shall announce "Code Red" within the area and adjacent areas. The "Code Red" location shall be announced over the PA system.
d. Contain Fire.
e. Fight fire. After safeguarding residents and reporting the fire (by pulling the fire alarm box), immediately start to extinguish or control the fire.

The facility's policy/ procedure #802/450 dated 6/2003 titled Tornado Safety read, in part:
Areas of Best Protection: Basements, small interior rooms with no windows, locker room and bathrooms, hallways away from doors and windows and not open to the direction of the tornado, rooms with heavy concrete floors or roof system.
Areas of Worst Protection: Gymnasiums and auditoriums, rooms with large windows and doors.
Precautionary Measures:
3. Under the direction of Administration and/or the DON (Director of Nursing)/Nursing Supervisor, patient care staff will initiate the movement of patients into the interior area of the hallway and close patient room doors once the room has been evacuated.