| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| TRINITY MISSION HEALTH AND REHAB OF R( | 300 HATCHER STREET ROCKY MOUNT, VA 24151 |

| (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 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid standard survey and and complaint survey was conducted 6/21/16 through 6/23/16. Two complaints were investigated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.<br><br>The census in this 180 certified bed facility was 141 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents #1 through #21 & #28) and 6 closed record reviews (Residents #22 through #27). | F 000 | Preparation and submission of this plan of correction by **Trinity Mission Health and Rehab of Rocky Mount, LLC,** does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. | |
| F 155 SS=D | 483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES<br><br>The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.<br><br>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.<br><br>This Requirement is not met as evidenced by: | F 155 | F-155<br><br>1. Resident #14 Durable Do Not Resuscitate (DDNR) was reviewed and completed on 06/22/16 by the physician.<br><br>Resident #15 Durable Do Not Resuscitate (DDNR) was reviewed and completed on 06/22/16 by the physician.<br><br>2. The Unit Managers will complete an audit of the current residents Durable Do Not Resuscitate (DDNR) by 07/22/16 to ensure the Durable Do Not Resuscitate (DDNR) are completed as required. | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Vicki D. Clark | Administrator | 7-15-16 |

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

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| F 155 | Continued From page 1 | F 155 | | |

Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate Durable Do Not Resuscitate (DDNR) for 2 of 28 Residents in the sample survey, Resident #14 and #15.

The Findings Included:

1. For Resident #14 the facility staff failed to ensure a complete and accurate Durable Do Not Resuscitate (DDNR).

Resident #14 was an 84 year old female who was admitted on 6/2/15. Admitting diagnoses included, but were not limited to: dementia, osteoporosis, hyperlipidemia and glaucoma.

The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 6/9/16. The facility staff coded that Resident #14 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #14 required limited (2/2) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On June 22, 2016 at 8:45 a.m. the surveyor reviewed Resident #14's clinical record. Review of the clinical record produced a Durable Do Not Resuscitate (DDNR). The DDNR was dated 3/31/16. Review of the DDNR sheet revealed that the DDNR was not accurate/complete. The DDNR had not documented whether Resident #14 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment.

Reference: Code of Virginia § 512.1-2987.1. Durable Do Not Resuscitate Orders. A. A Durable

3. The Licensed Nurses will be re-educated by the Staff Development Coordinator by 07/22/16 related to ensuring the Durable Do Not Resuscitate (DDNR) are completed as required.

4. The Unit Managers will complete an audit weekly for 4 weeks and monthly for 2 months to ensure Durable Do Not Resuscitate (DDNR) continue to be completed as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.

Completion date: 07/23/16

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Do Not Resuscitate Order may be issued by a physician for his patient with whom he has a bona fide physician/patient relationship as defined in the guidelines of the Board of Medicine, and only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf.

On June 22, 2016 at 9:45 a.m. the surveyor notified a Licensed Practical Nurse (LPN #1) and the Unit Manager (UM), who was an LPN, that Resident #14's DDNR was incorrect/inaccurate. The surveyor reviewed the clinical record with LPN #1 and the UM. The surveyor reviewed the DDNR with the LPN (#1) and the UM. The surveyor pointed out that the physician/facility staff had not determined whether Resident #14 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment.

On June 22, 2016 at 2:25 p.m. the survey team met with the Administrator (Adm) and Director of Nurses (DON).The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate DDNR for Resident #14.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate DDNR for Resident #14.

2. For Resident #15 the facility staff failed to ensure a complete and accurate Durable Do Not Resuscitate (DDNR).

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Resident #15 was a 48 year old male who was originally admitted on 8/15/15 and readmitted on 11/06/15. Admitting diagnoses included, but were not limited to: paraplegia, diabetes mellitus, anxiety, pressure ulcer, blind in one eye and a right above knee amputation.

The most current Minimum Data Set (MDS) located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 4/12/16. The facility staff coded that Resident #15 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #15 required total nursing care (4/2) with Activities of Daily Living (ADL's).

On June 22, 2016 at 3 p.m. the surveyor reviewed Resident #15's clinical record. Review of the clinical record produced a Durable Do Not Resuscitate (DDNR). The DDNR was dated 3/01/16. Review of the DDNR sheet revealed that the DDNR was not accurate/complete. The DDNR had not documented whether Resident #15 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment.

Reference: Code of Virginia § 512.1-2987.1. Durable Do Not Resuscitate Orders. A. A Durable Do Not Resuscitate Order may be issued by a physician for his patient with whom he has a bona fide physician/patient relationship as defined in the guidelines of the Board of Medicine, and only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's

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| F 155 | Continued From page 4<br>behalf.<br><br>On June 22, 2016 at 9:45 a.m. the surveyor notified the Administrator (Adm) that Resident #15's DDNR was incorrect/inaccurate. The surveyor reviewed the DDNR with the Adm. The surveyor pointed out that the physician/facility staff had not determined whether Resident #15 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment.<br><br>On June 23, 2016 at 11:10 a.m. the survey team met with the Adm, Director of Nurses (DON) and Regional Nurse Consultant (RNC).The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate DDNR for Resident #15.<br><br>No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate DDNR for Resident #15. | F 155 | F-156<br><br>1. Posting/ documentation regarding how to apply for Medicare/Medicaid was posted in the facility on 07/01/16 by the Administrator.<br><br>2. The Administrator will complete an audit on 07/12/16 to ensure required posting are posted in the facility as required.<br><br>3. The Administrator will be re-educated by the Regional Nurse Consultant by 07/12/16 related to ensuring required post/documentations are posted in the facility as required. | |
| F 156 SS=C | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. | F 156 | 4. The Administrator will complete an audit weekly for 4 weeks and monthly for 2 months to ensure required posting/documents continue to be posted in the facility as required The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up.<br><br>Completion date: 07/23/16 | |

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The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy

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groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This Requirement is not met as evidenced by:
Based on observation and staff interview it was determined that the facility staff failed to prominently display written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by Medicare and Medicaid benefits.

The Findings Included:

On June 21, 2016 at 3:30 p.m. this surveyor made an initial tour of the facility. The surveyor observed that the front lobby had several documents posted regarding reporting abuse and

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contact information for the State Agency and the local Ombudsman. This surveyor did not observe any posting/documentation regarding how to apply for Medicare/Medicaid and how to receive refunds for previous payments covered by Medicare/Medicaid.

On June 22, 2016 at 8:30 a.m. the surveyor made a walkthrough of the facility. The surveyor was unable to locate any posting/documentation for Medicare/Medicaid applications and benefits. The surveyor observed that the facility Unit Manager (UM) was standing in the hallway. The surveyor informed the UM that the surveyor was unable to locate the posting/posted documentation regarding how to apply for and use Medicare/Medicaid. The surveyor and UM made a tour of the facility. The UM was unable to locate the posting/posted documentation regarding Medicare/Medicaid applications and benefits. While walking through the front lobby the surveyor observed the Administrator (Adm) standing in a doorway. The surveyor informed the Adm that the UM and surveyor were unable to locate the written documentation regarding application of Medicare and Medicaid benefits. The Adm walked through the front lobby with the UM and surveyor. The Adm was unable to locate the written documentation regarding Medicare and Medicaid application and benefits. The Adm stated that the front lobby had experienced some water damage earlier in the year and that the written documentation regarding Medicare and Medicaid application and benefits had probably been removed due to damage.

On June 22, 2016 at 2:25 p.m. the survey team met with the Adm and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that the surveyor was unable to locate any

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| F 156 | Continued From page 8<br>posting/documentation for Medicare/Medicaid application and benefits.<br><br>No additional information was provided prior to exiting the facility as to why the facility staff failed to prominently display information regarding Medicare/Medicaid application and benefits. | F 156 | F-167<br><br>1. The notice/signage of the most recent Survey Results was posted on 07/01/16 by the Administrator. | |
| F 167 SS=C | 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE<br><br>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.<br><br>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.<br><br>This Requirement is not met as evidenced by:<br>Based on observation and staff interview, it was determined that the facility staff failed to post a notice/signage of the availability of the most recent survey results.<br><br>The Findings Included:<br><br>On June 21, 2016 at 3:30 p.m. the surveyor entered the building and observed a small clear wall mount that held a white three ring binder. The binder was labeled Survey Results. The surveyor opened the binder an observed the survey results for the 7/02/15 survey. The surveyor made an initial tour of the facility and was unable to locate a notice or signage regarding where the most recent survey results could be located for residents, families and public | F 167 | 2. The Administrator will complete an audit on 07/12/16 to ensure required notice/signs are posted as required.<br><br>3. The Administrator will be re-educated by the Regional Nurse Consultant on 07/12/16 related to ensuring notice/signs are posted in the facility as required.<br><br>4. The Administrator will complete an audit weekly for 4 weeks and monthly for 2 months to ensure notices/signs continue to be posted in the facility as required. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for monitoring and follow up.<br><br>Completion date: | 07/23/16 |

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| F 167 | Continued From page 9<br>for viewing.<br><br>On June 22, 2016 at 8:30 a.m. the surveyor notified the Administrator (Adm) that the signage notifying residents, families and the public where the most recent survey results were located could not be found. The Adm asked for clarification and stated she didn't know what the surveyor was asking about. The surveyor notified the Adm that signage had to be posted to direct residents, families and the public about where the results of the most recent survey were located. The Adm stated, "Oh I've never done that." The surveyor notified the Adm that the residents, families and public should not have to ask were the survey results were located.<br><br>On June 22, 2016 at 2:25 p.m. the survey team met with the Adm and Director of Nurses (DON). The surveyor notified the Administrative Team (AT) that the facility staff had not posted signage regarding were the results of the most recent survey was located for residents, families and public viewing.<br><br>No additional information was provided prior to exiting the facility as to why the facility staff failed to post a notice/signage of the availability of the most recent survey results for residents, families and the public viewing. | F 167 | | |
| F 256 SS=D | 483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS<br><br>The facility must provide adequate and comfortable lighting levels in all areas.<br><br>This Requirement is not met as evidenced by:<br>Based on observation and staff interview it was determined that the facility staff failed to provide | F 256 | F 256<br><br>1. The florescent light bulb was changed in the hallway near room 146 on 06/23/16 by the Maintenance Assistant.<br><br>2. An audit will be completed by the Maintenance Director on 07/15/16 to ensure adequate and comfortable lighting levels are maintained as required.<br><br>3. The Maintenance Department will be re-educated by the Administrator by 07/15/16 related to the requirements of maintaining adequate and comfortable lighting levels in the facility.<br><br>4. The Maintenance Director will complete audit weekly for 4 weeks and monthly for 2 months to ensure adequate and comfortable lighting levels continue to be maintained as required. The Administrator will submit a report to the Quality Assurance Committee monthly for 3 months. The Maintenance Director and Administrator will be responsible for monitoring and follow-up.<br><br>Date of compliance: | 07/23/16 |

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| F 256 | Continued From page 10<br>adequate and comfortable lighting levels on 1 of 6 wings in the facility. The light was out on one of the hallways on the skilled unit, located near room 146.<br><br>The Findings Included:<br><br>On June 22, 2016 at 8:30 a.m. the surveyor made a walkthrough of the facility. The surveyor observed that a florescent light in the hallway on the skilled unit, near room 146, was out.<br><br>On June 23, 2016 at 9 a.m. the surveyor made a tour of the facility with the Maintenance Director (MD). The surveyor and MD toured the skilled unit. The surveyor pointed out that the florescent light in the hallway, near room 146, was out. The MD stated he would get his helper to replace the light.<br><br>On June 23, 2016 at 11:10 a.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and Regional Nurse Consultant (RNC). The surveyor notified the Administrative Team (AT) that a florescent light on the skilled unit, located near room 146, was out on June 22, 2016 and earlier on June 23, 2016 when the surveyor made a tour of the facility with the MD.<br><br>No additional information was provided as to why the facility staff failed to provide adequate and comfortable lighting on the skilled unit in the hallway, near room 146. | F 256 | F-279<br><br>1. Resident #5 care plan was reviewed and updated to included Cognition, Activities of Daily Living/Rehabilitation, fall, Nutritional, and Psychotropic Drug use on 06/24/16 by the MDS Coordinator.<br><br>2. The MDS Coordinators will complete an audit of the current residents' Comprehensive Assessments by 07/22/16 to ensure comprehensive care plans have been developed on the identified triggers.<br><br>3. The MDS Coordinators will be re-educated by the Assistant Director of Nursing on 07/22/16 related to ensuring comprehensive care plans are developed for identified triggers on the Comprehensive assessments. | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. | F 279 | | |

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| F 279 | Continued From page 11<br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This Requirement is not met as evidenced by:<br>Based on staff interview and clinical record review, it was determined that the facility staff failed to develop a Comprehensive Care Plan (CCP) for 1 of 28 Residents in the sample survey, Resident #5.<br><br>The Findings Included:<br><br>For Resident #5 the facility staff failed to develop a Comprehensive Care Plan (CCP) to include a care plan for Cognition, Activities of Daily Living/Rehabilitation, Falls, Nutritional, and Psychotropic Drug Use as triggered and identified on an Admission/5Day Medicare Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 8/24/15.<br><br>Resident #5 was a 73 year old female who was admitted on 8/17/15. Admitting diagnoses included, but were not limited to the following: multiple sclerosis, pressure ulcer on the sacrum, | F 279 | 4. The Assistant Director of Nursing or Director of Nursing will complete audits weekly for 4 weeks and monthly for 2 months to ensure comprehensive care plans continue to be developed for the identified triggers on Comprehensive Assessments. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.<br><br>Completion date: | 07/23/16 |

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| F 279 | Continued From page 12 | F 279 | | |

neuralgia and congestive heart failure.

The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 5/9/16. The facility staff coded that Resident #5 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #5 required total nursing care (4/2) to with Activities of Daily Living (ADL's). The facility staff also coded that Resident #5 was totally incontinent of bladder and bowels.

On June 22, 2016 at 1 p.m. the surveyor reviewed Resident #5's clinical record. Review of the clinical record produced an Admission/5 Day Medicare MDS assessment with an ARD of 8/24/15. The facility staff coded that Resident #5 had a Cognitive Summary Score of 13. The facility staff coded in Section C-Cognitive Patterns that Resident #5 was able to report the correct year, was able to identify the correct month within 5 days, and was able to identify the correct day of the week. The facility staff also coded that Resident #5 was able to recall the items sock, blue and bed with verbal cueing. In Section G-Functional Status the facility staff coded that Resident #5 required total nursing care (4/2) with ADL's. In Section K-Swallowing/Nutritional Status the facility staff coded that Resident #5 was 65 inches tall, weighed 139 pounds and received a therapeutic diet. In Section N-Medications the facility staff coded that Resident #5 received 7 days on an antianxiety medication. In Section V. Care Area Assessment Summary (CAA'S) Resident #5 "triggered" for Cognition, ADL/Rehab, Falls, Nutritional Status and Psychotropic Drug Use. The facility staff documented that a care plan would be developed to address Resident #5's triggered deficits.

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| F 279 | Continued From page 13<br>Continued review of the clinical record produced the CCP. Review of the CCP failed to include a care plan for Resident #5 in the following areas: Cognition, ADL/Rehab, Falls, Nutritional Status and Psychotropic Drug Use.<br><br>On June 22, 2016 at 1:10 p.m. the surveyor notified the MDS Nurse, who was a Registered Nurse (RN #1), that Resident #5 "triggered" for Cognition, ADL ' s, Falls, Nutritional Status and Psychotropic Drug Use on the Admission/5 Day Medicare MDS with the ARD of 8/24/15. The surveyor notified the MDS Nurse that the facility staff documented that a care plan would be developed to address Resident #5 ' s triggered areas. The surveyor notified the MDS Nurse that review of the CCP failed to produce a care plan that addressed Cognition, ADL, Falls, Nutritional Status, and Psychotropic Drug Use for Resident #5. The MDS Nurse reviewed the CCP and was unable to locate a care plan that addressed Resident #5 ' s triggered areas.<br><br>On June 22, 2016 at 2:25 p.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that the facility staff failed to develop a CCP for Resident #5 to include Cognition, ADL, Falls, Nutritional Status Psychotropic Drug Use as "triggered" on the Admission/5 Day Medicare MDS with the ARD of 8/24/15.<br><br>No additional information was provided prior to exiting the facility as to why the facility staff failed to develop a CCP for Resident #5. | F 279 | F-309<br><br>1. Resident #6's medication was verified by the charge nurse that Omeprazole Sodium 20.6mg and Synthroid 225 mcg was given at 6:00am by LPN #1 per physician's orders and the Nurse Practitioner was notified 06/22/16.<br>LPN #1 was reeducated on 07/08/16 by the Director of Nursing on Medication Administration Documentation.<br><br>2. The Unit managers will complete an audit of the current residents' medication records by 07/22/16 to ensure medications are given and documented as required.<br>3. The licensed nurses will be re-educated by the Staff Development Coordinator by 07/22/16 related to the requirements of medication administration and documentation requirements.<br><br>4. The Unit managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure medications continue to be given and documented as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must | F 309 | | |

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| F 309 | Continued From page 14<br>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 staff interview and clinical record review, facility staff failed to administer medications per physician order for 1 of 28 residents in the survey sample (Resident #6).<br><br>Resident #6 was admitted to the facility 5/14/14 with diagnoses including hypertension, dementia, heart failure, asthma, and depression. On the annual minimum data set assessment (MDS) assessment with assessment reference date 4/17/16, the resident scored 5/15 on the brief interview for mental status and was assessed without signs of delirium or psychosis.<br><br>During clinical record review on 6/22/16 at approximately 2 PM, the surveyor noted that omeprazole sodium 20.6 mg and synthroid 225 mcg due at 6 AM were not signed as administered on the medication administration record (MAR). The surveyor discussed the concern with the nurse responsible for the resident's medications (LPN #1). LPN#1 stated that the 6 AM medications should have been administered by the night shift nurse.<br><br>The concern was reported to the administrator and director of nursing during a summary meeting on 6/22/16. No additional information was provided. | F 309 | The Director of Nursing will be responsible for monitoring and follow up.<br><br>Completion date: 07/23/16<br><br>F-333<br><br>1. Resident#5's physician was notified of the omissions of the sliding scale insulin on 06/22/16 by the charge nurse.<br>Resident #5 was re-assessed by the Unit Manager on 06/22/16 with no change in condition noted.<br><br>2. The Unit managers will complete an audit of the current residents' medication records by 07/22/16 to ensure medication are administered and documented as required per physicians' orders.<br><br>3. The licensed nurses will be re-educated by the Staff Development Coordinator by 07/22/16 related to administering medications and | |
| F 333 SS=D | 483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS | F 333 | | |

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| F 333 | Continued From page 15 | F 333 | | |

The facility must ensure that residents are free of any significant medication errors.

This Requirement is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 28 Residents (Resident #4) was free of significant medication errors.

The findings included.

The facility nursing staff failed to administer the Residents sliding scale insulin as ordered by the physician.

Resident #4 was admitted to the facility 11/13/15 and had been readmitted 06/16/16. Diagnoses included, but were not limited to, diabetes, glaucoma, anemia, chronic pain, and urinary retention.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/17/16 scored the Resident 15 out of a possible 15 points. Indicating the Resident was alert and orientated. Section I (active diagnoses) included diabetes.

The Residents clinical record included a signed (06/17/16) POS (physician order summary) that included orders for accuchecks AC (before meals) and HS (bedtime/hour of sleep) and novolog sliding scale insulin for a (BS) blood sugar of 140-199 2 units, 200-249 4 units, 250-299 6 units, 300-349 8 units, and for a BS of 350 or above 10 units.

documenting per physician's orders as required.

4. The Unit managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure medication continue to be administered and documented per physician's orders as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.

Completion date: 07/23/16

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| F 333 | Continued From page 16<br>A review of the Residents MAR (medication administration record) for 06/2016 indicated that on 06/17 at 8:00 p.m. the Residents BS was 157 no insulin was administered, 06/18 at 8:00 p.m. the Residents BS was 138 2 units of insulin was administered, 06/19 at 11:00 am the Residents BS was 164 no insulin was administered, at 4:30 p.m. it was 177 no insulin was administered and at 8:00 p.m. it was 174 and no insulin was administered, 06/20 at 8:00 p.m. the Residents BS was 179 no insulin was administered, 06/21 at 11:00 a.m. the Residents BS was 179 no insulin was administered and at 8:00 p.m. the Residents BS was 188 no insulin was administered.<br><br>On 06/22/16 at approximately 10:55 a.m. the surveyor interviewed LPN (licensed practical nurse) #1. LPN #1 reviewed the MAR with the surveyor and identified her initials for 06/19. After reviewing the MAR LPN #1 verbalized to the surveyor that she thought the Residents sliding scale insulin order began at 200.<br><br>The administrator and DON (director of nursing) were notified of the medication errors involving the Residents sliding scale insulin in a meeting with the survey team on 06/22/16 at approximately 2:20 p.m.<br><br>No further information regarding this issue was provided to the survey team prior to the exit conference. | F 333 | F 502<br><br>1. Resident #4's physician was notified on 06/22/16 that the January HBA1C was not obtained with no new orders given.<br>Resident #13's physician was notified on 6/22/16 that the March CBC was not obtained with no new orders given.<br><br>2. The Unit managers will complete an audit by 07/22/16 of the current residents' medical record to ensure labs have been obtained as ordered.<br><br>3. The licensed nurses will be re-educated by the Staff Development Coordinator by 07/22/16 to ensure labs are obtained as ordered.<br><br>4. The Unit managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure labs continue to be obtained as ordered. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. | |
| F 502 SS=D | 483.75(j)(1) ADMINISTRATION<br><br>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. | F 502 | | |

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| F 502 | Continued From page 17<br>This Requirement is not met as evidenced by:<br>Based on staff interview and clinical record review, the facility staff failed to obtain a physician ordered lab test for 2 of 28 residents, Residents #4, 13.<br><br>The findings included.<br><br>The facility staff failed to obtain the physician ordered lab test HBA1C.<br><br>The lab test HBA1C (hemoglobin A1c) is a blood test that provides information about an individual's average level of blood glucose, also called blood sugar, over the past 3 months.<br><br>Resident #4 was admitted to the facility 11/13/15 and had been readmitted 06/16/16. Diagnoses included, but were not limited to, diabetes, glaucoma, anemia, chronic pain, and urinary retention.<br><br>Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/17/16 scored the Resident 15 out of a possible 15 points. Indicating the Resident was alert and orientated. Section I (active diagnoses) included diabetes.<br><br>The Residents clinical record included a signed (06/17/16) POS (physician order summary) that included orders for a HBA1C every 3 months Jan/April/July/Oct.<br><br>During the clinical record review the surveyor was unable to locate the results for a HBA1C obtained in January. The surveyor asked the unit manager LPN (licensed practical nurse) #2 about the missing lab test. | F 502 | The Director of Nursing will be responsible for monitoring and follow up.<br><br>Completion date: | 07/23/16 |

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| F 502 | Continued From page 18 | F 502 | | |

On 06/22/16 at approximately 11:00 a.m. LPN #2 verbalized to the surveyor that the HBA1C in January had not been completed.

The administrator and DON (director of nursing) were notified of the above in a meeting with the survey team on 06/22/16 at approximately 2:20 p.m.

No further information regarding the missing lab test was provided to the survey team prior to the exit conference.

2. For Resident #13 the facility staff failed to obtain a physician ordered CBC in March 2016.

Resident #13 was an 87 year old female who was admitted on 2/28/12. Admitting diagnoses included, but were not limited to the following: psychotic disorder with hallucinations, glaucoma, major depression and diabetes mellitus.

The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 3/21/16. The facility staff coded that Resident #13 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #13 was independent (0/0) to requiring total nursing care (4/2) to with Activities of Daily Living (ADL's).

On June 22, 2016 at 9:50 a.m. the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced signed physician orders dated 5/10/16. Signed physician orders included, but were not limited to: " CBC EVERY MARCH DX (diagnoses) 401.9. " (sic) The order originated on 6/5/12.

Continued review of the clinical record failed to produce the results of the CBC for March 2016.

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| F 502 | Continued From page 19 | F 502 | | |

On June 22, 2016 at 10:45 a.m. the surveyor notified the Corporate Compliance Nurse (CCN) that Resident #13 had physicians order to obtain a CBC in March 2016. The surveyor notified the CCN that review of the clinical record failed to produce the results of the CBC. The surveyor and CCN reviewed the clinical record. The surveyor pointed out the specific order for the CBC to be obtained in March of every year. The CCN was unable to locate the results of the physician ordered CBC for March 2016.

On June 22, 2016 at 11:10 a.m. the CCN approached the surveyor and informed the surveyor that the facility staff had not obtained the CBC.

On June 22, 2016 at 2:25 p.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that the facility staff failed to obtain a physician ordered CBC in March 2016 for Resident #13.

No additional information was provided prior to exiting the facility as to why the failed to obtain a physician ordered lab, CBC, for Resident #13.

F 504 SS=E 483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN

The facility must provide or obtain laboratory services only when ordered by the attending physician.

This Requirement is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to obtain a physician order for laboratory testing performed for 1 of 28

F-504

1. Resident #12's physician was notified by the Charge Nurse that an HgbA1C on 05/03/16, PT/INR on 05/03/16, and a Phenobarbital and Primidone on 05/05/16 were drawn without physician orders. No new orders noted.

2. The Unit Managers will complete an audit of the current residents' medical records by 07/22/16 to ensure physician orders are obtained prior to drawing labs.

3. The licensed nurses will be re-educated by the Staff Development Coordinator by 07/22/16 to the requirements of obtaining physician's orders prior to drawing labs.

F 504 4. The Unit Managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure physician's orders continue to be obtained prior to drawing labs. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be

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| F 504 | Continued From page 20<br>residents (Resident #12).<br><br>The findings include:<br><br>The facility staff performed laboratory (lab) testing without physician orders for Resident #12.<br><br>Resident#12 was admitted to the facility on 4/16/15 with diagnoses of psychosis, dissociative disorder, attention deficit disorder, bipolar, post traumatic stress disorder, depression, hypertension, anxiety, and fibromyalgia.<br><br>A significant change Minimum Data Set (MDS) with a reference date of 3/17/16 assessed the resident with a cognitive score of "15" of "15". The resident was assessed as independent with activities of daily living except requiring extensive assistance of 1 person for bathing.<br><br>The clinical record was reviewed. The record contained lab results for a HgbA1C ( measures averages blood glucose levels) dated 5/3/16, a PT/INR ( measures anticoagulant levels) dated 5/3/16, and two drug level lab tests for Phenobarbital and Primidone dated 5/5/16.<br><br>The record did not contain the physician orders for these lab tests. The unit manager (LPN#1) was asked about the orders on 6/22/16 at 11:05 a.m. LPN#1 was unable to find any physician orders for the lab tests.<br><br>The administrator, director of nursing, and the regional nurse consultant were informed of the findings during a meeting with the survey team on 6/22/16 at 5:00 p.m. | F 504 | responsible for monitoring and follow up.<br><br>Completion date: | 07/23/16 |
| F 510 SS=D | 483.75(k)(2)(i) RADIOLOGY/DIAGNOSTIC SVCS ONLY WHEN ORDERED | F 510 | | |

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| F 510 | Continued From page 21<br>The facility must provide or obtain radiology and other diagnostic services only when ordered by the attending physician.<br><br>This Requirement is not met as evidenced by:<br>Based on staff interview and clinical record review, facility staff failed to obtain a physician ordered radiology exam for 1 of 28 residents in the survey sample (Resident #20).<br><br>Resident #20 was readmitted to the facility on 6/8/16 with diagnoses including hypertension, encephalopathy, diabetes mellitus, cardiopulmonary disease, and above the knee amputation. On the minimum data set assessment (MDS) with assessment reference date 4/4/16, the resident scored 14/15 on the brief interview for mental status. The resident was assessed as being without signs of delirium, psychosis, or behaviors affecting others.<br><br>During clinical record review on 6/23/16, the surveyor noted a physician order dated 6/8/16 for a CXR (chest X-ray) 2 views wheezing COPD (cardiopulmonary disease) r/o (rule out) pneumonia. Radiology results on the clinical record dated 6/8/16 were for chest - 1 view (AP (anterio-posterior)). The record contained no documentation to indicate that the order had been changed or that the physician had been notified that only one view had been obtained.<br><br>The surveyor discussed the process for obtaining the chest X-ray with the resident's nurse on 6/23/16. The nurse stated that the nurse taking the order called the radiology provider and read the order to the person taking the order. The provider then faxed the order for the technician to the nurse's station. The nurse attached the | F 510 | F-510<br><br>1. Resident #20's physician was notified that a 2 view x-ray was ordered on 06/08/16 and only a 1 view x ray was obtained with no new orders given.<br>Resident #20 was re-assessed by the Unit Manager on 07/15/16 with no change in condition noted.<br>2. The Unit Managers will complete an audit by 07/22/16 of the current residents' medical record to ensure radiology and other diagnostic services are provided per physician orders.<br><br>3. The licensed nurses will be re-educated by the Staff Development Coordinator by 07/22/16 related to ensuring radiology and other diagnostic services are provided per physician orders<br><br>4. The Unit Managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure radiology and other diagnostic services continue to be provided per physician's orders. The Director of Nursing will submit a report to the | |

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| F 510 | Continued From page 22<br>written order to the faxed order for the technician to check prior to obtaining the X-ray. She stated that there is a triple check to ensure the technician performs the right test.<br><br>The unit manager, director of nursing, and administrator were notified of the concern during a summary meeting on 6/23/16, | F 510 | Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.<br><br>Completion date: | 07/23/16 |
| F 514 SS=E | 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>Based on observation, staff interview and clinical record review it was determined the facility staff failed to keep complete, accurate clinical records for 2 of 28 residents (Residents #17, 14).<br><br>Findings:<br><br>1. Resident #17 was admitted to the facility on 3/10/10. His diagnoses included ESRD (end-stage-renal disease.) The resident's clinical record was reviewed on 6/23/16 at 9:00 AM.<br><br>Resident #17's MDS (minimum data set) | F 514 | F-514<br>1. Resident #17's physician and the dialysis center were notified by the Unit Manager on 06/23/16 related to the missing and incomplete dialysis communication sheets with no new orders noted.<br>Resident #17 was re-assessed by the licensed nurse on 06/23/16 with no change in condition noted.<br><br>Resident #14's physician was notified on 06/23/16 by the Charge Nurse and an order clarification related to the Comprehensive Metabolic Profile was obtained.<br><br>2. The Unit managers will complete an audit by 07/22/16 of the current residents' medical record to ensure dialysis communication sheets are completed and monthly POSs reflect current physician's orders with | |

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assessment dated 3/31/16 coded the resident as cognitively unimpaired. He was coded with ESRD

The resident's CCP (comprehensive care plan, updated 5/9/16, indicated the problem of end stage renal disease. The intervention was dialysis "as ordered."

Resident #17's physician's orders, signed and dated 6/7/16 included an order for the staff to get the resident to dialysis on Mondays, Wednesdays and Fridays.

The clinical record contained a dialysis communication sheet with a section for facility staff to fill out the date and vital signs prior to the resident going out. This information was conveyed to the off-site dialysis facility where staff were to complete their section of the form and send it back. This was to occur for each dialysis session, three days a week as scheduled.

The records were reviewed for March 2016 through June 23rd 2016. The inspector observed there were NO communication sheets for the following dates: 6/22/16, 6/17/16, 6/13/16, 6/10/16, 6/8/16, 5/23/16, 5/20/16,5/11/16, 5/13/16, 5/4/16, 5/6/16, 3/9/16. Incomplete sheets were observed on 3/4/16, 3/25/16, 5/27/16, and 6/6/16.

These observations were shared with LPN I at 9:30 AM. She said sometimes the dialysis clinic did not send the info back at all and they (nursing staff) were supposed to call the clinic and get the documentation completed.

The administrator was informed of these findings on 6/23/16 at 10:00 AM. No additional info was provided.

clarifications are completed as required.

3. The licensed nurses will be re-educated by the Staff Development Coordinator by 07/22/16 related to ensuring dialysis communication sheets are complete and monthly POS are current per physician's orders with clarification orders obtained as required.
4. The Unit Managers will complete audits weekly for 4 weeks and monthly for 2 months to ensure dialysis communication continue to be completed and clarification orders continue to be obtained as required. The Director of Nursing will submit a report to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow up.

Completion date: 07/23/16

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2. For Resident #14 the facility staff failed to ensure a complete and accurate Physician Order Sheets (POS's).

Resident #14 was an 84 year old female who was admitted on 6/2/15. Admitting diagnoses included, but were not limited to: dementia, osteoporosis, hyperlipidemia and glaucoma.

The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 6/9/16. The facility staff coded that Resident #14 had a Cognitive Summary Score of 3. The facility staff also coded that Resident #14 required limited (2/2) to total nursing care (4/2) with Activities of Daily Living (ADL's).

On June 22, 2016 at 8:45 a.m. the surveyor reviewed Resident #14's clinical record. Review of the clinical record produced a signed Physician Order Sheets (POS's). Review of the signed POS ' s revealed the following order: "COMP (Comprehensive Metabolic Profile) (CMP) Q (EVERY) 6 MONTHS (JAN/APR/JUL/OCT) (January, April, July, October)." (sic) The order originated on 9/8/15. The order read to obtain the COMP (CMP) every 6 months, but then stated to draw the COMP (CMP) quarterly. The order was not clearly defined as to when to obtain the COMP (CMP).

Continued review of the clinical record produced the results of a COMP (CMP) every quarter (October, January, April and July).

On June 22, 2016 at 9:45 a.m. the surveyor notified a Licensed Practical Nurse (LPN #1) and the Unit Manager (UM), who was an LPN, that

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| F 514 | Continued From page 25<br>Resident #14's POS's were incorrect. The surveyor reviewed the signed POS's with LPN (#1) and the UM. The surveyor pointed out that order for the COMP (CMP) was not clear. The surveyor pointed out that the order read for the lab to be obtained every 6 months, however, the order also directed for the facility staff to obtain the COMP (CMP) every quarter. The surveyor reviewed the Oct, Jan, April and July COMP (CMP) results with LPN (#1) and UM. The surveyor notified LPN (#1) and UM that the order to obtain the COMP (CMP) was not clear.<br><br>On June 22, 2016 at 2:25 p.m. the survey team met with the Administrator (Adm) and Director of Nurses (DON).The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate POS's for Resident #14. The surveyor notified the AT that the physician order for obtaining a CMP (CMP) was not clear.<br><br>No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate POS's for Resident #14. | F 514 | | |

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| F 000 | Initial Comments | F 000 | | |

An unannounced Medicare/Medicaid standard survey and and complaint survey was conducted 6/21/16 through 6/23/16. Two complaints were investigated. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.

The census in this 180 certified bed facility was 141 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents #1 through #21 & #28) and 6 closed record reviews (Residents #22 through #27).

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:
The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.
12 VAC 5-371-150. Resident Rights.
12 VAC 5-371-150 (A,B.1,B.3,C,D): Cross reference to F- 155,156.

12 VAC 5-371-150. Resident Rights.
12 VAC 5-371-150 (B.3): Cross reference to F-167.

12 VAC 5-371-370. Quality of Life.
12 VAC 5-371-370 (A, B,C,D,E,G,H,I): Cross reference to F-256.

12 VAC 5-371-250. Resident assessment and care planning.
12 VAC 5-371-250 (G) Cross Reference to F-279

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12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (A THRU G) Cross reference to F-309.

12 VAC 5-371-220. Quality of Care.
12 VAC 5-371-220 (B) Cross reference to F- 333.

12 VAC 5-371-310. Administration.
12 VAC 5-371-310 (A) Cross reference to F-502, 504.

12 VAC 5-371-360. Clinical Records
12 VAC 5-371-360 (A,E,f,j) Cross Reference to F-514