STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

(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 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid survey was conducted 8/9/16 through 8/11/16. Complaints were investigated during the survey. 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 312 certified bed facility was 298 at the time of the survey. The survey consisted of 27 current Resident reviews (Resident #1 through #27) and 3 closed reviews (Resident #28 through #30)

F 225 SS=G 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS — F 225

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dan R Sutton — TITLE: Administrator — (X6) DATE: 9/1/16

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 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken This REQUIREMENT is not met as evidenced by Based on staff interview, facility document review, clinical record review , and in the course of a complaint investigation, the facility staff failed to ensure 1 of 30 residents was free from abuse(Resident #1) The findings include The facility staff failed to ensure Resident #1 was free from abuse Resident #1 was admitted to the facility on 12/5/12 with diagnoses of neurogenic bladder, dementia, hypertension, fractured femur, anxiety, congestive heart failure, gastro-esophageal reflux disease, and osteoporosis The current quarterly MDS with a reference date of 5/29/16 was reviewed The resident was assessed with a cognitive score of "0" of ' 15" The resident was assessed requiring total assistance of 2 persons for toileting, dressing,	F 225	Past noncompliance no plan of correction required	

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F 225	Continued From page 2	F 225		

bed mobility, transfers, bathing, and hygiene The resident was coded to resist care

The comprehensive care plan was reviewed The care plan included a problem listed the resident was alert but delusional and had episodes of being combative and resistive to care. The interventions included to attempt redirection techniques when resident became confused and provide support and reassurance when expressing negative ideations.

The director of nursing (DON) was interviewed on 8/10/16 at 1:45 p.m. about the incident The DON stated a family member had provided her with a video taken in the resident's room from a "nannie cam" set up by the family member The DON stated she viewed the video and immediately terminated the certified nursing assistant (CNA#1) involved The police were notified, APS notified, DHP notified, and the Office of Licensure and Certification notified

The video was viewed by two members of the survey team The surveyors observed CNA#1 enter Resident #1's room on 3/15/16 CNA#1 approached the bed and did not speak to the resident CNA#1 pulled the covers off the resident and roughly pulled off the blue booties the resident had on her feet. She then pulled the resident's gown off and roughly pulled it off her arms and rubbed it in the resident's face The resident was holding up in hands in a defensive manner. CNA#1 then stepped out of view and water could be heard running The resident was left uncovered at this time. CNA#1 returned with a pan of water for bathing. She grabbed the resident's arm and jerked her up and roughly turned her to her side and pushed on her, then

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F 225	Continued From page 3	F 225		

grabbed her arm and pulled her up and then grabbed her hair and lifted the resident off the bed. The CNA spoke to the resident and could be heard saying "I hope you do spit on me." CNA#1 then glanced to the door and could be seen spitting in the resident's face which she roughly wiped off. At this point a voice could be heard and a family member entered the room. CNA#1 then handled and spoke to the resident in gentle manner as she spoke with the family member.

The DON provided the facility investigation into the incident.

The DON provided the facility plan of correction as follows
The CNA was terminated and Resident #1 was examined and no injuries noted
All residents cared for by CNA#1 were assessed and interviewed if possible and none had any complaints
All staff were inserviced on "Caring for Residents with Dementia, Resident Rights, and Treating Residents with Respect and Dignity".
Resident #1 will have 2 CNAs whenever she requires care and house RN supervisors will monitor care more closely for all residents. The nannie cam will remain in place without audio and only pointed towards Resident #1.
The completion date was noted to be 3/31/16.

The DON and quality assurance director were informed on 8/10/16 at 4:00 p.m. that this complaint would be substantiated as a past non compliance issue

F 278 SS=D 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED — F 278

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F 278	Continued From page 4 The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) for 1 of 30 residents (Resident #1). The findings include: The facility staff failed to ensure the MDS was	F 278	F 278 Resident #1's MDS was modified to show that no Foley catheter is present. 8/11/16 The MDS of all residents with Foley catheters that have received an order for removal will be audited to show that no Foley catheter is present when the update of the MDS is due, or if a significant change occurs. This will be completed by the MDS Assessment Coordinator. 9/16/16 Results of the audit will be reviewed by the Quality Assurance Coordinator and Director of Nursing with appropriate action taken. 9/16/16 The Director of Nursing will ensure compliance. 9/16/16 Quarterly, 10% of all residents who have had Foley catheters removed will have their MDS audited to ensure that the Foley catheter is not marked on the MDS that was completed after Foley removal. This will be completed by the MDS Assessment Coordinator. 9/23/16 Audit results will be reviewed by the Quality Assurance Coordinator and the Director of Nursing with appropriate action taken. 9/23/16	

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F 278	Continued From page 5 accurate for Resident #1. Resident #1 was admitted to the facility on 12/5/12 with diagnoses of neurogenic bladder, dementia, hypertension, fractured femur, anxiety, congestive heart failure, gastro-esophageal reflux disease, and osteoporosis. The current quarterly MDS with a reference date of 5/29/16 was reviewed. The resident was assessed with a cognitive score of "0" of "15". The resident was assessed requiring total assistance of 2 persons for toileting, dressing, bed mobility, transfers, bathing, and hygiene. The resident was coded to have a Foley catheter. The clinical record was reviewed. The record contained a physician order to remove the Foley catheter on 3/24/16. A staff nurse (LPN#2) was interviewed on 8/10/16 at 3:00 p.m. LPN#2 stated the resident did not have a catheter and was doing well at this time without the catheter and voiding adequate amounts. The director of nursing and Quality assurance nurse were informed of the finding during a meeting with the survey team on 8/10/16 at 4:00 p.m.	F 278	The QA Coordinator will ensure compliance. 9/23/16 (See Attached Form) These systemic changes will ensure continued compliance with the regulation. 9/23/16	
F 280 SS=D	483.20(d)(3) 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	F280 Resident #1's care plan was revised to show that no Foley catheter was present. Voiding incontinently with appropriate care plan interventions, was added. 8/11/16	

ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER, INC.

FOLEY CATHETER MDS AUDIT

LIST OF RESIDENTS WITH FOLEY CATHETERS	REMOVAL DATE	MDS AFTER REMOVAL OF FOLEY MARKED	IF YES, ACTION TAKEN
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
		☐ YES ☐ NO	
COMPLETED BY:		REVIEWED BY:	

FORM: FOLEY CATHETER MDS AUDIT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 6 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by. Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan for 1 of 30 residents (Resident #1). The findings include The facility staff failed to review and revise the comprehensive care plan for Resident #1 to reflect the resident no longer had a Foley catheter in use. Resident #1 was admitted to the facility on 12/5/12 with diagnoses of neurogenic bladder, dementia, hypertension, fractured femur, anxiety, congestive heart failure, gastro-esophageal reflux disease, and osteoporosis The current quarterly MDS with a reference date of 5/29/16 was reviewed. The resident was	F 280	A one-time 100% audit of care plans of all residents whose Foley catheter has been removed will be conducted by the MDS Assessment Coordinator to ensure that measures related to the Foley catheter have been discontinued, and measures related to current bladder status are present. 9/16/16 Results of this audit will be reviewed by the QA Coordinator and DON with appropriate action taken. 9/16/16 The DON will ensure compliance. 9/16/16 Quarterly, an audit of 10% of all residents whose Foley has been removed during the quarter will be conducted to ensure that Foley catheter measures are not present on the care plan and measures related to current bladder status are present. 9/23/16 The QA Coordinator and DON will review the results of the audit with appropriate action taken. 9/23/16 The QA Coordinator will ensure compliance. 9/23/16 (See Attached Form) These systemic changes will ensure continued compliance with the regulation. 9/23/16	

ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER, INC.

FOLEY CATHETER CARE PLAN AUDIT

LIST OF RESIDENTS WITH FOLEY CATHETERS REMOVED	MEASURES ON CARE PLAN RELATED TO FOLEY CATHETER	IF YES, ACTION TAKEN
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
COMPLETED BY:	REVIEWED BY:	

FORM: FOLEY CATHETER CARE PLAN AUDIT

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F 280	Continued From page 7 assessed with a cognitive score of "0" of "15". The resident was assessed requiring total assistance of 2 persons for toileting, dressing, bed mobility, transfers, bathing, and hygiene. The resident was coded to have a Foley catheter The clinical record was reviewed. The record contained a physician order to remove the Foley catheter on 3/24/16 The comprehensive care plan was reviewed. The care plan contained a problem listed the resident had bowel incontinence and a Foley catheter due to urinary retention from neurogenic bladder. The interventions included catheter care every shift, monitor catheter tubing for kinks or twists, change Foley catheter q 30 days and prn, irrigate Foley catheter with 30-40 ml NS prn, and flush with 30 ml BID to maintain patency. A staff nurse (LPN#2) was interviewed on 8/10/16 at 3:00 p.m. LPN#2 stated the resident did not have a catheter and was doing well at this time without the catheter and voiding adequate amounts. The director of nursing and Quality assurance nurse were informed of the finding that the care plan had not been revised during a meeting with the survey team on 8/10/16 at 4:00 p.m.	F 280	F 280	
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.	F 285	F285 A PASRR Level 2 screening has been requested and the screening team will come to Roman Eagle and complete the Level 2 on Resident #22.	9/23/16

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F 285 Continued From page 8

A nursing facility must not admit, on or after January 1, 1989, any new residents with
(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission:
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and
(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation
(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and
(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation

For purposes of this section:
(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1)
(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.

F 285 A one-time 100% audit of residents who have a diagnosis of mentally challenged (intellectually disabled) will be conducted by the Social Services Director to ensure the correct PASRRs are present on the electronic medical record. 9/16/16

Results of this audit will be reviewed by the QA Coordinator and Assistant Administrator with appropriate action taken. 9/16/16

Prior to admission of a resident with the diagnosis of mentally challenged (intellectually disabled), the Admission Coordinator will ensure that the facility has the correct PASRR screening. This will be verified by the Assistant Administrator. 8/15/16

The Assistant Administrator will ensure compliance. 9/16/16

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F 285	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to ensure a complete and accurate PASRR (preadmission screening and Resident review) for 1 of 30 Residents. (Resident # 22) The findings included: For Resident # 22 the facility staff failed to ensure an accurate PASSR. Resident #22 was admitted to the facility on 07/29/16. Diagnoses included but not limited to intellectual disabilities, depression, gastroesphageal reflux disorder, hypothyroidism and schizophrenia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 08/05/16 coded the Resident as 15 out of 15 in section C, cognitive patterns. Section A, subsection A1510 of the MDS, level II PASRR Conditions, coded the Resident as "Intellectual Disability" Resident #22's clinical record was reviewed on 08/11/16. It contained a level 1 PASRR dated 06/12/06. Section A3 "Does the individual have a diagnosis of mental retardation (MR) which was manifested before age 18" was checked as "no" The surveyor spoke with the DON (director of nursing) on 08/11/16 at approximately 1030 regarding Resident #22's PASRR. DON stated that since Resident was only "mild ID" she did not need the level II PASRR. The concern of the incorrect PASRR was	F 285	Quarterly, 10% of all residents with the diagnosis of mentally challenged (intellectually disabled), electronic medical record will be audited by the Social Services Director to ensure that the appropriate PASSR screening is present. The Quality Assurance Coordinator and Assistant Administrator will review the results of the audit with appropriate action taken. 9/23/16 The QA Coordinator will ensure compliance. 9/23/16 (See Attached Form) These systemic changes will ensure continued compliance with the regulation. 9/23/16	

ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER, INC.

PASSR SCREENING AUDIT

RESIDENT WITH DIAGNOSIS OF MENTALLY CHALLENGED (INTELLECTUALLY DISABLED)	PASSR SCREENING CORRECT	IF NO, ACTION TAKEN
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	

COMPLETED BY:	REVIEWED BY:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 285	Continued From page 10 discussed during a meeting with the administrative staff on 08/11/16 at approximately 1235. No further information was provided prior to exit	F 285		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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	F 441	F441 Resident #6's dressing is being changed every M-W-F and prn with appropriate infection control measures followed. 8/12/16 LPN #1 has been inserviced on appropriate infection control techniques when performing wound care. 8/12/16 A one-time 100% audit will be conducted by the Staff Development Coordinator of residents receiving wound care by the treatment nurse to ensure appropriate infection control measures are followed. 9/16/16 (See Policy Attached) The results of the audit will be reviewed by the Quality Assessment Coordinator and Director of Nursing with appropriate action taken. 9/16/16 The DON will ensure compliance. 9/16/16	

DRESSINGS - CLEAN

POLICY STATEMENT

It is the policy of this facility to perform dressings as ordered by physician.

EQUIPMENT:

1. Appropriate dressings
2. Clean gloves
3. Prescribed cleaning solution
4. Container for soiled dressings

Procedure

1. Explain procedure to resident and bring equipment to bedside. Screen resident.
2. Assist resident to required position and expose area to be dressed.
3. Wash hands thoroughly.
4. Clean work surface with antiseptic.
5. Wash hands with antiseptic.
6. Open dressings and needed supplies.
7. Put on clean gloves. Remove soiled dressings and discard in container.
8. Place barrier beneath wound if likelihood of touching linen.
9. Wash hands with antiseptic. Put on clean gloves.
10. Cleanse wound with prescribed solution (if ordered).
11. Change barrier beneath wound if soiled.
12. Apply dressings. Secure with tape if necessary.
13. Remove gloves and dispose in container.
14. Tie and discard bag containing soiled dressings.
15. Wash hands.
16. Take soiled dressing to dirty utility room.
17. Wash hands thoroughly.
18. Chart procedure in clinical nursing record, condition of wound and surrounding area, character and amount of drainage. Include pertinent observations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING _____ B. WING _____	C 08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER	2526 NORTH MAIN STREET DANVILLE, VA 24540

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F 441	Continued From page 11 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to follow infection control policy and procedure during wound care for 1 of 30 residents (Resident #6). The findings include: The facility staff failed to follow infection control policy and procedure during wound care for Resident #6. Resident #6 was admitted to the facility on 2/23/16 and re-admitted on 7/21/16 with diagnoses of pressure ulcer, hypertension, Alzheimer's disease, delusional disorder, anemia, anxiety, transient ischemic attack, osteomyelitus, chronic pain, and gastro-esophageal reflux disease. The current significant change Minimum Data Set (MDS) with a reference date of 7/28/16 assessed the resident with a cognitive score of "8" of "15". The resident was assessed requiring total assistance of 1 person for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene. A staff nurse (LPN#1) was observed performing wound care for Resident #6 on 8/10/16 at 10:35 a.m. LPN#1 carried supplies into the room in	F 441	Quarterly, The Staff Development Coordinator will audit the treatment nurse performing wound care to 10% of residents receiving wound care. Results of audit will be reviewed by the QA Coordinator and Director of Nursing with appropriate action taken. 9/23/16 The QA Coordinator will ensure compliance. 9/23/16 (See Attached Form) These systemic changes will ensure continued compliance with the regulation. 9/23/16	

ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER, INC.

WOUND CARE AUDIT

RESIDENTS RECEIVING WOUND CARE	WOUND CARE PERFORMED FOLLOWING APPROPRIATE INFECTION CONTROL MEASURES (according to policy)	IF NO, ACTION TAKEN
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	
	☐ YES ☐ NO WOUND CARE PROVIDED BY:	

COMPLETED BY:	REVIEWED BY:

FORM: WOUND CARE AUDIT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495015	A. BUILDING _____ B. WING _____	C 08/11/2016

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F 441	Continued From page 12	F 441		

plastic baggies and placed the baggies on the resident's bed. LPN#1 then prepared a clean barrier on the bedside table, washed her hands, placed the clean items on the barrier from the baggies and placed the baggies on the bedside table. LPN#1 washed her hands and donned gloves and removed the old dressing from the resident's sacral area. LPN#1 then removed the old packing from the wound and proceeded to clean the wound by flushing with normal saline and patting the wound dry. LPN#1 then placed the new packing in the wound and covered the wound with the new dressing. LPN#1 failed to change gloves between removing the old dressing and placing the new clean dressing. LPN#1 then cleaned her supplies and placed them back into the plastic baggies and carried the baggies back to the wound supply cart in the hall. LPN#1 was informed of the findings and stated she usually did change gloves after removing the old dressing.

The director of nursing was asked for the facility policy and procedures for wound care. The policy stated for handwashing that hands should be washed "before and after handling items potentially contaminated with any resident's blood,excretions, or secretions". The procedure for a clean dressing was to "remove soiled dressings and discard in container, wash hands with antiseptic, and put on clean gloves , then cleanse the wound and apply the clean dressing".

The director of nursing and quality assurance director were informed of the finding during a meeting with the survey team on 8/10/16 at 4:00 p.m.

F 514 483.75(l)(1) RES

F 514

F514

Resident #8's physician order was clarified to state that a nasal cannula or face mask may be used to administer oxygen at 2-4 liters prn. 8/10/16

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F 514 SS=D	Continued From page 13 RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented, readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 30 residents (Resident #8) The findings included: Resident #8 was admitted to the facility on 7/18/14 with the following diagnoses of, but not limited to dementia, anemia, high blood pressure, high cholesterol and osteoporosis. The quarterly MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 4/22/16 coded Resident #8 as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. The resident was also coded as requiring total dependence from 1 staff member for dressing, personal hygiene and bathing.	F 514	A one-time 100% audit of all residents with physician orders for oxygen will be conducted by nursing supervisors to ensure that the order states nasal cannula or face mask unless counter-indicated. The nursing supervisors will check residents with oxygen to ensure oxygen is being administered by the ordered method. 9/16/16 Results of this audit will be reviewed by the QA Coordinator and DON with appropriate action taken. 9/16/16 Each shift, the medication nurse will check the administration of oxygen on residents on the unit where they are working, to ensure oxygen is being administered according to the physician's order. This is then documented on the MAR. 8/12/16 The DON will ensure compliance. 9/16/16 Quarterly, the electronic records of 10% of all residents receiving oxygen will be audited to ensure that the physician order for oxygen administration matches the method of administration of oxygen (nasal cannula/face mask) on the resident. This audit will be conducted by the nursing supervisors. 9/23/16	

ROMAN EAGLE REHABILITATION AND HEALTH CARE CENTER, INC.

OXYGEN METHOD AUDIT

RESIDENTS RECEIVING OXYGEN PHYSICIAN ORDERED METHOD NASAL CANNULA/FACE MASK	PHYSICIAN ORDERED METHOD ON RESIDENT, APPLIED CORRECTLY	IF NO, ACTION TAKEN
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	
	☐ YES ☐ NO	

COMPLETED BY:	REVIEWED BY:

FORM: OXYGEN METHOD AUDIT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 14 The clinical record of Resident #8 was reviewed by the surveyor on 8/9/16 at approximately 3pm. The resident ' s MAR (Medication Administration Record) for August, 2016 reflected the following physician order. " Oxygen 2-4 L/M (liters per minute) via (by) face mask d/t (due to) hypoxia " An observation was made by the surveyor on 8/10/16 at 8.10 am. The resident was observed being fed by a CNA (Certified Nursing Assistant). The resident had oxygen at 2 liters per minute being administered by nasal cannula. At 11 am, the director of nursing (DON) was notified of the above observation made by the surveyor. The DON stated " I believe he was sick and had to use facial mask but they should had switched all of that to nasal cannula when he got better. " At 4 pm, the director of nursing and quality assurance nurse were notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 8/11/16	F 514	Results of this audit will be reviewed by the QA Coordinator and DON with appropriate action taken. 9/23/16 The QA Coordinator will ensure compliance. 9/23/16 (See Attached Form) These systemic changes will ensure continued compliance with the regulation. 9/23/16 Submission of this plan of correction is made in compliance with federal mandates and does not constitute an admission by the nursing facility that deficiencies exist, were correctly cited or require correction. 9/23/16 Allegation of Compliance: This plan of correction with the stated correction dates constitutes the nursing facility's allegation of compliance with the listed federal and state licensure requirements. 9/23/16	