STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E215	A. BUILDING _____ B. WING _____	06/07/2018

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 6/5/18 through 6/7/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicaid standard survey inspection was conducted 6/5/18 through 6/7/18. No 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 60 certified bed facility was 59 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents #6, #43, #20, #34, #52, #48, #28, #47, #23, #34, #50, #3, #40, #17, #39, #26, #5) and 2 closed record reviews (Residents #60 (a), (b).	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 637		7/13/18

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

Electronically Signed | 06/28/2018

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F 637	Continued From page 1 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility policy, and the RAI (Resident Assessment Instrument) 3.0 Manual, the facility failed to identify and complete a significant change in status assessment (SCSA) Minimum Data Set (MDS) for one resident (#5) out of a sample of 19 residents surveyed after the resident had declines in weight and appetite. Findings include: Resident #5 was admitted to the facility on 9/21/2015. Her diagnoses included: Alzheimer's disease, Parkinson's disease, Depression, Anxiety, and Gastro-Esophageal Reflux disease. A review of the medical record showed a SCSA MDS with an assessment reference date of 2/9/2018, and a Quarterly MDS with an assessment reference date of 4/25/2018. The 2/9/2018 MDS showed the resident had poor appetite or overeating (MDS field D0200E2) for half or more of the days (code 2) assessed by this MDS, and a weight of 163 pounds. The 4/25/18 MDS showed the resident had poor appetite or overeating (MDS field D0200E2) for nearly every day (code 3) of the period assessed by this MDS, and a weight of 143 pounds. The 4/25/2018 MDS recorded a weight loss of more than 10% over 180 days in MDS item K0300. On 6/7/2018 at 12:30 PM, Admin F (the corporate MDS consultant) was asked why a SCSA had not been completed in lieu of the 4/25/10 Quarterly MDS. On 6/7/2018 at 1:50 PM, Admin F stated to the surveyor "we should have done a significant	F 637	F □ 637 Comprehensive Assessment after Significant Change 1. A significant change assessment with ARD of February 9, 2018 was completed and submitted on resident #5 on June 13, 2018. The care plan has been revised by the Interdisciplinary Team (IDT) to include the significant change. 2. All residents within the facility are at potential risk for not having a significant change and status assessment completed. The MDS coordinator will review all residents for change in condition by June 29, 2018 and any resident identified as meeting the criteria will have a significant change MDS completed within 14 days. 3. Residents will be evaluated weekly at the At Risk meeting by the IDT for significant changes with ADR□s set as needed. When two or more areas of change are identified and the IDT determines a significant change is not required a clinical note will be entered into the medical record. The Director of Clinical Reimbursement/Designee will re-educate the IDT by June 28, 2018 on the criteria and procedure needed to schedule a significant change MDS and to ensure proper documentation in the clinical record after change is identified. 4. The Director of Clinical Reimbursement/Designee will review two residents MDS□s weekly for four weeks then one resident weekly for eight weeks for identification and completeness of a	

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F 637	Continued From page 2 change- there is no note to show why one wasn't done." A review of the RAI MDS 3.0 Manual, version 1.15R showed the following guidance: If a significant change in status is identified in the process of completing any OBRA assessment except Admission and SCSAs, code and complete the assessment as a comprehensive SCSA instead. (Page 2-20) A "significant change" is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting"; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. (Page 2-22) The final decision regarding what constitutes a significant change in status must be based upon the judgment of the IDT. MDS assessments are not required for minor or temporary variations in resident status - in these cases, the resident's condition is expected to return to baseline within 2 weeks. However, staff must note these transient changes in the resident's status in the resident's record and implement necessary assessment, care planning, and clinical interventions, even though an MDS assessment is not required. (Page 2-24) A SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement. In this example, a resident with a	F 637	significant change MDS. The results of the audits will be reported at the quarterly QA meeting by the MDS Coordinator/designee for evaluation of compliance and ongoing monitoring for the continuous improvement. 5. All corrective actions will be completed by July 13, 2018.	

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F 637	Continued From page 3 5% weight loss in 30 days would not generally require a SCSA unless a second area of decline accompanies it. Note that this assumes that the care plan has already been modified to actively treat the weight loss as opposed to continuing with the original problem, "potential for weight loss." This situation should be documented in the resident's clinical record along with the plan for subsequent monitoring and, if the problem persists or worsens, a SCSA may be warranted. (Page 2-25) A review of the provider's Resident Assessment Instrument Policy and Procedure shows: 1) The Assessment Coordinator or designee is responsible for ensuring that the Interdisciplinary Assessment Team conduct timely resident assessments and reviews according to the following schedule: b) When there has been a significant change in the resident's condition No further information was provided prior to exit.	F 637		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		7/13/18

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F 657	Continued From page 4 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed, for 1 resident (Resident #50) in the survey sample of 19 residents, to review and revise the care plan. The facility staff failed to review and revise the care plan to include interventions for a facial skin disorder. The Findings included: Resident #50 was a 76 year old who was admitted to the facility on 9/19/16. Resident #50's diagnoses included Diabetes Mellitus Type 2, Depressive Disorder, Anxiety Disorder, and Dry Scaly Skin (facial and behind both ears). The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 4/25/18 was reviewed. It coded Resident #50 as having a Brief Interview of Mental Status	F 657	F □ 657 Care Plan Timing and Revision 1. The facility failed to review and revise the care plan for resident #50 to include interventions for a facial skin disorder. The care plan was revised with interventions on June 7, 2018. 2. The DON/Designee will review all residents all residents□ interventions to ensure the care plan aligns with current orders. Care plans will be updated as indicated by the DON/Designee by June 29, 2018. 3. The DON/Designee will conduct staff education on the Comprehensive Care Plan and how to ensure interventions are specific to orders by July 11, 2018. 4. The DON/Designee will audit care plan interventions on three residents weekly for four weeks then two residents weekly for eight weeks. The results of the audits will be reported at the quarterly QA meeting by the DON/Designee for	

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F 657	Continued From page 5 Score of 15, indication no cognitive impairment. On 6/6/18 at 9:24 A.M., an interview was conducted with Resident #50 in her room. She stated, "I took very good care of my skin. I had very nice skin. Now I have an itchy rash on my face and behind my ears. I keep asking for some medication, and they just ignore me. The nurse just keeps telling me not to scratch it. It itches terribly all the time." Resident #50 was observed to have large patches of darkened, dry scaly raised areas on her face, which included her entire forehead and chin. On 6/6/18 a review was conducted of Resident #50's clinical record, revealing the following signed Physician's order, "1/30/18. Triamcinolone Acetonide 0.1%. Apply thin layer to facial area near hairline and behind ears D/T (due to) Dry Scaly Skin. BID (twice daily) x 14 days then PRN (as needed). According to the Medication Administration Record, the medication was administered for 14 days only, and never used again. Resident #50's care plan was reviewed. After the facial skin disorder was identified, and a treatment ordered, the facility staff failed to review and revise the care plan to include interventions. On 6/6/18 at 10:00 A.M., an interview was conducted with Licensed Practical Nurse C (LPN C). She showed the surveyor the large tube of Triamcinolone acetonide, which appeared to still be about 80% full. She stated that the medication hadn't been administered because it was a PRN order. We then entered Resident #50's room. When asked to describe Resident #50's facial skin, she stated, "Dryness and discoloration of	F 657	evaluation of compliance and ongoing monitoring for the continuous improvement. 5. The corrective action will be completed by July 13, 2018.	

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F 657	Continued From page 6 her forehead in both temple areas and chin. Also, some bumps. Dryness in the folds of her neck. I see a reddened area that is hard to the touch, it's a raised area, no drainage, and flaky skin on her chin." On 6/7/18 at 10:30 A.M., an interview was conducted with the Executive Nurse (Administration D) in Resident #50's room. When asked to describe the condition of Resident #50's skin, the Executive Nurse stated, "Some bumps on her chin, some raised areas that's kinda hard. The skin on her forehead is dry and has a rash." On 6/7/18 at approximately 4:00 P.M., the Director of Nursing (Administration B), and the Administrator (Administration A) were informed of the findings. They did not provide an explanation or any documentation regarding why Resident #50's care plan had not been reviewed and revised.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interview, facility documentation and clinical record review, the facility staff failed for one resident, Resident #43 in a survey sample of 19 residents, provide incontinence care. Resident #43 did not receive incontinence care from 10:15 AM until 2:20 PM.	F 677	F- 677 ADL Care Provided for Dependent Residents 1. The CNA was immediately educated by the DON on June 7, 2018 to ensure that incontinence care is performed at least every two hours and as needed. Re-education for the same topic will be completed by the DON at the nursing staff	7/13/18

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F 677	Continued From page 7 The findings included: Resident #43 was admitted to the facility on 11/10/17. Diagnoses included Alzheimer's dementia, atrial fibrillation and high blood pressure. Resident #43's most recent MDS (minimum data set) with an ARD (assessment reference date) of 5-28-18 was coded as a quarterly assessment. The resident was coded as having severe cognitive impairment.. Resident #43 was also coded as extensive to total assistance of one to two staff member to perform activities of daily living (ADL's) including toileting. On 6/6/18 at 10:55 AM, Resident #43 was observed to be up in her chair in the dining room, sitting with her spouse. On 6/06/18 at 11:00 AM, an interview with the spouse was conducted. The spouse stated, "They are not changing her diapers, they are short staffed, especially on weekends." He went on to state from the time she is up in the morning until 2:45 PM, she is not changed and that often when she is changed she is "soaked." He also stated that she is not gotten up until 10-11:00 AM sometimes because of staffing. He stated he did bring this to the Administrator's attention, and it has gotten somewhat better. On 6/06/18 at 2:30 PM, CNA(certified nursing assistant) A was asked to see incontinence care. She stated it had already been done by CNA (B). CNA (A) opened the brief for a skin observation. The resident's groin and backside were slightly red. There was no urine odor.	F 677	meeting on July 11, 2018. 2. All residents requiring assistance with toileting/incontinence assistance are at potential risk for lack of incontinence care. DON/designee will immediately educate on June 21, 2018 and ongoing to all staff on timeliness of toileting/incontinence care 3. The DON/Designee will provide in-service on timely incontinence care to nursing on June 21, 2018 and ongoing. DON/Designee will monitor the ADL incontinence report to ensure incontinence care is provided. 4. The DON/Designee will monitor three residents per week for four weeks then two residents for eight weeks to ensure incontinence care is performed timely. The results of the incontinence care observation audit will be reported quarterly by the DON/designee at the QA meeting for evaluation and compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. The corrective action will be completed by July 13, 2018.	

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F 677	Continued From page 8 On 6/06/18 at 3:11 PM, an interview was conducted with CNA (B). She stated, "I got her up at 9:00 AM. I put her back to bed at 2:20 PM and changed her." Stated, "She had incontinent care at 10:10-10:15." She admitted that it was 4 hours between incontinence changes. She went on to state that the facility only had 4 CNA's on the day shift today and "We need more help. I had 15 residents today." Review of the facility staffing actually revealed there were 7 CNA's on staff for the 7-3 shift. Review of Resident #43's care plan (no date) revealed the following: "Potential for impaired skin integrity, incontinent of bladder." Interventions included: "Offer assistance and /or provide incontinence care promptly when soiled." Review of the facility's policy and procedure for perineal care included the following: "Perineal care will be provided every shift and prn (as needed)." On 6/6/18 at 3:41 PM, the Administrator and DON (director of nursing) were notified of above findings.	F 677		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		7/13/18

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F 880	Continued From page 9 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 10 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review , the facility failed to ensure an effective prevention infection control program. LPN (licensed practical nurse) A and B failed to wash their hands between residents during medication administration. The findings included: On 6/6/18 at 8:20 AM, during observation of a medication administration, LPN (B) was observed coming out of a resident's room wearing gloves. She removed her gloves and proceeded to pour the next resident's medications without cleaning her hands. On 6/6/18 at 8:45 AM, LPN (B) removed the water container from the medication cart. The pocket containing the water pitcher had particles	F 880	F □ 880 Infection Prevention & Control 1. The LPN was immediately educated by the DON on June 7, 2018 to ensure proper handwashing between residents during medication administration 2. All residents within the facility are at potential risk for improper handwashing between residents during medication administration. 3. The DON/Designee will provide in-service to the licensed nursing staff on June 21, 2018 and ongoing regarding the necessity to adhere to the facility procedure for infection control relating to handwashing between residents during medication administration by the DON/ Designee 4. The DON/Designee will observe two nurses per week for four weeks then one nurse weekly for eight weeks to ensure	

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F 880	Continued From page 11 of dark debris at the bottom of the pocket. On 6/6/18 at 8:55 AM, LPN (A) prepared medications. After the administration of the medications, the LPN did not wash or clean her hands after the administration or before the pouring the medications of the next resident. On 6/07/18 at 10:51 AM, a review of the infection control program was conducted with the facility educator (RN-registered nurse) A and the DON (director of nursing). The DON stated her expectation was for the staff to "Wash hands after each contact." Review of the facility's policy and procedure regarding handwashing revealed, ""Hands should be washed after removing gloves, gowns or masks, and before and after medication administration." On 6/6/18, at the end of the day exit, the Administrator and DON were notified of the above findings.	F 880	proper handwashing between residents during medication administration. The results of the handwashing audit will be reported by the DON/designee quarterly at the QA meeting for evaluation and compliance and ongoing monitoring for continuous improvement analysis after the implementation. 5. The corrective action will be completed by July 13, 2018.	