MASONIC HOME OF VIRGINIA

P.O. Box 7866
Henrico, VA 23231-0366

804-222-1694
1-800-262-4644
Fax 804-226-4567

March 5, 2018

Mrs. Elaine Cacciatore
Virginia Department of Health OLC

Mrs. Cacciatore,

Please find the attached Plan of Correction for the Masonic Home of Virginia for our biennial inspection last held on 2/14/18.

Regards,

Robert Adkins
Senior Administrator

COMMONWEALTH of VIRGINIA
Department of Health
Office of Licensure and Certification

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

TYY 7-1-1 OR
1-800-828-1120

9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
FAX (804) 527-4502

February 28, 2018

Mr. Robert Adkins Administrator
Masonic Home of Virginia
4101 Nine Mile Road
Richmond, Virginia, 23223

RE: Masonic Home of Virginia
NH2628

Dear Mr. Adkins:

An unannounced biennial State licensure survey, ending February 14, 2018, was conducted by the Office of Licensure and Certification. All references to regulatory requirements are found in Chapter 12 VAC 5-371 of the Rules and Regulations for the Licensure of Nursing Facilities.

Enclosed is the Copy of the Statement of Deficiencies for the Health Survey. This document contains a listing of the deficiencies found at the time of this inspection.

You are required to file a plan for correcting these deficiencies. Your statements must reflect the specific detailed actions you will take to correct deficiencies, prevent a recurrence of the deficiencies, and measures implemented to maintain compliance. You must also give the specific calendar date on which correction of each deficiency is expected to be completed. The response "Corrected" is not an acceptable response because it does not fulfill the requirement to provide information on preventing recurrence or maintaining compliance. The response "will train staff" is not an acceptable response unless specific information is given on the plan for frequency and methods to evaluate results.

Correction/completion dates must be within forty-five (45) days from the day of the inspection.

After signing and dating your Plan of Correction, please retain one copy of the Report for your files and return the original to this office within ten (10) working days from receiving the report. You will be notified if your Plan of Correction is not acceptable.

A copy of the completed survey report form will be kept on file in this office and will be available for public review. This Division is required to make copies of this report available to other Federal and State regulatory or reimbursement agencies upon request.

If you have any questions, please call me at (804) 367-2100.

Sincerely,

Paul Wade
for

Elaine Cacciatore, LTC Supervisor

Enclosures:
CC: Ombudsman, Joani Latimer

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NP	A. BUILDING _____ B. WING _____	02/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MASONIC HOME OF VIRGINIA	4101 NINE MILE ROAD RICHMOND, VA 23223

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 2/13/18 through 2/14/18. The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated. The census in this 67 bed facility was 21 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1 through #3).	F 000	12VAC4-371-140 Policies and Procedures: Upon receiving notification that the identified incident was not properly documented on one occurrence with resident #3, our staff completed the necessary paperwork to identify the incident. By Monday, March 26, 2018, all nursing staff will have participated in a mandatory inservice on how to properly identify, investigate, document and provide timely notification to a nursing supervisor for all injuries of unknown origin. Director of Nursing or her designee will perform daily audits over all three nursing shifts beginning Monday, March 12 on all Care Center residents, and continue for a 30 day period to ensure staff are in compliance with this identified deficient practice. After 30 days, the Director of Nursing or her designee will complete random audits across all shifts for a period of 15 days to ensure ongoing compliance.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-140 Policies and Procedures. 12VAC5-371-140A. Based on staff interview, facility documentation review, and clinical record review, the facility staff failed for one (Resident #3) of 3 residents in the survey sample to implement the abuse policy. Facility staff observed a 10-11 centimeter (3-4 inch) skin tear of unknown origin on Resident #3's right leg, however the facility staff failed to conduct a thorough investigation and failed to report the injury of unknown origin to the State Agency. The findings included: Resident #3 was admitted to the facility on 6/1/17 with the diagnoses of, but not limited to, dementia, anemia, and delusional disorder-paranoia. The most recent Minimum Data Set (MDS) was a	F 001		

Robert Olk ADMINISTRATOR 3/5/18

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

RECEIVED
MAR 08 2018
VDH/OLC

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F 001	Continued From Page 1	F 001	12VAC4-371-140 Policies and Procedures (Continued)	

quarterly assessment with an Assessment Reference Date (ARD) of 11/29/17. The MDS coded Resident #3 with severe cognitive impairment; no behaviors; impaired vision; unsteady balance; and required extensive assistance from staff for bed mobility, transfers, dressing, and hygiene; and was dependent on staff for bathing.

On 2/13/18 at 3:35 p.m. Resident #3's clinical record was reviewed. The review revealed a physician's order dated 7/22/17 which included: "Skin tear tx (treatment) to R (right) inner calf CLEANSE AREA W/ NORMAL SALINE, APPLY A THIN LAYER OF BACITRACIN TOPICALLY. COVER WITH NON-ADHESIVE DRESSING AND CHANGE DAILY UNTIL HEALED (**MAY APPLY STERI-STRIPS AS NEEDED, NOTIFY PHYSICIAN OF ANY SIGNS AND SYMPTOMS OF INFECTION OR OTHER COMPLICATION**). The Treatment Administration Record (TAR) had a stop date of October 11, 2017. The diagnosis on the TAR was listed as "MINOR LACERATIONS/ABRASIONS." Resident #3's clinical record included, but not limited to, skin tears and treatments on the following dates: 11/28/17-right wrist, 11/14/17-right forearm, 10/31/17-right forearm, and 7/10/17-left knee.

On 2/13/18 at 4:25 p.m. during a medication pass observation with Licensed Practical Nurse-E (LPN-E), Resident #3 was observed sitting in a recliner chair in her room, alert and conversational. She was well groomed and had long, polished and decorated fingernails. The edges were rounded and appeared smooth. When asked about her nails, Resident #3 stated "Oh yes, I like them this way, I go and get them done."

On 2/14/18 at 9:40 a.m. an interview was

An audit form has been created to complete both the initial 30 day audit as well as the randomized 15 day audit to follow. Weekly skin assessments will be reviewed for changes from prior week to further audit for any injuries of unknown origin.

The audit form will be provided to the Administrator on a weekly basis and upon completion of the plan of correction.

Status of the monitoring and audit will be reported at the monthly Care Center Quality Assurance meetings in March, April, and May 2018.

All new nursing employees will be trained on the proper handling of injuries of unknown origin.

Compliance with this regulation and all steps above will be considered in place as of Monday, March 26, 2018.

Robert
QUK
3/5/18

• State of Virginia

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F 001	Continued From Page 2	F 001		

conducted with Registered Nurse-A (RN-A). When asked about Resident #3's skin tears, RN-A stated she has "Very dry skin" we apply "lotion daily, encourage fluids which are left at the bedside." When asked about the resident's long nails, RN-A stated she "Likes her nails long and painted," "She digs into her skin sometimes if she scratches."
A review of the skin tear investigation with RN-A revealed on 7/21/7 a 10 cm skin tear on Resident #3's inner calf was noticed after Certified Nursing Assistant-B (CNA-B) took her out of the bath tub. RN-A stated the nurses complete a "skin tear" report then an investigation is done by the QA (Quality Assurance) and nursing staff. There was no formal investigation into the cause of the skin tear. A statement from the resident was documented as she didn't know how it happened. When asked why a thorough investigation wasn't conducted RN-A stated "It looks like it fell through the cracks." Review of Resident #3's care plan included fluid encouragement, education on risks of having long nails, apply moisture barrier to skin, and medicated cream per MD order. The behavior care plan included Resident #3 had a history of demanding that her husband provide ADL (activities of daily living) care, despite his failing health.

On 2/14/18 at 10:15 a.m. Resident #3 was observed being transferred by Certified Nursing Assistant-A (CNA-A). CNA-A instructed the resident to hold onto the walker and assisted Resident #3 to stand. The resident stated she wanted to use the wheelchair to get to the bathroom so CNA-A pulled the wheelchair over and assisted Resident #3 to turn and sit. No concerns were identified during the transfer process.

On 2/14/18 at 10:45 a.m. RN-A was asked about

Robert
QAK 3/5/18

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F 001	Continued From Page 3	F 001		

the facility process on investigating and reporting injuries of unknown origin. RN-A explained the QA nurse (Admin-C) meets with her or the Team Leader (LPN-B) and they will add additional information if needed. She stated they look for what can be put in place to prevent it. RN-A stated "We were in the transition from paper to computer. RN-A stated the 11 cm skin tear healed in October (2017) and the doctor had put her on an antibiotic and bactroban ointment. When asked if the skin tear should have been considered an injury of unknown origin, RN-A stated "Yes, and should've been investigated." The facility abuse policy was requested.

Review of facility policy titled "Abuse Prohibition Protocol" dated as revised 7/1/14 included: "...C. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property shall be investigated and reported to the administrator of the facility and to other officials in accordance with the law through established procedures.."

On 2/14/18 at 2:35 p.m. the Administrator was informed of the failure to investigate and report Resident #3's injury of unknown origin.

On 2/14/18 at 3:00 p.m. a routine emergency preparedness and abuse protocol interview was conducted with CNA-C. CNA-C stated she had been a CNA for 30 years. When asked what she would do if she saw a skin tear on a resident, CNA-C replied I "Would tell the charge nurse." When asked what she would expect to happen after it was reported, CNA-C stated she "Would expect them to ask what happened and investigate the why, where, and when, and address the area, wrap it."

Robert
3/5/18

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Robert Galk 3/15/18