STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. BUILDING _____ B. WING _____	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HEALTHCARE CENTER	508 RISON STREET DANVILLE, VA 24541

(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
E 000	Initial Comments An unannounced Medicare/Medicaid standard surveyand Emergency Preparedness survey was conducted 04/24/18 through 04/26/18. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Three complaints were investigated during the survey. The census in this 60 certified bed facility was 53 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 5 closed record reviews.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/24/18 through 4/26/18. Three 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. The census in this 60 certified bed facility was 53 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 5 closed record reviews.	F 000		
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	F 657		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/14/18

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 657	Continued From page 1 resident. (C) A nurse aide with responsibility for the resident. (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 staff interview and clinical record review the facility staff failed to review and revise the plan of care for 1 of 17 Residents in the final survey sample, Resident # 46. The findings included The facility staff failed to review and revise the care plan for Resident # 46 to reflect that he no longer had a left femoral permacath. Resident # 46 is a 72-year-old-male who was originally admitted to the facility on 11/24/17, with a readmission date of 2/13/18. Diagnoses included but were not limited to: end stage renal disease, hypertension, type 2 diabetes mellitus, and anemia. The clinical record for Resident # 46 was	F 657	**Resident #46 Comprehensive Care Plan and physician orders has been updated to include correct dialysis access.** **The MDS Coordinator and MDS nurse will be reeducated by the Regional Reimbursement Nurse on updating care plans including Dialysis access. Licensed staff will be reeducated that the hemodialysis site being assessed matches the MD order prior to documentation** **All current Care Plans for dialysis residents have been reviewed for accuracy to include the correct dialysis access site as applicable. All physician orders for dialysis residents have been reviewed for accuracy to include the correct dialysis access site.** **A care plan and physician orders audit will be done weekly x 4 weeks by Director of Nursing or designee then monthly on all new admits going forward to ensure accuracy of dialysis access sites.** **The Director of nursing will bring the audit results to the monthly Quality Assurance Committee meeting for review and recommendations.** **Completion date 5/16/18**	

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F 657	Continued From page 2	F 657		

reviewed on 4/25/18 at 1:12 pm. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/10/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 46 had a BIMS (brief interview for mental status) score of 7/15, which indicated that Resident # 46 had severe cognitive impairment. Section O of the MDS assesses special treatments, procedures, and programs. In section O0100 J., the facility staff documented that Resident # 46 had dialysis while a resident of the facility within the last 14 days.

The current plan of care for Resident # 46 was initiated on 11/27/17. A focus area on the current plan of care for Resident # 46 was documented as "Resident receives dialysis treatments 3 times weekly. ESRD (end stage renal disease) with left femoral permacath." Interventions included but were not limited to: "Monitor shunt/vas cath site for bleeding or s/s (signs and symptoms) of infection," and "Assess/monitor dressing to shunt."

According to the current physician's orders, Resident # 46 has a current order that were signed by the physician on 3/1/18 to "Check L (left) permacath femoral every shift for HD (hemodialysis)." Upon review of the MAR (medication administration record) for March and April of 2018, the surveyor observed that the facility staff had been documenting that the left femoral permacath was being checked every shift.

On 4/25/18 at 2:45 pm, the surveyor conducted an interview with Resident # 46. The surveyor asked Resident # 46 if he could show the site his

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F 657	Continued From page 3 dialysis access site. Resident #46 lifted his shirt and showed the surveyor a dialysis site on his left upper arm. The site was covered with gauze and paper tape. The surveyor then asked Resident # 46 if he had an access site in his left femoral area. Resident # 46 stated, "I did at one time." On 4/25/18 3:34 pm, the surveyor asked LPN (licensed practical nurse) #1 to show her the dialysis site on Resident # 46. LPN # 1 went to Resident # 46's left arm, lifted his shirt, and showed the surveyor the site on the left upper arm that was covered with gauze and paper tape. The surveyor reviewed the MAR with LPN #1. LPN # 1 agreed that the facility staff was signing that a left femoral permacath was being checked every shift. LPN #1 and the surveyor went back in Resident # 46's room and Resident # 46 gave permission to look at his left femoral area. LPN # 1 and the surveyor assessed Resident # 46's left and right femoral areas. There was no permacath observed in the left or right femoral area of Resident # 46. There was an old scar observed in the left femoral area of Resident # 46. On 4/25/18 at 3:49 pm, The DON (director of nursing) and administrator made aware of the findings. No further information regarding this issue was provided to the survey team prior to the exit conference on 4/26/18.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		

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F 684	Continued From page 4 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to follow physician orders for 2 of 20 Residents in the sample survey, Resident #33 and Resident #17. 1. For Resident #33 the facility staff failed to follow physician orders to administer Magnesium Oxide every a day. 2. For Resident #17 the facility staff failed to follow physician orders for tubi grips to the lower extremities, and failed to ensure that Resident # 17 received accuchecks and sliding scale coverage as ordered by the physician. The Findings Included: 1. Resident #33 was a 75 year old male, who was originally admitted on 9/11/17 and readmitted on 3/18/18. Admitting diagnoses included, but were not limited to: dysphagia, atrial fibrillation, diabetes mellitus, hypertension, post-traumatic stress disorder and vascular dementia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/28/18. The facility staff coded that Resident #33 had a Cognitive Summary Score of 12. The facility staff also coded that Resident #33 required extensive	F 684	**Resident #33 physician orders are accurate. The magnesium oxide was not restarted per MD due to normal Mag level.** **Resident # 17 physician orders are accurate and being followed to include tubi grips to bilateral lower extremities and obtaining blood glucose levels and using ordered sliding scale insulin administration as ordered.** **All resident physician orders have been reviewed for accuracy and are being followed.** **Licensed nurses will be educated by Director of Nursing or designee on entering orders in Point Click Care, completing transcription of orders with a 2 nurse verification, carrying out physician orders, performing treatments prior to documenting in the medical record, and to document refusals or treatment by the resident.**	

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F 684	Continued From page 5 assistance (3/2) with Activities of Daily Living (ADL's). On April 25, 2018 at 8:25 a.m., the surveyor reviewed Resident #33's clinical record. Review of the clinical record produced signed physician orders dated 3/20/18. Signed physician orders included, but were not limited to: "Mag Ox (Magnesium Oxide) 400mg po (by mouth) daily supplement." (sic) Continued review of the clinical record produced the April 2018 Medication Administration Records (MAR's). Review of the April 2018 MAR's failed to document the administration of the Magnesium Oxide during April 2018. On April 25, 2018 at 9:50 a.m., the surveyor notified the Director of Nursing (DON) that Resident #33 had a physician order to receive Magnesium Oxide every day. The surveyor notified the DON that the Magnesium Oxide order was not included on the April 2018 MAR's. The surveyor notified the DON that Resident #33 had not received the physician ordered Magnesium Oxide. The surveyor reviewed Resident #33's clinical record with the DON. The surveyor specifically pointed out the physician order for the Magnesium Oxide every day. The surveyor then reviewed Resident #33's April 2018 MAR's with the DON. The DON was unable to locate documentation that the facility staff had administered the physician ordered Magnesium Oxide on the April 2018 MAR's. On April 26, 2018 at 7:30 a.m., the surveyor met with Administrator (Adm). The surveyor notified the Adm that Resident #33 had a	F 684	**Physician orders will be reviewed daily Monday thru Friday in the daily clinical meeting by Director of Nursing or designee to ensure applicable transcription to medication administration record. Random checks of medication administration records and treatment administration record will be completed by the Director of Nursing or designee to ensure complete documentation of administration and/or refusals.** **The Director of Nursing will bring the audit results to be reviewed at the monthly Quality Assurance Committee meeting for review and recommendations.** **Completion date 5/16/18**	

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F 684	Continued From page 6 physician order to receive Magnesium Oxide every day. The surveyor notified the Adm that Resident #33 had not received the Magnesium Oxide for the month of April 2018. No additional information was provided prior to exiting the facility as to why the facility staff failed to follow physician orders for Resident #33. The facility staff failed to administer Magnesium Oxide every day. 2. The facility staff failed to ensure that: Resident # 17 had tubi-grips applied as ordered by the physician, and failed to ensure that Resident # 17 received accuchecks and sliding scale coverage as ordered by the physician. Resident # 17 is a 79-year-old-male who was originally admitted to the facility on 3/17/16, with a readmission date of 1/12/18. Diagnoses included but were not limited to: type 2 diabetes mellitus, hyperkalemia, dysphagia, vascular dementia without behavioral disturbance, and hypertension. The clinical record for Resident # 17 was reviewed on 4/24/18 at 11:29 am. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 2/19/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 17 had a BIMS (brief interview for mental status) score of 11/15, which indicated that Resident # 17's cognitive status is moderately impaired. The current plan of care for Resident # 17 was reviewed and revised on 2/21/18. A focus area documented on the current plan of care for Resident # 17 was "At risk for skin breakdown related to: decreased mobility, weakness,	F 684		

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F 684	Continued From page 7	F 684		

incontinence, peg tube, DM (diabetes mellitus), fragile tissue with hx (history) of breakdown/abscess." The goal is documented, as "BLE (bilateral lower extremities) will continue to have treatment as ordered and no complications thru next review Interventions included but were not limited to "Meds/labs/treatments as ordered," and "Monitor for skin breakdown."

The current physician's orders for Resident # 17 contains an order for "Tubi-grips to bilateral lower extremities every day as resident will allow for edema," that was signed by the physician on 3/19/18.

On 4/24/18 at 10:50 am, the surveyor observed Resident # 17 sitting in the hallway in his wheelchair. Resident # 17 was dressed in dark blue slacks, green shirt, grey hooded jacket, and blue non-skid socks. The physician ordered tubi-grips were not observed on Resident # 17's bilateral lower extremities.

On 4/24/18 at 3:32 pm, the surveyor was in the room with Resident # 17 conducting an interview. During this interview, the physician ordered tubi-grips were not observed on Resident # 17's bilateral lower extremities.

On 4/25/18 at 8:40 am, Resident # 17 was observed sitting in the hallway in his wheelchair dressed in a tan button up shirt, with a white tee shirt underneath, brown slacks, a grey hooded jacket, and blue non- skid footwear. The physician ordered tubi-grips were not in place on bilateral lower extremities.

On 4/25/18 at 9:59 am, The surveyor reviewed the April 2018 TAR (treatment administration

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F 684	Continued From page 8 record) for Resident # 17 and observed that facility staff had documented that tubi-grips had been applied to bilateral lower extremities as ordered by the physician on 4/24/18 and 4/25/18 on 7-3 shift. The surveyor and ADON (assistant director of nursing) ADON reviewed the order on the April 2018 TAR for tubi-grips to bilateral lower extremities every day as resident will allow. The surveyor and ADON observed the bilateral lower extremities for Resident # 17 together and the ADON and agreed that tubi-grips were not in place as ordered by the physician. The ADON stated, "I will get those on him." On 4/25/18 at 10:02 am, RN #1 approached surveyor and stated, "I have them on him now." "I had to cut him another pair because they were nasty and I was waiting for the bacitracin to dry." Surveyor informed RN#1 that the treatment had been signed off as completed and the tubi-grips were not in place. The surveyor also informed RN # 1 that Resident # 17 did not have on tubi-grips on 4/24/18. RN # 1 stated, "Did he refuse them." The surveyor informed RN # 1 that according to the clinical record, there was no documentation that Resident # 17 refusing the tubi-grips and according to the documentation, the tubi-grips had been applied as ordered. RN# 1 stated "OK." On 4/25/18 at 10:08 am, RN # 1 stated, "I'm going to mark his refusal from yesterday that was my fault for not documenting." On 4/25/18 at 10:10 am, the DON (director of nursing) was made aware of the findings as stated above. During the clinical record review for Resident # 17 that was conducted on 4/24/18 at 11:29 am, the	F 684		

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F 684	Continued From page 9 surveyor noted that Resident # 17 also has current orders for accu checks ACHS (before meals and at hour of sleep) that was initially signed by the physician on 1/12/18. Upon further of the clinical record specifically the MAR and the electronic medical record weights and vitals tab, the surveyor noted that accucheck results were not documented on 2/19/18 at 8:00 pm, 2/20/18 at 4:30 pm, 2/20/18 at 8:00pm, and 3/29/18 at 11:30am. On 4/24/18 at 11:35 am, the surveyor spoke with the ADON and asked if there was any other place in the clinical record that the facility staff documented accucheck results. The ADON informed the surveyor that the staff only documented accucheck results on the MAR and in the electronic medical record under the weights and vitals tab. Upon review of the February 2018 physician's order sheet that was signed by the physician on 2/1/18, the surveyor observed an order for "Novolog Flexpen 100/ml (milliliter) inject 0units subcutaneously every morning before breakfast per sliding scale" with the time to be administered as 6:30 am. A single line was drawn through this order. Another order was observed on the physician's order sheet that read "Accuchecks before meals and at bedtime" that was noted to be printed on the physician's order sheet) Observed hand written underneath was "sliding scale AC&HS 0-200= 2u (units), 201-250=6u, 251-300=8u, 301-350=12u, >350 14u" The times printed to be administered were 6:00 am, 11:30 am, 4:30 pm, and 8:00 pm. Upon review of the MAR for February 2018, the facility staff documented administration through the 2/5/18 11:30 am dose. A telephone order dated 2/5/18 at	F 684		

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1230 was documented as "Clarification on Novolog sliding scale BS (blood sugar) 0-150 0u, 151-200 2u." On 2/5/18, handwritten on the MAR was an order written as "Novolog Flexpen Sliding Scale 0-150=0u, 151-200=2u, 201-250=6u, 251-300=8u, 301-350=12u, > 350=14u." Times handwritten in on the MAR for administration were 6:00 am, 11:30 am, and 4:30 pm. The surveyor observed that the 8:00 pm time had not been transcribed with this order. The facility staff documented administration on the MAR at the 6:30 am, 11:30 am, and 4:30 pm times from 2/5/18 through 2/28/18.

Upon review of physician's order sheet for March 2018, the surveyor observed an order for "Novolog flexpen SSC (sliding scale coverage) 151-200=2u, 201-250=6u, 251-300=8u, 301-350=12u, >350=14u." The times documented for administration was6:30 am, 11:30 am, and 4:30 pm" The March 2018 physician's order sheet was signed by the physician on 3/6/18. The surveyor observed that the medication had not been given as ordered by the physician from 2/5/18 through 3/5/18 due to the time being omitted when transcribed.

Upon review of the April 2018 physician's order sheet, the surveyor observed an order that was printed on the physician's order sheet documented as "Novolog Flexpen 100/ml unit Inject subcutaneously per sliding scale as directed: 0-200=2u, 201-250=6u, 251-300=8u, 301-350=12u, >350 14u for diabetes. The surveyor noted that there is a discrepancy in the order from the previous month. According to the signed March 2018 order 151-200=2u administered, the order currently written on the April 2018 physician's order sheet is documented

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F 684	Continued From page 11 as 0-200=2u. The physician signed the April 2018 physician's order sheet on 4/3/18 making the sliding scale order that was printed on the April 2018 physician's order sheet an active order as of that date. On 4/24/18 at 11:47 am, the surveyor spoke with the DON regarding the discrepancies in the Novolog Flexpen orders. The DON reviewed the medical record for Resident # 17 along with the surveyor. During this time, the DON along with the surveyor reviewed the physician's progress notes. A physician's progress note dated 2/1/18 had "Current medications" for Resident # 17 including but not limited to "Novolog 100 unit/ML solution sliding scale Subcutaneous daily at lunch and dinner." A physician's progress note written on 3/2/18 has documented that "Current medications" for Resident # 17 including but is not limited to "Novolog 100 unit/ML solution sliding scale subcutaneous daily at lunch and dinner." Documented under "Treatment" on the physician's progress note dated 3/2/18 for Resident # 17 included but is not limited to "Continue Novolog Solution, 100 unit/ML, sliding scale, subcutaneous, daily at lunch and dinner." A physician's progress note dated 4/6/18 has "Current Medications" for Resident # 17 including but not limited to "Novolog 100 unit/ML solution sliding scale subcutaneous daily at lunch and dinner." Documented as "Treatment" on the 4/6/18 physician's progress note includes but is not limited to "Continue Novolog 100 unit/ML, sliding scale, subcutaneous, daily at lunch and dinner."	F 684		

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F 684	Continued From page 12 On 4/24/18 at 11:56 am, the surveyor spoke with the DON and discussed that what is in the progress notes does not reflect what Resident # 17 has ordered. The surveyor asked the DON what the facility goes by as far as insulin orders for Resident # 17. The DON stated that the facility follows the telephone orders and the physician's order sheets. The DON stated that the facility does not utilize progress notes for orders because the doctors transcribe them and sometimes the facility does not receive the progress notes for weeks. The DON stated that she would talk to the doctor and get this clarified. On 4/24/18 at 2:12 pm, the DON informed the surveyor that she had spoken to the doctor and informed her of the discrepancies with the insulin orders for Resident # 17. The DON stated, "I told her it was a mess." The DON stated the physician had given order to clarify the insulin coverage and that the physician would like for the Novolog to be given at lunch and dinner On 4/25/18 at 3:50 pm, the administrator and DON were made aware of the findings as stated above. No further information regarding these issues was provided to the survey team prior to the exit conference on 4/26/18.	F 684		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of	F 773		

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F 773	Continued From page 13 practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to obtain a physician ordered laboratory test for 1 of 20 Residents in the sample survey, Resident #33. For Resident #33 the facility staff failed to obtain a physician ordered Digoxin level. The Findings Included: Resident #33 was a 75 year old male, who was originally admitted on 9/11/17 and readmitted on 3/18/18. Admitting diagnoses included, but were not limited to: dysphagia, atrial fibrillation, diabetes mellitus, hypertension, post-traumatic stress disorder and vascular dementia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/28/18. The facility staff coded that Resident #33 had a Cognitive Summary Score of 12. The facility staff also coded that Resident #33 required extensive assistance (3/2) with Activities of Daily Living (ADL's). On April 25, 2018 at 8:25 a.m., the surveyor	F 773	**Resident #33 lab was obtained and was within normal range and has been reviewed by MD.** **Orders obtained for labs in past 2 weeks have been reviewed to ensure lab was obtained and MD made aware of results.** **Licensed nurses will be educated by Director of Nursing or designee on carrying out MD orders to include transcription to lab book of all applicable lab orders and reporting lab orders and follow up during shift to shift report.** **Physician orders will be reviewed daily Monday thru Friday in the daily clinical meeting by the Director of Nursing or designee to ensure ordered labs have been obtained and results received and communicated to MD. An additional lab audit will be completed weekly x 4 weeks by Director of Nursing or designee.**	

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F 773	Continued From page 14 reviewed Resident #33's clinical record. Review of the clinical record produced a physician order dated 3/21/18 for: "Digoxin 125mcg tablet for> Lanoxin take 1 tab (tablet) by mouth every day for A-Fib (atrial fibrillation) check pulse and hold if <60." (sic) Continued review of the clinical record produced a physician telephone order dated 3/23/18. The physician telephone order read: "Obtain Digoxin level in 1 week." (sic) Continued review of the clinical record failed to produce the results of the physician ordered Digoxin level. On April 25, 2018 at 8:30 a.m., the surveyor notified the Director of Nursing (DON) that Resident #33 had a physician order dated 3/23/18 to obtain a Digoxin level in one week. The surveyor notified the DON that review of the clinical record failed to produce the results of the physician ordered Digoxin level. The surveyor and DON reviewed Resident #33's clinical record. The surveyor specifically pointed out the physician telephone order dated 3/23/18 to obtain the Digoxin level in one week. The surveyor then reviewed the laboratory findings in the clinical record with the DON. The DON was unable to locate the results of the physician ordered Digoxin level. The DON stated she would contact the laboratory vendor and see if the Digoxin level had been obtained. On April 25, 2018 at 9:05 a.m., the DON approached the surveyor and notified the surveyor that the Digoxin level had not been obtained.	F 773	**The Director of Nursing will bring the audit results to be reviewed at the monthly Quality Assurance Committee meeting for review and recommendations.** **Completion date 5/16/18**	

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F 773	Continued From page 15 On April 265 2018 at 3:45 p.m., the survey met with Administrator (Adm) and DON. The surveyor notified the Administrative Team (AT) that Resident #33 had a physician order dated 3/23/18 to obtain a Digoxin Level. The surveyor notified the AT that the Digoxin level had not been obtained. No additional information was provided prior to exiting the facility as to why the facility staff failed to follow the physician order to obtain a Digoxin level.	F 773		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews	F 809	**All residents are being offered evening snacks.** **Licensed nurses and Certified Nursing Assistants (CNAs) will be educated by Director of Nursing or designee to continue to offer evening snacks, CNAs are to continue to document offered, not offered, refusals on Activity of Daily Living (ADL) sheets, the nurses are to verify offering and documentation and the staff is to continue to document / sign off when snacks are delivered from dietary.**	

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F 809	Continued From page 16 and resident council minutes, the facility staff failed to consistently provide an evening snack for residents in the facility. Findings: On 4/25/18 at 10:00 AM the resident council meeting minutes were reviewed for February, March and April 2018. The minutes included on-going complaints from the residents about not receiving their HS (hour of sleep) snack. On 2/28/18 the minutes included an inservice, conducted by the DON, which addressed the second shift staff handing out HS snacks and customer service. On 4/4/18 the residents again expressed concern at a meeting that HS snacks were not coming out or if they were they were left on the bedside table at ten o'clock or after the resident had gone to sleep. On 4/25/18 ten alert and oriented resident council members (Members 1-10) were interviewed by a member of the survey team. All ten members agreed they were still not receiving the HS snack, even when they asked for one. The residents said they would put on their call light and ask for a snack but more often than not the CNA would say they'd be right back with something and they never saw them again. Residents #1, 5, and 10 said they observed the CNAs walking around eating food on second shift while making rounds. These residents said they thought the CNAs were eating their snacks and not bringing them to their rooms. On 4/25/18 at 3:15 PM the DM (dietary manager) was interviewed about the snacks. She showed	F 809	**Random resident ADL audits will be completed by Director of Nursing or designee to ensure compliance of offering evening snacks and documentation. This will be a resident council topic monthly to validate improvement of this process.** **The Director of Nursing will bring the audit results and applicable resident council minutes to be reviewed at the monthly Quality Assurance committee meeting for review and recommendation.** **Completion date 5/16/18**	

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F 809	Continued From page 17 the surveyor the sign-up sheet that she required nursing staff to sign off on when dietary staff delivered the resident snacks each evening. The DM stated, "I was at the last resident council meeting when they complained of that. We now get the CNAs to sign-off when we deliver the resident's snacks to the floor. We're doing out part back here in the kitchen." On 4/25/18 at 4:15 PM the facility administrator and DON were informed the residents had complained they were still not receiving their snacks when they asked for them. The facility DON said she had addressed this matter with the second shift nursing staff and did not understand why they still were not receiving their snacks. No additional information was provided prior to the team exit.	F 809		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		

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F 842	Continued From page 18 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842	**Resident #33 clinical record to include Medication Administration Record (MAR) is complete and accurate.** **Resident #41 behavior sheets are no longer being utilized as the medication has been discontinued.** **Resident #46 clinical record to include PT/INR (prothrombin time/international normalized ratio) is complete and accurate.** **Current resident clinical records have been reviewed to ensure completion and accuracy to include their MAR and behavior monitoring sheets.** **Licensed nurses will be educated by the Director of Nursing or designee on the anticoagulant policy to include PT/INR flowsheets and following up that labs have been obtained, completing documentation on behavior monitoring sheets for all residents ordered antipsychotic medications and nurse verification for review of transcriptions to avoid errors on MARs.**	

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F 842	Continued From page 19 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate clinical record for 3 of 20 Residents in the sample survey, Resident #33, Resident #41 and Resident #46. The Findings Included: 1. For Resident #33 the facility staff failed to ensure complete and accurate April 2018 Medication Administration Records (MAR's). Resident #33 was a 75 year old male, who was originally admitted on 9/11/17 and readmitted on 3/18/18. Admitting diagnoses included, but were not limited to: dysphagia, atrial fibrillation, diabetes mellitus, hypertension, post-traumatic stress disorder and vascular dementia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 3/28/18. The facility staff coded that Resident #33 had a Cognitive Summary Score of 12. The facility staff also coded that Resident #33 required extensive assistance (3/2) with Activities of Daily Living (ADL's).	F 842	**Physician orders will be reviewed Monday thru Friday in the daily clinical meeting by the Director of Nursing or designee to ensure ordered labs have been obtained and results received including PT/INRs and communicated to MD. Behavior monitoring sheets and MARS will be audited weekly x 4 then randomly by Director of Nursing or designee to ensure completion and accuracy.** **The Director of Nursing will bring the audit results and applicable resident council minutes to be reviewed at the monthly Quality Assurance committee meeting for review and recommendation.** **Completion date 5/16/18**	

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F 842	Continued From page 20 On April 25, 2018 at 8:25 a.m., the surveyor reviewed Resident #33's clinical record. Review of the clinical record produced signed physician orders dated 3/20/18. Signed physician orders included, but were not limited to: "Claritan (Loratadine) 10mg po (by mouth) daily-allergies." (sic) Continued review of the clinical record produced the hard copy (paper) April 2018 Medication Administration Records (MAR's). Review of the April 2018 MAR's identified that the facility staff had electronically added the Claritin (Loratadine) on the MAR's. Additionally someone had hand written the same order on the April 2018 MAR's. The surveyor noted that the facility staff were signing off in both places that the Claritin (Loratadine), indicating that the facility staff were administering Claritin (Loratadine) 20 mg daily. On April 25, 2018 at 8:30 a.m., the surveyor notified the Director of Nursing (DON) that Resident #33 had a physician order for Claritin (Loratadine) 10 mg every day. The surveyor notified the DON that the April 2018 MAR's documented in two separate locations that Resident #33 was receiving Claritin (Loratadine) 10mg (for a total dosage of 20mg every day). The surveyor reviewed Resident #33's clinical record with the DON. The surveyor reviewed the signed physician orders with the DON and specifically pointed out the physician order for the Claritin (Loratadine) 10mg every day. The surveyor then reviewed the April 2018 MAR's with the DON. The surveyor specifically pointed out the two separate entries for the Claritan (Loratadine) 10mg every day. The surveyor pointed out that the facility staff were	F 842		

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F 842	Continued From page 21 documenting in both places that they were administering the Claritan (Loratadine) 10mg. The DON stated that she thought there was a transcription error for the Claritan (Loratadine). The DON left the surveyor and went to speak to the medication nurse. The DON returned to the surveyor and stated that the medication nurse had only administered one Claritan (Loratadine) 10mg tablet. The DON alerted the surveyor that another surveyor had made a medication pass and pour observation during the 8 a.m. medication time and had observed Resident #33 getting his medications. The surveyor went and spoke to the surveyor who had completed the medication pass and pour observation. That surveyor stated that Resident #33 had only received one tablet of the Claritan (Loratadine) medication. On April 265 2018 at 3:45 p.m., the survey met with Administrator (Adm) and DON. The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a complete and accurate clinical record for Resident #33. The surveyor notified the AT that the facility staff had made a transcription error and had added the physician ordered Claritan (Loratadine) to the April 2018 MAR's twice. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #33. For additional information regarding Resident #33 refer to F Tags 684 and 773. 2. The facility staff failed to ensure that behavior monitoring associated with the use of Seroquel	F 842		

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was complete for Resident # 41.

Resident # 41 is a 70-year-old-male who was originally admitted to the facility on 2/23/17 with a readmission date of 3/23/18. Diagnoses included but were not limited to: delusional disorders, type 2 diabetes mellitus, anxiety disorder, and heart failure.

The clinical record for Resident # 41 was reviewed on 4/24/18 at 12:22 pm. The most recent MDS (minimum data set) for Resident # 41 was a 14-day assessment with an ARD (assessment reference date) of 4/6/18. Section C of the MDS assesses cognitive patterns. In section C0500, the facility staff documented that Resident # 41 had a BIMS (brief interview for mental status) score of 12/15, which indicated that Resident # 41's cognition is moderately impaired. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 41 received antipsychotic medication 5 of 7 days during the 7-day look back period.

The current plan of care for Resident # 41 was initiated on 2/27/18. The facility staff documented a focus area as "At risk for adverse effects R/T (related to) psychoactive medication use: Anxiety, Depression, delusional disorder/ telling stories that are untrue including that he is with the FBI (federal bureau of investigation)." Interventions include but is not limited to: "Monitor medications for effectiveness," and "Report changes in behavior or mood state."

The physician signed the current physician's orders for Resident # 41 on 4/3/18. Resident # 41 had orders since readmission on 3/23/18 for

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Seroquel 25 mg tablet take 0.5 tab by mouth every morning for psychosis with delusions, and Seroquel 25 mg tablet take 1 tab (tablet) by mouth at bedtime for psychosis with delusions. A telephone order was written on 4/4/18 at 3:30 pm, included orders to "D/C (discontinue) Seroquel."

Upon review of the March 2018 "Behavior/Intervention Monthly Flow Record" sheet for Resident # 41, the surveyor observed missing behavior/intervention documentation for day and evening on March 25, 2018, day on March 26, 2018, day on March 27, 2018, day, evening, and night on March 29, 2018, day and evening on March 30, 2018, and day on March 31, 2018.

On 4/24/18 at 12:30 pm, the surveyor conducted an interview with Resident # 41. During the interview, Resident # 41 informed the surveyor that he worked for the FBI and was responsible for a big sting operation that happened in Florida many years ago.

Resident # 41 also informed the surveyor that as a part of his job with the FBI, he was a bodyguard for President John F. Kennedy when he was in office.

On 4/25/18 at 3:50 pm, the administrator and director of nursing was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 2/26/18.

3. The facility staff failed to have accurate information in the clinical record for Resident #46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. BUILDING _____ B. WING _____	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HEALTHCARE CENTER	508 RISON STREET DANVILLE, VA 24541

(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 842	Continued From page 24 related to PT/INR (prothrombin time/international normalized ratio). Resident # 46 is a 72-year-old-male who was originally admitted to the facility on 11/24/17, with a readmission date of 2/13/18. Diagnoses included but were not limited to: end stage renal disease, hypertension, type 2 diabetes mellitus, and anemia. The clinical record for Resident # 46 was reviewed on 4/25/18 at 1:12 pm. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 4/10/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 46 had a BIMS (brief interview for mental status) score of 7/15, which indicated that Resident # 46 had severe cognitive impairment. The current plan of care for Resident # 46 was initiated on 11/27/17. The facility staff documented as a focus area "At risk for altered cardiac/respiratory status, atrial fibrillation, anemia, coronary artery disease, cerebrovascular accident, hx (history) dysphagia, hypertension, Hx myocardial infarction, hx of deep vein thrombosis with inferior vena cava filter, hx of pleural effusions." Interventions include but is not limited to "Meds/labs as ordered," and"Notify MD (medical doctor) prn (as needed) with any changes." A telephone order was written on 3/29/18 at 2200, was written to "Continue same dose of Coumadin, Recheck PT/INR in 1 week."	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. BUILDING _____ B. WING _____	C 04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD HEALTHCARE CENTER	508 RISON STREET DANVILLE, VA 24541

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F 842	Continued From page 25 The surveyor reviewed the clinical record and did not locate a PT/INR drawn on 4/5/18 as ordered on 3/28/18. Upon further review of the clinical record, the surveyor noted a telephone order that was written on 4/7/18 at 11pm that was written to "D/C (discontinue) PT/INR for 4/6/18," and "Draw PT/INR on 4/9/18." On 4/24/18 at 1:34 pm, the surveyor spoke with the DON (director of nursing) about the missing PT/INR on 4/5/18 and the order to discontinue the order for PT/INR for 4/6/18 after the date had passed. On 4/24/18 at 2:28 pm, the DON showed the surveyor a paper that that the facility used to track labs. Written on the paper was that Resident # 46 had lab orders for PT/INR and had "refused lab." The surveyor asked the DON if this paper was part of the clinical record for Resident # 46 and DON stated "No." The DON also showed the surveyor PT/INR results dated 4/6/18 at 1700. The surveyor asked the DON why the lab was not in the chart. The DON stated that the lab had been obtained but the results were not sent to the facility. The surveyor then spoke to the DON about the telephone order that was written on 4/7/18 at 11pm to D/C PT/INR for 4/6/18. The DON stated that the night nurse must have looked in the chart, realized that the PT/INR for 4/6/18 was not there, and thought that it had not been drawn and got the order to D/C the PT/INR on 4/6/18. On 4/24/18 at 3:50 pm, the administrator and DON was made aware of the findings as stated above. No further information was provided to the survey	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495166	A. BUILDING _____ B. WING _____	C 04/26/2018

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F 842	Continued From page 26 team prior to the exit conference on 4/26/18.	F 842		