STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NP13055	A. BUILDING _____ B. WING _____	03/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODHAVEN NURSING HOME	13055 WEST LYNCHBURG/SALEM PIKE MONTVALE, VA 24122

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F 000	Initial Comments An unannounced biennial State licensure inspection was conducted 3/7/18 through 3/8/18. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 48 non-participating bed facility was 24 at the time of the survey. The survey sample consisted of 3 current Resident reviews..	F 000	12VAC5-371 110.B.2. Management and Administration The facility administrative team shall report to county APS and state VDH-OLC whenever there is suspected abuse, neglect, or exploitation as per Code of Virginia 63.2-1603 through 1610. Prior to the survey, a staff in-service had been conducted by a county APS official entitled, "Mandated Reporting Practices." Facility staff is more keenly aware of their individual responsibility to report suspected abuse, neglect, or exploitation to county APS office and state VDH-OLC. An evaluation of all residents has been made by the Administrative Team to determine those vulnerable to abuse, neglect and exploitation. The administrative team has determined better approaches to protect all facility residents from abuse, neglect or exploitation. On March 29, 2018, a retired CNA was hired to visually monitor common areas occupied by residents. The monitor wears a security guard uniform and as such, has eliminated reports of suspected abuse, neglect, or exploitation of residents. Male and female residents are no longer permitted to sit on multi-seat sofas at the same time. Nursing shift reports continue to provide information of any incidents of suspected abuse, neglect or exploitation.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 1. 12VAC5-371 110.B.2. Management and Administration. Based on staff interview, clinical record review and facility document review it was determined that the Management and Administration failed to follow applicable federal, state or local laws and regulations for 1 of 3 Resident in the sample survey, Resident #3. The facility staff failed to report sexual abuse perpetrated by Resident #3 to the local Adult Protective Agency (APS) and the State Agency. The Findings Included: Resident #3 was an 81 year old male who was admitted on 04/26/15. Admitting diagnoses included, but were not limited to: edema, muscle weakness, lack of coordination, abnormalities of the gait, major depression, alcoholic cirrhosis of the liver, ascites, alcoholic abuse, cerebrovascular accident, hypertension, and dementia with	F 001		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X8) DATE
Dawn Davies	Administrator	07/31/2018

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Alzheimer's.

On March 7, 2018 at 1:15 p.m., the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced Nursing Progress Notes. The Nursing Progress Notes were dated 8/29/17, 12/11/17 and 2/12/18. The Nursing Progress Notes read ...

"8/29/17 (11-7) (the 11 p.m. to 7 a.m. shift) Resident observed touching female inappropriately this morning-grabbing female residents breast-rubbing on them and then as C.N.A. (certified nursing assistant) was walking over to them he had his hand on female residents private area. Female resident was removed from this residents way. C.N.A. told resident not to touch female resident in that way, resident became angry, stood up and got in residents face yelling "I'm insane that's why I'm here." "I am not in my right mind, my wife won't have anything to do with me." "I can do anything I want cause I'm not in my right mind." C.N.A. walked away as not to argue with resident, res (resident) went and sat down on the couch." (sic)

"12/11/17 7am 11-7 nurse (name of nurse withheld) reported pt (patient) was using inappropriate language c (with) a female resident this am. Was telling the female resident (who has Alzheimers) that "you have really pretty breasts, why don't you pull up your shirt and show them to everybody!? 11-7 removed female resident from lobby and reminded pt that his behavior and verbal comments were inappropriate." (sic)

"2/12/18 Rsd (resident) was reported by nurse in prior shift to be sexually inappropriate with other female rsds (residents). Rsd (resident) was redirected and became aggressive toward nursing staff; rsd was monitored for remainder of shift."

Each resident evaluated to be at risk of perpetrating or being a victim of suspected abuse, neglect or exploitation will be closely monitored by all facility staff.

Please refer to the enclosed articles on "9 Ways to Handle Alzheimer's and Sexually Inappropriate Behavior" and "Sexual Aggression between Residents in Nursing Homes." Both of these articles shall be used for facility staff in-service to be conducted by the administrative team, on or by 08-31-18.

All above completed on 08-31-18

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(sic)

On March 7, 2018 at 1:45 p.m., the surveyor sat down with the Director of Nursing (DON) and asked if she or the facility had reported Resident #3's sexual abuse to the Adult Protective Service (APS) or to the State Agency. The DON stated that she had not known she had to report anything to APS or the State Agency. The surveyor notified the DON that Resident #3 had sexually abused a/the female resident(s) of the facility. The surveyor and DON reviewed Resident #3's clinical record. The surveyor specifically reviewed Resident #3's nursing progress notes that documented that Resident #3 had made sexually inappropriate comments to the female residents. The DON stated that she had not reported anything to APS or the State Agency. The DON stated that she began working at the facility in July of 2017.

On March 7, 2018 at 4:10 p.m. the survey team met with the Administrator (Adm) and DON. The surveyor notified the Administrative Team (AT) that Resident #3 had sexually abused a/the female resident(s) of the facility. The surveyor asked the Adm if he had reported the sexual abuse to APS or the State Agency. The Adm stated that he had not reported the incidents to APS or the State Agency. The Adm stated that if he had to report issues like this he would be continually making reports to APS and the State Agency. The Adm stated that Resident #3 had behaviors and that was all. The surveyor informed the Adm that she, the surveyor, was worried about the female residents of the facility. The surveyor notified the AT that Resident #3 stating to a female patient that she had pretty breasts and for her to expose her breasts to Resident #3 was coercion. The surveyor notified the AT that they had to report any and all allegations of abuse to APS and the State

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Agency. The surveyor also alerted the AT that a 5 day follow up of the investigation also had to be sent to the State Agency as well. The surveyor requested the facility policy and procedure for abuse and reporting abuse.

Code of Virginia, §§ 63.2-1603 through 1610. Summarizes that all licensed and certified roles in public health are required to report or cause a report to be made to Virginia Adult Protective Services (APS) either by calling the APS Hotline (1-888-83-ADULT) or the appropriate local department of social services whenever they have reasonable cause to suspect that an adult aged 60 or over or an incapacitated adult aged 18 and over and who is known to them in their professional or official capacity may be abused, neglected, or exploited.

Requirements of the State Agency: Incidences of mistreatment, abuse, neglect, and misappropriation of resident personal property are to be reported to the Adult Protective Services Unit of the Va. Department of Aging and Rehabilitative Services (DARS) as required by § 51.5-148 of the Code of Virginia. All alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriate of resident property are reported immediately to the OLC (Office of Licensure and Certification) as required by 42 CFR § 483.15.

On March 8, 2018 at 8:15 a.m., the surveyor asked the DON for the copies of Resident #3's clinical record that had been requested on 3/7/18. The DON hand delivered the requested copies of Resident #3's clinical record. The surveyor reviewed the copies of Resident #3's clinical record and reviewed the copies with the DON. The surveyor specifically pointed out the Nursing Progress Note dated 8/29/17 that documented

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that Resident #3 was rubbing on a female resident's breasts and touched her "private area." Again, the surveyor notified the DON that the female resident(s) had been abuse and that no one had reported the sexual abuse to APS or to the State Agency.

On March 8, 2018 at 10 a.m., the surveyor once again asked the Adm for a copy of the facility policy and procedure for Abuse and Neglect. The Adm stated that he did not have a specific policy and procedure that addressed abuse and neglect. The surveyor informed the Adm that she had reviewed the white binder that had been left in the conference room as labeled as survey ready book. The surveyor informed the Adm that the facility staff had included a copy of the Code of Virginia in the survey ready book. The surveyor also stated that several papers were comingled in the Code of Virginia and under Resident Rights. The surveyor asked if these documents were his policies and he stated, "Yes." The surveyor notified the Adm that one of the "policies" was titled "Resident Behavior and Facilities Practices Policy."

The policy read in part ... "Abuse. Residents shall be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. ... The facility shall ensure that all alleged violations regarding mistreatment, neglect, abuse, or injuries of unknown source and misappropriation of resident's property are reported immediately to the administrator and the State survey and certification agency."

On March 8, 2018 at 1:15 p.m., the surveyor notified the AT that Resident #3 had not only made verbal sexual suggestive comments to a female resident, but, Resident #3 had also rubbed on a female residents breasts and her "private area."

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The surveyor notified the AT that the sexual abuse should have been reported to APS and the State Agency.

No additional information was provided prior to exiting the facility as to why Management and Administration failed to follow applicable federal, state or local laws and regulations for Resident #3. The facility staff failed to report sexual abuse to the Adult Protective Services and to the State Agency.

For additional information regarding Resident #3 refer to 12VAC5-371-220.B., 12VAC5-371-240.E. and 12VAC5-371-300-A.

12VAC5-371-150. Resident Rights

Based on staff interview and facility document review, it was determined that the facility staff failed to implement policies and procedures regarding Resident Rights in the facility.

The facility staff failed to implement a facility policy and procedure for Resident Rights. The facility failed to implement its own policy and procedure to ensure that the previous survey results were accessible to the residents.

The Findings Included:

On March 7, 2018 at 11:45 a.m. the survey team entered the locked facility and was escorted in the building and through a locked door into the administrative suite of the facility. The survey team observed a white binder titled "Survey Results" located on a small table in the hallway of the administrative suite. The surveyor picked up the binder and reviewed the previous surveys dated 7/29/15, 12/17/10 and 12/27/10.

12VAC5-371-150. Resident Rights

Upon admission, residents and their legal representatives are notified and shown by the administrative team where previous survey results are made accessible. The previous survey results were from the 7/29/15 survey. This represents the most recent conducted survey by state VDH-OLC.

All residents are notified and shown by the administrative team where previous survey results are made accessible.

A second binder entitled "Surveys" has been placed in the resident living room.

The "Surveys" binder will be weekly monitored by the administrative team.

All above completed on 03-31-18

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On March 7, 2018 at 1 p.m. the surveyor reviewed a white binder that had placed in the conference room and labeled as a survey ready book. The surveyor noted that the binder contained facility labeled documents along with a copy of the Code of Virginia. The surveyor noted that a document intermingled in the State Code of Virginia and under the heading of Resident Rights read ...

"Resident Rights ... Examination of survey results. Each resident shall have the right to examine the results of the most recent facility survey conducted by Federal or State surveyors. Residents may also examine any plan of correction in effect in the facility."

On March 8, 2018 at 10 a.m. the surveyor asked the Adm for the several policies and procedures. The Adm stated that he did not have specific policy's for certain areas. The surveyor identified that the AT had placed facility labeled documents in the white binder labeled as a survey ready binder. The surveyor asked the Adm if the documents were the facility's policy's and procedures. The Adm stated yes that was part of their procedures.

On March 8, 2018 at 12:15 p.m. the surveyor informed the Administrative Team (AT) that the survey ready white binder that had been left in the conference room had been reviewed. The surveyor notified the AT that the binder included a copy of the Code of Virginia and also included a document under Resident Rights that stated that the residents would have access to the survey results. The surveyor notified the AT that the survey results were not available for the Residents to review. The surveyor notified the AT that the survey results were behind a locked door and not easily accessible to the residents to review. The

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F 001	Continued From Page 7 Adm stated that that the Code of Virginia did not say that the survey results had to be available to the residents. The surveyor acknowledged that the Code of Virginia did not mandate that the survey results had to be accessible to the residents, however, the facility policy stated that the survey results would be accessible. The surveyor notified the AT that the results were not accessible. The Adm stated if he put the survey results out in the facility they would disappear. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to implement their own policy and procedure related to Resident Rights. 2. 12VAC5-371 220.B. and F. Nursing Services Based on staff interview and clinical record review it was determined that the facility staff failed to implement written resident care policies and procedures which support an active program of nursing care directed toward assisting all residents to achieve outcomes consistent with their highest level of self-care and independence for 2 of 3 Residents in the sample survey, Resident #3 and Resident #1. 1. For Resident #3 the facility staff failed to follow physician orders to obtain a BMP every 3 months (April, July, October and January). 2 .For Resident #1 the facility staff failed to provide showers/tub baths twice a week. The Findings Included: 1. Resident #3 was an 81-year-old male who was admitted on 4/26/15. Admitting diagnoses included, but were not limited to: edema, muscle weakness, lack of coordination, abnormalities of the gait, major depression, alcoholic cirrhosis of	F 001	12VAC5-371 220.B. Nursing Services A discrepancy was noted between physician telephone order of 04-10-2017 and current physician's orders obtained monthly from consulting pharmacy. A new physician order was obtained on 07-20-2018. Monthly physician's orders from consulting pharmacy shall reflect attending physician's most recent orders for laboratory work. The monthly pharmacy printouts will be reviewed by 2 staff nurses for accuracy. Discrepancies will be corrected by facility nurses and faxed to pharmacy for revision. All above completed on	07-31-18

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the liver, ascites, alcoholic abuse, cerebrovascular accident, hypertension, and dementia with Alzheimer's.

On March 7, 2018 at 1:15 p.m., the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced signed physician orders dated 3/4/18. Signed physician orders included, but were not limited to: "BMP every three months-Apr (April)/, Jul (July)/, Oct (October)/, Jan (January) - On Lasix and Spironolactone. Spironolactone F/C 25mg tablet for> Aldactone F/C take ½ tab (tablet) (12.5mg) by mouth every day for edema. Furosemide 20mg tablet for> Lasix take ½ tab (10mg) by mouth twice daily for edema." (sic) Both the Spironolactone and Lasix were initiated on 4/26/16.

Continued review of the clinical record produced the results of a BMP that had been obtain in July 2017 and January 2018.

On March 7, 2018 at 1:45 p.m., the surveyor notified the Director of Nursing (DON) that Resident #3's physician had written an order for a BMP to be obtained every 3 months (April, July, October and January). The surveyor notified the DON that the BMP had been obtained in July 2017 and January 2018. The surveyor notified the DON that review of the clinical record failed to produce the BMP results for April and October 2017. The surveyor reviewed the clinical record with the DON. The surveyor specifically reviewed the signed physician orders and the BMP results dated 7/11/17 and 1/23/18. The DON said she thought a physician's order had been obtained to discontinue the BMP every three months. The surveyor and DON reviewed Resident #3's clinical record. The DON and surveyor were unable to locate a physician order to discontinue the BMP's every three months.

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On March 7, 2018 at 4:10 p.m. the survey team met with the Administrator (Adm) and DON. The surveyor notified the Administrative Team (AT) that Resident #3 had a physician order to obtain a BMP every three months. The surveyor notified the AT that review of Resident #3's clinical record failed to produce the results of the BMP for April and October 2017.

No additional information was provided prior to exiting the facility as to why the facility staff failed to follow physician orders, to obtain a BMP every three months, for Resident #3.

For additional information regarding Resident #3 refer to 12VAC5-371-110.B., 12VAC5-371-240.E. and 12VAC5-371-300-A.

3. 12VAC5-371 240.E. Physician Services

Based on staff interview and clinical record review it was determined that the physician failed to write a Physician Progress Note with each visit for 2 of 3 Residents in the sample survey, Resident #3 and Resident #1.

The Findings Included:

1. Resident #3 was an 81 year old male who was admitted on 4/26/15. Admitting diagnoses included, but were not limited to: edema, muscle weakness, lack of coordination, abnormalities of the gait, major depression, alcoholic cirrhosis of the liver, ascites, alcoholic abuse, cerebrovascular accident, hypertension, and dementia with Alzheimer's.

On March 7, 2018 at 1:15 p.m., the surveyor reviewed Resident #3's clinical record. Review of

12VAC5-371-240.E. Physician Services

The administrative team shall notify in writing that all attending physicians shall comply with 12VAC5-371-240. Attending physician's progress notes are to be contained in each resident's clinical record.

On March 8, 2018 the attending physician's progress notes were downloaded into the resident's clinical records from physician's email to the facility administrator.

A new procedure is now in place so to minimize future non-compliance. The medical director has developed a form template to be used by attending physicians to document physician's orders, treatments and medical care to comply with 12VAC5-371-240.

The administrative team shall monitor compliance of attending physicians on a monthly basis.

All above completed on 07-31-18

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the clinical record failed to produce Physician Progress Notes. The last Physician Progress Note that could be located in the clinical record was dated 11/7/16.

On March 7, 2018 at 1:45 p.m., the surveyor sat down with the Director of Nursing (DON) and reviewed Resident #3's clinical record. The surveyor asked the DON how often the physician came and saw Resident #3. The DON stated that the physician came to see Resident #3 about every two months. The surveyor notified the DON that the surveyor was unable to locate any Physician Progress Notes in Resident #3's clinical record. The surveyor reviewed Resident #3's clinical record with the DON. The surveyor pointed out the most current Physician Progress Note located in the clinical record was dated 11/7/16. The DON stated that Resident #3's physician was supposed to bring a flash drive to the facility and have all of the Physician Progress Notes printed. The DON stated that she would let the surveyor look at her, the DON's, phone to see the text messages between the DON and the physician. The surveyor declined to review the text messages between the DON and the physician.

On March 7, 2018 at 4:10 p.m. the survey team met with the Administrator (Adm) and DON. The surveyor notified the Administrative Team (AT) that Resident #3's clinical record did not contain any Physician Progress Notes. The surveyor notified the AT that the most current Physician Progress Note located in the clinical record was dated 11/7/16. The DON reiterated that the physician had stated he was going to bring a flash drive to the facility and print all of his progress notes. The DON once again stated that the surveyor could look at the text messages between her, the DON, and the physician on her phone.

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No additional information was provided prior to exiting the facility as to why the physician failed to write a Physician Progress Note with every visit for Resident #3.

For additional information regarding Resident #3 refer to 12VAC5-371-110.B., 12VAC5-371-220.B. and 12VAC5-371-300-A.

4. 12VAC5-371-300.B. Pharmaceutical Services

Based on observation, staff interview, clinical record review and facility document review it was determined that the facility staff failed to implement policies and procedures related to the administration of medications for 1 of 3 Residents in the sample survey, Resident #3.

The Findings Included:

Resident #3 was an 81-year-old male who was admitted on 4/26/15. Admitting diagnoses included, but were not limited to: edema, muscle weakness, lack of coordination, abnormalities of the gait, major depression, alcoholic cirrhosis of the liver, ascites, alcoholic abuse, cerebrovascular accident, hypertension, and dementia with Alzheimer's.

On March 7, 2018 at 1:15 p.m., the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced signed physician orders dated 3/4/18. Signed physician orders included, but were not limited to: "Furosemide 20mg tablet for> Lasix take ½ tab (10mg) by mouth twice daily for edema." (sic)

Continued review of the clinical record produced Resident #3's Care Plan. Review of the Care Plan identified the following "Problem" and

12VAC5-371-300.B.
Pharmaceutical Services

Self-administration of drugs was not consented to by the Resident #3's POA.

For most residents at this facility, legal representatives do not consent to self-administration of drugs. However, the facility has policies and procedures for evaluating residents fpr self-administration of drugs.

In this case, the resident knows that he may not self-administer drugs, although he tells you that he doesn't like it, and that he is capable of taking his medicine. He would be dismissive not being compliant. He is alert and can be argumentative, and he is a vocal complainer about many aspects of his care and current life situation. He prefers being in control as noted in the findings contained in this report.

The LPN administering medications for Resident #3 did not follow the consent. Instead she used her nursing judgment based on her knowledge of the resident's wishes, and accordingly used a different approach.

The resident occupies a bed in a shared room. Since his admission, he has long been the sole occupant in the room.

The LPN agreed to allow the resident some independence in taking this particular medication.

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"Interventions/Services." "Problem Medication Administration-Resident is dependent in medications administration. He frequently decides he isn't going to be medication compliant and refuses medicines if he thinks they are not given at the very minute he wants them. Interventions/Services All medications are administered by licensed nursing staff. Medication reviews will be conducted by pharmacy & M.D., as required by regulations. Resident will be encouraged to remain medication compliant." (sic)

On March 8, 2018 at 8 a.m., the surveyor stepped into Resident #3's room to see how he had slept. Resident #3 stated he had not slept well. The surveyor noted a plastic medication cup on Resident #3's dresser. The surveyor looked into the plastic medication cup and observed a small white pill that had been broken in half. The surveyor picked up the plastic medication cup and exited Resident #3's room.

On March 8, 2018 at 8:05 a.m., the surveyor stepped out of Resident #3's room and observed a Licensed Practical Nurse (LPN) standing at the medication cart. The surveyor stepped over to the medication cart and informed the LPN that the plastic medication cup, containing a white pill that had been broken in half, was located in Resident #3's room. The surveyor asked the LPN if she knew what the name of the medication was. The LPN yelled, "I know exactly what it is." The LPN then yelled, "It's his Lasix." The LPN then yelled that she had left the Lasix in Resident #3's room for him to take. The surveyor asked if Resident #3 had been assessed to self-administer his own medications. LPN yelled, "No" to the surveyor. LPN then yelled at the surveyor and stated, "I was trying to treat him like an adult."

On March 8, 2018 at 9:15 a.m., the surveyor

The surveyor interfered with resident care by taking the resident's medicine from his bedside while the resident watched her. Rather, the surveyor should have approached the nurse first about the medicine. The LPN could have then explained her approach to the suveyor. The surveyor's questions could have been answered by the nurse regarding consents and protocols, etc. without involving the resident.

On March 8, 2018, the resident complained to the LPN about being treated like a baby. The LPN then called the resident's physician, and obtained a telephone order permitting the nurse to leave the resident's medicine at the resident's bedside.

Within a few days, a new resident was admitted to a room 10, now shared by Resident #3. The DON obtained a physician's order to rescind the order permitting medicine to be left at the resident's bedside.

The DON and LPN have explained to Resident #3 with an emphasis on safety for him and other residents, that medicines must be taken by him as nurses observe him doing so.

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F 001	Continued From Page 13 notified the Director of Nursing (DON) that a plastic medication cup containing medication had been found in Resident #3's room. The surveyor notified the DON that the LPN working the medication cart had identified the medication as Resident #3's Lasix. The surveyor notified the DON that the LPN had stated that she, the LPN, had left the Lasix in Resident #3's room for him to take. The surveyor also notified the DON that Resident #3's care plan documented that Resident #3 was dependent on the nursing staff for medication administration. The surveyor asked if Resident #3 had been assessed for self-administration of medications and the DON stated, "No." Lastly, the surveyor asked for the facility policy and procedure for medication administration. The DON stated that the Administrator (Adm) had all the policies and that she would get the policy when the Adm came into work. On March 8, 2018 at 9:30 a.m., the surveyor was sitting at the nurses' station and observed the Pharmacy Policy and Procedure manual. The surveyor read the policy and procedure titled, "6.0 General Dose Preparation and Medication Administration." The policy and procedure read in part ... "3.9 Facility staff should not leave medications or chemicals unattended." On March 8, 2018 at 9:35 a.m., the surveyor notified the Adm that the LPN working the medication cart had left Resident #3's medications in his room. The Adm stated, "She shouldn't have left them in there." The surveyor asked if Resident #3 had been assessed to self-administer his own medications and the Adm stated he did not think so. On March 8, 2018 at 10 a.m., the Adm approached the surveyor and hand delivered a	F 001	The nurse(s) administering drugs have been instructed by the DON that medications may only be left at resident's bedside when so ordered by the attending physician and with the consent of the residents' legal representative. The DON shall monitor compliance monthly. All above completed on	07-31-18

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document titled, "Notifications and Consents." The Adm pointed out that the document identified that on 5/1/16 that Resident #3's wife had documented that she did not want her husband, Resident #3, to be assessed for self-administration on medications.

On March 7, 2018 at 4:10 p.m. the survey team met with the Administrator (Adm) and DON. The surveyor notified the Administrative Team (AT) that the LPN working the medication cart had not implemented pharmacy policies and procedures for medication administration. The surveyor notified the AT that the LPN had left Resident #3's medications in his room for him to self-administer the medications.

No additional information was provided prior to exiting the facility as to why the facility staff failed to implement pharmacy policies and procedures. The LPN had left Resident #3's medications in his room for his to self-administer. The medications were unattended.

For additional information regarding Resident #3 refer to 12VAC5-371-110.B., 12VAC5-371-220.B. and 12VAC5-371-240-E.

5. 12VAC5-371-370.A. Maintenance and Housekeeping

Based on observation and staff interview it was determined that the facility failed to provide a sanitary, safe, and comfortable environment for the facility Residents'.

The Findings Included:

On March 7, 2018 at 11:50 a.m., the surveyor made an initial tour of the facility. The surveyor

12VAC5-371-370-A.
Maintenance and Housekeeping

Several items observed in the findings contained in this report were corrected on or by end of survey date 03-08-18, completed by facility maintenance staff.

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F 001	Continued From Page 15 made the following observations: Front lobby heavy accumulation of dust on the three air vents located in the ceiling. Dining room heavy accumulation of dust on the three air vents located in the ceiling. In the hallway near room. In the hallway near room, the front lobby on the left hand side of the hallway the surveyor observed a sharp pipe that extended into the path of the hallway. Room #1- three soiled ceiling tiles. In the bathroom, the tub had been disconnected from the water supply. It appeared that the water lines had been cut. The water pipes were exposed. Sharp water pipes were observed where the water supply had been disconnected from the tub. #2- four soiled ceiling tiles. Plaster was broken away from the wall exposing a sharp jagged edge at about a waist level. In the bathroom, the tub had been disconnected from the water supply. It appeared that the water pipes had been cut. The sharp water pipes were exposed where the water had been disconnected from the tub. Large pieces of the wallpaper were peeling away from the wall. Room #3- 1 soiled ceiling tile. Broken heat register with sharp edges exposed. Room #4- In the bathroom 1 broken tile at the shower. The broken tile was located at the shower and was at ankle level. The broken tile had sharp and jagged edges. Room #6- six soiled ceiling tiles. In the bathroom the ceiling had two large areas were the paint had	F 001	All residents rooms identified in the findings of this report are being evaluated for tile repair/replacements, ceiling painting and replacements of ceiling tiles. All repairs shall be completed by facility maintenance staff. A book for repairs is maintained at the facility utility room and each day facility maintenance staff review and then coordinate repairs identified by facility staff members. Providing a sanitary, safe and comfortable environment is an ongoing demand for facility maintenance staff. Improvements and assurance of maintaining a sanitary, safe and comfortable environment shall be reviewed by the administrative team monthly and monitored for compliance with facility maintenance and housekeeping staff. All above completed on	08-31-18

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a bubbling effect. The bathroom also had wallpaper that was peeling away from the wall. The bathroom also had five broken tiles. One of the tiles was at the shower and at the ankle level. The broken tile had sharp and jagged edges.

In the Hallway at room #6 were three soiled ceiling tiles.

Room #7 had one soiled ceiling tile.

Room #8 the bathroom had peeling wallpaper.

Room #9 the bathroom had two broken tiles at the shower. The tiles were at the knee level near the shower. The broken tiles had sharp and jagged edges.

Room #10 had large areas of peeling wallpaper at the closet. The bathroom also had peeling wallpaper. The bathroom had one broken tile that had sharp and jagged edges. The broken tile was at the knee level.

In the hallway near room #10, the surveyor observed three areas where the wallpaper was lifting/peeling away from the wall. The surveyor noted that one of the areas had scotch tape applied in an attempt to reattach the wallpaper to the wall.

Room #11 the bathroom had an area of bubbling paint on the ceiling. The shower did not have a shower head/nozzle.

Room #12 had one soiled ceiling tile.

In the hallway near Room #12 had one soiled ceiling tile.

In Room #13, the wallpaper at the window was

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peeling away from the wall. Approximately 1 ½ feet of wallpaper had lifted/peeled away from the wall. The surveyor observed 2 soiled ceiling tiles in the room. In the bathroom, the bathtub had been disconnected from the water supply. It appeared that the pipes had been cut. The disconnected water pipes were sharp and jagged on the edges. The surveyor noted that the pipes were still leaking and that someone had rolled up approximately eight balls of toilet paper and paper towels and placed them in the water that was leaking from the pipes.

On March 8, 2018 at 8:10 a.m., the surveyor made a tour of the facility with one of the Maintenance Men (MM). The surveyor noted that several of the resident rooms had the doors closed indicating that staff were providing care in those rooms. The surveyor made a sporadic tour of the facility with the Maintenance Man (MM). The surveyor pointed out the soiled ceiling tiles, exposed sharp water pipes that had been cut away from the tubs, the broken ceiling tiles, the bubbling paint on the bathroom ceilings and the peeling wallpaper to the MM. The MM stated that all of the bathtubs had been disconnected from the water supply a long time ago. The MM stated that they were slowly making repairs and fixing everything. The surveyor asked when the repairs had been started. The MM stated he did not know. The surveyor asked if the facility had a time line as to when all of the repairs would be completed and the MM stated, "No." The MM stated that the facility had two part time MM. The MM stated he worked on Thursdays and Fridays.

On March 8, 2018 at 1:15 p.m., the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that the facility staff failed to ensure an environment that was sanitary, safe, and comfortable for the facility Residents'. The

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F 001	Continued From Page 18 surveyor notified the Administrative Team (AT) of the concerns that she had identified during her tour of the facility. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a sanitary, safe and comfortable environment for the Residents' of the facility. 6. 12VAC5371-190 Safety and Emergency Procedures Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement safety and emergency procedures for 1 of 3 residents in the survey sample. Resident # 1. The findings included The facility staff failed to notify the Office of Licensure and Certification when Resident # 1 was kidnapped from the facility. Resident # 1 is an 80-year-old female who was originally admitted to the facility on 12-18-17. Diagnoses included but were not limited to: sacral pressure ulcer, hypertension, pressure ulcer of sacral region, malignant breast cancer, and type 2 diabetes mellitus. The clinical record for Resident #1 was reviewed on 3/7/18 at 12:20 pm. While reviewing the nurses notes the surveyor observed a note that was written on 12/23/17 at 1:00 pm that stated "Resident out with niece for lunch." A nurse's note written on 12/23/17 at 6:00 pm stated "Received a call from niece that resident had family coming to her house and would like to stay the night and would return resident to WHN first thing in the morning. This nurse voiced concerns that resident would be missing her meds as this was a last minute discussion. Niece stated	F 001	12VAC5-371-190 Safety and Emergency Procedures The findings in this report were based on hearsay which was not factually accurate. Resident #1 was out of facility with a family member. There was no restriction on visitation or of taking resident out of facility indicated on the consent form signed by the resident's legal representative at time of the resident's admission. The administrative team determined that there was no emergent danger that would require notifying the OLC as per regulation.	

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F 001	Continued From Page 19 that she still had meds from when resident was at (facility name withheld) where she resided before WNH." A nurse's note written on 12/24/17 at 8:30 am stated, "This nurse called niece (niece name withheld) asking what time she planned to bring resident back to the facility as her 9am meds were soon due. Niece stated that resident was doing well, had woken around 5 am and at that time niece changed wound dressing stating, "The Dr. (doctor) at (facility name withheld) had shown her how and what to use." Niece stated more family was due from out of town and resident wishes to stay to visit till around lunchtime. This nurse asked niece to please advise WNH as to a time frame of arrival and voiced concern of resident being new to the facility and us not knowing much about her. Niece assured the nurse that resident was doing well and enjoying the family visits and that she would call to notify us of a time. This nurse stated, "You do plan on bringing her back today correct?' Niece assured this nurse she would and would call later with a time." A nurse's note written on 12/24/17 at 1pm stated, "Received a call from niece stating resident was doing well and they had found out more family was coming for a party later in the evening. This nurse stated, "I'm getting a little concerned about her medications and that she has been gone so long." Niece again assured me that it was only because resident had not seen those family members in so long. This nurse asked if POA was aware of resident being with niece. The niece assured this nurse he was and she would call again with a time of arrival." A nurse's note written on 12/24/17 at 1:20 pm stated, "This nurse called (POA name withheld) and discovered he was not in fact aware of the	F 001	The administrative team, during the admission process, now redoubles efforts to understand family wishes, and consents of the residents' legal representative. A sign in log sheet is now kept at the main entrance of facility, showing date, visitor name, resident name, reason for visit, and time in and out. The administrative team shall keep log sheet for review by OLC. All above corrected on	04-26-18

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situation. He told this nurse that (niece's name withheld) is in fact not a niece and has no rights to take resident anywhere. He asked me to call niece and tell her to bring resident back immediately and for this nurse to call police to send someone to resident's home where niece had been staying. This nurse called niece and got voicemail. Left message stating POA was unaware she had resident and she needed to bring resident back immediately and that law enforcement would be called. This nurse called police to apprise of situation. They transferred me to Bedford police and they said they would send an officer to WNH to get a report."

A nurse's note written on 12/24/17 at 1:40 pm, stated, "(sheriff deputy name withheld) was given info on the situation. He asked for administration to be called in. This nurse tried to call DON and notify her of the situation. DON said she was on her was. Alerted (sheriff deputy name withheld) of this." DON arrived at WNH and conferred with (sheriff deputy name withheld) of situation. This nurse went to resident's room with CNA to see if resident's clothes had been taken as well. This nurse found an envelope with (POA name withheld) name on it, opened it up and realized it was a letter explaining that (niece's name withheld) had intended to remove resident from the facility. This nurse took the letter to DON and (sheriff deputy name withheld)."

A nurse's note written on 12/24/17 at 9:30 pm, stated "Received a call from (employee name withheld) at (facility name withheld) that resident has been brought in by law enforcement in Tennessee and was aware of the situation and was asked to call for resident's med list. She states that transport will not be available back to WNH until probably after Christmas but that POA has been notified and wishes her returned to

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WNH. This nurse called DON to make her aware resident is now safe."

A nurse's note written on 12/26/18 at 6:00pm stated, "Resident has returned to WNH via Tennessee EMS transport. Resident accompanied by POA. (POA name withheld) who reiterated to staff that only he and his wife or his son and his wife and their attorney are the only ones to receive information on the resident or have contact with resident. POA stated that if (niece's name withheld) calls or attempts to come to the facility that she is not to be let in and to notify him and the law enforcement immediately. No signs or symptoms of discomfort or distress from resident at this time. VS 97.8,68,16.117/62,95 R/A. No signs or symptoms of injury. Will continue to monitor and provide support."

On 3/7/18 at 2:08 pm, the surveyor spoke with the director of nursing about the incident as written above. The surveyor asked the director of nursing if she felt that the Resident # 1 had been kidnapped. The director of nursing stated "Oh yes." The surveyor then asked if she had reported this incident to the Office of Licensure and Certification. The director of nursing stated that she reported the incident to adult protective services, local law enforcement, and the ombudsman, but had not reported the incident to the Office of Licensure and Certification and did not know that she had to.

On 3/8/18 at 9:20 am, the surveyor requested a policy for kidnapping. The administrator provided the surveyor with a copy on the policy for elopement and stated that the facility would utilize this policy in the event of a kidnapping as well. According to the facility policy under "responding to an actual elopement, section 4 has a bullet point that includes but is not limited to "report the

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F 001	Continued From Page 22 incident to the state authorities as required." According to 12VAC5-371-190, Section E. states "In the event of a disaster, fire, emergency or any other condition that may jeopardize the health, safety and well-being of residents. The organization shall notify the OLC of the conditions and status of the residents and the licensed facility as soon as possible." On 3/8/18 at 11:20 am, the director of nursing and administrator were 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 3/8/18. 7. 12VAC5-371 220 Nursing Services Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement written care policies and procedures which support an active program of nursing care directed toward assisting all residents to achieve outcomes consistent with their highest level of self-care and independence for 1 of 3 residents in the survey sample Resident # 1. The findings included: The facility staff failed to notify the attending physician and/or responsible party of changes in condition for Resident # 1. Resident # 1 is an 80-year-old female who was originally admitted to the facility on 12-18-17. Diagnoses included but were not limited to: sacral pressure ulcer, hypertension, pressure ulcer of sacral region, malignant breast cancer, and type 2	F 001	12VAC5-371-220. Nursing Services Resident #1 identified in the findings of this report is a Hospice patient, in which the Hospice agency is responsible for the patient's plan of care. The facility nursing staff coordinates with the Hospice nursing staff to provide the patient's with highest practicable physical, mental, and psychosocial well-being. The facility agrees to notify the Hospice agency when there is a significant change in the Hospice patients physical, mental, social, or emotional status. None of the findings in this report show a significant change in the Hospice patient's physical, mental, social or emotional status.	

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F 001	Continued From Page 23 diabetes mellitus. The clinical record for Resident #1 was reviewed on 3/7/18 at 12:20 pm. A nurse's note written on 12/18/17 at 5:15 pm stated, "CNA (certified nursing assistant) notified me of skin tear upon transferring rsd. (resident) to w/c (wheelchair) for dinner. Small 1.5 cm (centimeter) area cleaned and covered with band-aid. Will continue to monitor. V/S (vital signs) 98.0-108-20-107/63-96% O2 RA (room air)." This surveyor did not locate documentation that the physician or responsible party had been notified about the incident as written above. A nurse's note written on 1/15/18 at 12:30 am stated, "During ADL (activities of daily living) CNA noticed redness to left hip and called this nurse to residents room. This nurse noted redness and very light blue color around redness on resident's left hip and another area of redness with very light blue color on pelvis bone. Provon applied to both areas. Will pass on to 7-3 nurse to notify hospice in the morning. Resident turned and repositioned. Will continue to monitor." This surveyor did not locate any documentation in the clinical record that the physician or responsible party had been notified of the area as stated above. A nurse's note written on 2/3/18 at 6:45 pm stated "Resident slid out of chair to floor at dinnertime. No injuries noted. V/S 97.4-90-18-128/68-94% O2. No c/o (complaints of) pain POA notified." This surveyor did not locate any documentation in the clinical record that the physician was made aware of the fall as written above. A nurse's note written on 2/12/18 at 2:30 am stated, "During ADL care CNA noted bruising to right foot, notified this nurse. This nurse assessed resident's right leg and foot and noted top of right foot, into ankle and pinky toe and toe next to it to	F 001	There are no incident reports on record regarding any of the findings contained in this report. Although observations were made by facility CNAs and reported to the facility nurse, and that medical treatment was provided Resident #1 there was no notification made to the attending physician or Hospice physician made by facility nurses. The legal representative was not notified as the observations made were within scope of nurses' judgment. In each finding, the facility nursing staff notified the Hospice nursing staff, and documented nurses notes in Resident #1's clinical record. In each finding, appropriate nursing care was provided to Resident #1 by facility nursing staff and by Hospice nursing staff. There are no reports of a need to alter treatment significantly to the Hospice patient's plan of care. The administrative team and facility medical director shall revise policy and procedure regarding the appropriate notification of others to conform to 12VAC5-371-220.H. All above completed on	08-31-18

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have yellow/greenish color bruising. Also right foot and halfway up resident's leg to be edematous. Resident had two falls one on 2/3/18 and one on 1/29/18. Will pass on for 7-3 to notify hospice of bruising and swelling to right leg and foot." This surveyor did not locate any documentation in the clinical record that the physician and responsible party had been made aware of the incident as written above.

On 3/7/18 at 1:00 pm, the surveyor spoke with the Director of nursing about the information as stated above and requested feedback about physician and responsible party notification. The Director of nursing stated that she would check into it.

On 3/8/18 at 9:10 am, the surveyor spoke with the director of nursing about notification of the physician and responsible party for Resident # 1. The director of nursing stated that if the documentation is not there then she does not have any.

According to the facility policy on notification of changes that was provided to the survey team by the facility. "The facility will immediately inform the resident and consult with the resident's physician, if appropriate, when changes occur. I unknown, the facility should also notify the resident's legal representative or interested family member."
"Notification of changes shall include:
1. An incident involving the resident which results in injury and the potential for requiring physician intervention;
2. A significant change in the resident's physical, mental, or psychological status, such as a deterioration in health, mental, or psychosocial status, in life-threatening conditions or clinical complications;
3. A need to alter treatment significantly;"

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F 001	Continued From Page 25 On 3/8/18 at 12:10 pm, the survey team met with the administrator and the director of nursing and made them aware of the findings as written above. No further information was presented to the survey team prior to the exit conference on3/8/18. The facility staff failed to ensure that Resident # 1 received tub or shower baths at least twice weekly. Resident # 1 is an 80-year-old female who was originally admitted to the facility on 12-18-17. Diagnoses included but were not limited to: sacral pressure ulcer, hypertension, pressure ulcer of sacral region, malignant breast cancer, and type 2 diabetes mellitus. The clinical record for Resident #1 was reviewed on 3/7/18 at 12:20 pm. The facility ADL flow record for December 2017, January 2018 and February 2018 was reviewed for Resident #1. According to the clinical record, the only date that Resident # 1 received a shower was 12/19/17. On 3/7/18, at 12:40 pm the surveyor spoke with the director of nursing regarding the showers for Resident # 1. After reviewing the documentation in the clinical record along with the surveyor, the director of nursing agreed that documentation in the clinical record did not reflect that Resident # 1 had received at least 2 tub baths or showers weekly since her admission on 12/18/17. No further information was provided to the survey team prior to the exit conference on 3/8/18. 8. 12 VAC5-371 240 Physician Services Based on staff interview, facility document review,	F 001	12VAC5-371 220.F. Nursing Services Upon review of resident #1's ADL sheet for bathing, it is documented that Resident # 1 receive daily total sponge (bed) baths due to her medical condition. Both Hospice nursing staff and facility nursing staff provided appropriate bathing for the resident. The resident plan of care reflects the bathing protocol for this resident. All residents are evaluated by facility nurses upon admission to determine their ability to tolerate tub or shower baths, or whether the resident shall receive daily sponge (bed) baths. These protocols will be addressed in each residents' plan of care. Documentation will be monitored by facility nursing staff on ADL sheets for each resident. All above completed on	07-31-18

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F 001	Continued From Page 26 and clinical record review, the facility staff failed to ensure that the physician progress notes were in the clinical record for 1 of 3 residents within the survey sample Resident #1 . The findings included: The facility staff failed to ensure that physician progress notes were in the clinical record for Resident#1. Resident # 1 is an 80-year-old female who was originally admitted to the facility on 12-18-17. Diagnoses included but were not limited to: sacral pressure ulcer, hypertension, pressure ulcer of sacral region, malignant breast cancer, and type 2 diabetes mellitus. The clinical record for Resident # 1 was reviewed on 3/7/18 at 12:20 pm. This surveyor could not locate any physician progress notes in the clinical record, which would indicate that the physician had seen Resident # 1 since her admission on 12-18-17. On 3/7/18 at 12:20 pm, the surveyor spoke with the director of nursing regarding no physician progress notes since admission for Resident # 1. The director of nursing stated that the facility has recently changed medical directors and the facility has been having a difficult time getting the physician to send the progress notes to the facility. On 3/8/18 at 9:23 am, the administrator made the survey team aware that the physician had emailed a large file of progress notes to the facility on the morning of 3/8/18. On 3/8/18 at 12:10 pm, the administrator and director of nursing was made aware of the findings as stated above. No further information was	F 001	12VAC5-371-240. Physician Services The administrative team shall notify in writing to all attending physicians to comply with all elements contained in 12VAC5-371-240. The administrative team shall monitor compliance of attending physicians on a monthly basis. All above completed on	08-17-18

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provided to the survey team prior to the exit conference on 3/8/18.

Based on observation and staff interview, facility staff failed to ensure that dietary staff failed to ensure sanitary kitchen conditions as applied to 12VAC5-421.

The findings included

The facility staff failed to ensure that hair restraints were applied appropriately on two employees that were serving food on the tray line for lunch, failed to ensure that pans for food storage and preparation was air dried, a soiled paper towel was observed in clean pans, the facility can opener was dirty, and a soiled chux pad was observed in the kitchen floor near the dishwasher

On 3/7/18 at 11:50 am, during the initial tour of the kitchen this surveyor observed a soiled chux pad on the floor in the kitchen near the dishwasher. The surveyor asked a kitchen employee where the dried pans were stored. The kitchen employee showed the surveyor a rack in the kitchen were several silver pans were store. The surveyor asked the kitchen employee if she could lift the pans. When the kitchen employee lifted the second and third pan, a copious amount of water fell from each pan

On 3/7/18 at 11:55 am, a kitchen employee lifted the dried pans at the request of the surveyor. When the kitchen employee lifted the pan on the top and removed it from the shelf a soiled white paper towel was observed in the pan. The kitchen employee removed the soiled paper towel and put the paper towel in the trash and replaced the pan on the shelf.

On 3/7/18 at 12:03 pm, the surveyor observed the

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F 001	Continued From Page 28 facility can opener with dried brown and red substances on it and white hair like particles on the can opener. The surveyor brought the soiled can opener to the attention of the kitchen employee. On 3/8/18 at 11:27 am, the surveyor observed 2 kitchen staff members placing food on the resident trays from the tray line. Both employees were wearing hairnets however all hair was not secured in the hair heat and hair was observed coming from the front, sides and back of the hairnets. On 3/8/18 at 11:35 am, the surveyor made the facility administrator aware of the observation as stated above. The administrator agreed with the surveyor that all hair should be secured in a hairnet while serving food for the residents. The administrator stated that he will conduct and in-service on the proper application of hairnets. The administrator also told the surveyor that the chux pad was used last week because the grease trap had broken and the chux pads were used to soak up the grease and stated "But that was last week it should not be there now." No further information was provided to the survey team prior to the exit conference on 3/8/18. 9. 12VACS-371-140 (A, E,- 3. a,b) as referenced by § 32.1-126.01 of the State Code of Virginia. Based on staff interview and facility document review the facility staff failed to ensure that background checks were obtained in 30 days and sworn statement or affirmations disclosing any criminal convictions or pending charges for 10 of 11 employee records reviewed.	F 001	12VAC5-421. Food Regulations The findings contained in this report have been addressed by the administrative team with the dietary staff on 03-08-18. On 06-12-18 an annual survey was conducted by the Bedford Department of Health. There were no deficient practices noted during this survey. Monthly, the consulting dietitian reviews all aspects of the residents' dietary needs as related to their medical care. The dietitian shall review the findings of this report and conduct an in-service with dietary staff on or before August 31, 2018. All above completed on	08-31-18

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F 001	Continued From Page 29 The findings included The facility staff failed to have background checks completed within 30 days of hire for 10 of 11 employees and 1 of 11 employee records did not have a sworn statement or affirmation of disclosure. On 3/8/17 at 10:20 am, the surveyor reviewed employee records that were provided by the facility. Upon review of the employee records, the surveyor observed that the background checks had not been completed within 30 days of hire. Employee #1 hire date 9/30/17. Background check completed 1/25/18. Employee #2 hire date 10/13/16. Background check completed 7/13/17. Employee # 3 hire date 11/10/17. Background check completed 1/25/18. Employee #4 hire date 10/27/17. Background check completed 1/25/18. Employee #5 hire date 9/14/17. Background check completed 1/25/18. Employee # 6 hire date 6/15/16. Background check completed 3/31/17. Employee # 7 hire date 7/24/17. Background check completed 9/1/17. Employee #9 hire date 6/15/16. Background check completed 3/31/17. Employee #10 hire date 5/4/16. Background check completed 3/31/17.	F 001	12VAC5-371-140 (A, E, -3. a,b) Policies and Procedures The VDH-OLC conducted the last unannounced survey on 07-14/15-15. The facility was in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. A change was made effective 07-01-16 to Title 32.1-Chapter 5-32.1-126.01. The administrative team was not made aware to obtain background checks within 30 days of employment. The administrative team is now aware of this requirement and shall put it into practice. All documents set forth as required by the Code of Virginia shall be contained in facility employee records for review by VDH-OLC surveyors. All above completed on	07-31-18

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F 001	Continued From Page 30 Employee #11 hire date 1/19/17. Background check completed 3/31/17. While reviewing Employee # 8's record this surveyor could not locate a sworn statement in the employee file. On 3/8/18 at 10:45 am, the surveyor spoke with the administrator regarding employee background checks not being completed within 30 days of hire. The administrator stated to the surveyor "All that the health department requires is that criminal record checks are in the chart." "We try to get them as soon as possible that is the difference from Medicare and Medicaid." On 3/8/18 at 10:51 am, the surveyor asked the administrator about the missing sworn disclosure statement for Employee #8. The administrator reviewed the file for Employee # 8 and stated, "I believe you are right, it's not there." No further information was provided to the survey team prior to the exit conference on 3/8/18.	F 001		