STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

(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 Emergency Preparedness survey was conducted 11/27/18 through 11/29/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/27/18 through 11/29/18. 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 130 bed certified bed facility was 127 at the time of the survey. The survey sample consisted of 31 current resident record reviews and two closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal	F 550	For those residents found to have been effected by the deficient practice of failing to provide a dignified dining experience staff were instructed on correct procedures. Staff members are to be seated when assisting residents at meals unless otherwise as indicated on individual care plan. In addition all residents are to be served the same time as their table mates. Staff should feed only one resident at a time.	11/28/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert A Crowe	ADMINISTRATOR	12-14-18

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 550	Continued From page 1 access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a dignified dining experience in the 5th floor activity/dining area during lunch on 11/27/18 for four of 33 residents in the survey sample, Residents #70, #67, #58, and #83. 1. The facility staff stood over Residents #70, #67, #58, and #83, while feeding them in the 5th floor activity/dining area. 2. Resident #70 was not served her tray at the same time her tablemate's were. She was not	F 550	The facility will identify other residents as having the potential to be affected by the same deficient practice by viewing every meal time as an opportunity to fail to provide a dignified experience. Therefore all residents residing at The Virginia Home have the potential to be affected by the same deficient practices. The following procedures/systemic changes will be implemented to ensure that the deficient practice does not recur. Nursing staff and feeding assistants will be in serviced on the following policies: Feeding a Resident, and The Person Centered Dining Approach. ADON or Designee will complete training. The facility plans to monitor its performance to ensure that solutions are sustained by monitoring at least one meal a day on each shift. This will be completed by the Nursing Supervisors Using a quality assurance tool to indicate that observed residents rights are upheld during meal times. Observations will indicate compliance with a dignified existence and meal time experience with person centered care in a homelike environment. This includes Timely meal delivery to each resident as well as feeding individually to promote quality of life and each resident's individuality.	12/17/18 1/13/19 1/13/19

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F 550	Continued From page 2 served until approximately 10 minutes after her table mates were eating. The findings include: 1. The facility staff stood over Residents #70, #67, #58, and #83, while feeding them in the 5th floor activity/dining area. Resident #70 was admitted to the facility on 5/20/08 with the diagnoses of but not limited to multiple sclerosis, urinary retention, intestinal adhesions with partial obstruction, osteoporosis, mood disorder, hypothyroidism, and insomnia. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 10/11/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for eating. Resident #67 was admitted on 4/8/11 with the diagnoses of but not limited to multiple sclerosis, insomnia, and depression. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/11/18. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for eating. Resident #58 was admitted to the facility on 10/30/03 with the diagnoses of but not limited to cerebral palsy, anemia, and high blood pressure. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/4/18. The resident was coded as being cognitively intact in ability to make	F 550	The QA (quality assurance) tool will be given to the DON on a weekly basis. Any concerns with non- compliance will addressed immediately by Nursing management. The DON will report the quality assurance results to the QAPI (Quality Assurance and Preformance Improvement) committee on a monthly basis for a four month time period.	1/13/19

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F 550	Continued From page 3 daily life decisions. The resident was coded as requiring total care for eating. Resident #83 was admitted to the facility on 6/8/98 with the diagnoses of but not limited to spastic quadriplegic cerebral palsy, seizures, mood disorder, anorexia, neuromuscular dysfunction of the bladder, headache syndrome, and muscle spasms. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 10/18/18. The resident was coded as severely cognitively impaired in ability to make daily life decisions. The resident was coded as requiring total care for eating. On 11/27/18 at 12:41 p.m., (when trays arrived to the unit), lunch was observed on the 5th floor activity/dining room. The following was observed: On 11/27/18 at 12:46 p.m., CNA #1 (Certified Nursing Assistant) stood over Resident #58 to feed him. She did not sit down next to him to feed him until 12:48 p.m., approximately 2 minutes after she started feeding him while standing up over him. On 11/27/18 at 12:49 p.m., CNA #2 was standing over Resident #83 while feeding her. On 11/27/18 at 12:51 p.m., Resident #70 was served her tray, approximately 10 minutes after her tablemate's. CNA #2 stood over Resident #70 while feeding her. On 11/27/18 at 12:53 p.m., CNA #2 who was standing over Resident #70 feeding her, went to the other side of the table to assist Resident #67 with feeding. She handed Resident #67 his fork, then went back to Resident #70, and proceeded	F 550		

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F 550	Continued From page 4 to stand over Resident #70 to feed her again. At 1:03 p.m., 1:04 p.m., and a second time at 1:04 p.m., she repeated the process of going between Resident #70 and Resident #67, feeding each, back and forth. On 11/27/18 at 2:50 p.m., in an interview with CNA #1, she stated that staff should not feed residents while standing over them. CNA#1 stated staff should feed only one resident at a time and residents at a table should all be served at the same time; so that no one has to wait while watching, others at the table eat. CNA #1 stated all the staff knows all this and what was observed during dining should not have occurred. A review of the facility policy "Feeding a Resident" documented, "5. Be seated yourself if this is possible....8. Give the resident choices and make the mealtime as pleasant as possible..." The policy did not state that staff should not stand over a resident to feed them. A review of the facility policy, "The Person Centered Dining Approach" documented, "Person centered care and hospitality services, including dining, will be a vital part of everyday living. The person centered dining approach will focus on each individual's needs related to food, nutrition, and dining....4. All individuals will be treated with the utmost courtesy, respect and dignity. Each person will be treated as a guest...." On 11/29/18 at 8:56 a.m., ASM #2 (Vice President/Chief Operating Officer) was made aware of the findings. No further information was provided by the end of the survey.	F 550		

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F 550	Continued From page 5 2. Resident #70 was not served her tray at the same time her tablemates were. She was not served until approximately 10 minutes after her table mates were eating. Resident #70 was admitted to the facility on 5/20/08 with the diagnoses of but not limited to multiple sclerosis, urinary retention, intestinal adhesions with partial obstruction, osteoporosis, mood disorder, hypothyroidism, and insomnia. The most recent MDS (Minimum Data Set) was an annual assessment with an ARD (Assessment Reference Date) of 10/11/18. The resident was coded as cognitively intact in ability to make daily life decisions. The resident was coded as requiring extensive assistance for eating. On 11/27/18 at 12:41 p.m. (when trays arrived to the unit), lunch was observed on the 5th floor activity/dining room. The following was observed: On 11/27/18 at 12:47 p.m., Resident #70 asked about her tray. She was sitting at a table with three other residents. The other three residents were already eating their meal, as they were served immediately when the trays arrived to the room at approximately 12:41 p.m., CNA #1 (Certified Nursing Assistant) informed Resident #70 that she will get it (her meal) when someone is ready to feed her. A couple minutes later, another resident who was also at the same table as Resident #70, then asked about Resident #70's tray. CNA #1 stated that she (Resident #70) will get it (her meal) when it is time for her (Resident #70) to eat. On 11/27/18 at 12:51 p.m., Resident #70 was served her tray, approximately 10 minutes after	F 550		

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F 550	Continued From page 6 her table mates. On 11/27/18 at 2:50 p.m., in an interview with CNA #1, she stated that residents at a table should all be served at the same time and no one should have to wait while watching others at the table eat. CNA #1 stated all the staff knows all this and what was observed during dining should not have occurred. A review of the facility policy "Feeding a Resident" documented, "8. Give the resident choices and make the mealtime as pleasant as possible..." The policy did not state that each resident at a given table should be served at the same time. A review of the facility policy, "The Person Centered Dining Approach" documented, "Person centered care and hospitality services, including dining, will be a vital part of everyday living. The person centered dining approach will focus on each individual's needs related to food, nutrition, and dining....4. All individuals will be treated with the utmost courtesy, respect and dignity. Each person will be treated as a guest...." The policy did not state that each resident at a given table should be served at the same time. On 11/29/18 at 8:56 a.m., ASM #2 (Vice President/Chief Operating Officer) was made aware of the findings. No further information was provided by the end of the survey.	F 550		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to	F 622	For those residents found to have been affected by the deficient practice, the facility reviewed the current census to note any immediate orders for transfers or discharges.	11/28/18

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F 622	Continued From page 7 remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.	F 622	A checklist of documentation required for transfers and discharges was created to keep on site in order to indicate and confirm the documents that will be sent to the receiving provider. At the time of the deficiency the facility failed to evidence documentation of the documents sent to the hospital for previous facility initiated discharges. However, no other instances of the deficiency affected other residents during the time of the survey. As all residents have the potential to be affected by the deficient practice if they are discharched or transferred, the measures that the facility has taken will ensure the deficient practice does not adversely affect anyone in the future. All residents sent to the hospital have the potential to affected by the deficient practice. All residents sent to the hospital will have a transfer form completed indicating all documentation sent with the resident at the time of transfer. The completed document will be scanned into the residents medical chart by the nursing secretary.	12/28/18

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F 622	Continued From page 8 §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary,	F 622	The following procedures and systemic changes will be implemented to ensure that the deficient practice does not recur: Education will be provided to all nursing supervisors and the nursing secretary by the ADON or designee. Education will be documented on a sign-in sheet in order to capture all key staff members noted above.	1/13/19
		F 622	The facility plans to monitor its performance to ensure that solutions are sustained by a monthly audit of charts of the residents transferred to the hospital. The MDS Coordinator will be responsible for auditing and submitting data to the DON and the QAPI Committee Chair each month by the last day of the month. If issues are found, the MDS Coordinator will immediately notify/consult with the ADON/DON. Additionally education may be provided in order to sustain 100% compliance with documentation of the documents sent to the hospital for every resident's facility initiated transfer.	12/31/18

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F 622	Continued From page 9 consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence that all required documentation was provided to the receiving facility upon transfer to the hospital for three of 33 residents in the survey sample; Residents #105, 36, and 71. 1. The facility staff failed to evidence documentation of the documents sent to the hospital for a facility initiated transfer for 8/24/18 for Resident #105. 2. The facility staff failed to evidence documentation that Resident #36's comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer on 10/19/18. 3. The facility staff failed to evidence documentation of the documents sent to the hospital for Resident # 71's facility initiated transfer on 11/17/18. The findings include: 1. The facility staff failed to evidence documentation of the documents sent to the hospital for a facility initiated transfer for 8/24/18 for Resident #105. Resident #105 was admitted to the facility on 6/20/2000, with a most recent readmission of	F 622		

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F 622	Continued From page 10 8/27/18, with diagnoses that included but were not limited to: multiple sclerosis [a nervous system disease that affects the brain and spinal cord, damaging the myelin sheath (the material that surrounds and protects the nerve cells). This damage slows down or blocks messages between the brain and the body. (1)], chronic kidney disease, neurogenic bladder [lack of bladder control due to a brain, spinal cord, or nerve condition. (2)], dementia, high blood pressure, diabetes, and low back pain. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/01/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily decision making. The nurse's note dated 8/24/18 at 2:36 p.m. documented in part, "Resident was seen by the MD (medical doctor) today for excessive drowsiness ...We will continue to monitor and follow up as needed." The nurse's note dated 8/24/18 at 6:59 p.m. documented in part, "Resident has been sleeping very soundly since the start of this shift. Currently unable to awaken her. Her current VS (vital signs) are stable. Will not respond to verbal or physical stimulus. Will notify MD and plan to transfer to [hospital's name] ER (emergency room) dept (department) for medical evaluation." The physician's order dated 8/24/18 at 7:05 p.m. documented in part, "Send to [hospital's name] ER dept for evaluation of AMS (altered mental status), [a change in mental status such as	F 622		

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F 622	Continued From page 11 confusion, memory loss, loss of alertness, and disorientation (3)]." Review of the clinical record failed to evidence what resident information, including clinical information, was included/provided to the receiving facility for the resident's transfer. An interview was conducted with LPN (licensed practical nurse) #3 on 11/28/18 at 2:24 p.m., regarding what information is sent with residents transferred to the hospital. LPN #3 stated we send their orders but really, the supervisor does that. I stay with the resident until the rescue squad calls. The supervisor does all the paperwork." An interview was conducted with LPN #5, the supervisor, on 11/28/18 at 2:34 p.m., regarding what paper work is sent to the hospital when a resident is transferred to the hospital. LPN #5 stated, the facility send a "Transfer Form" and any attachments required, physician orders, labs (laboratory test results), the care plan, history and physical, nurses notes and face sheet." LPN #5 provided this writer with a copy of the "Transfer Form." The "Transfer Form," documented in part, Residents' name, language spoken, code status, reason for transfer and actions taken prior to transfer. The "Transfer Form," documented the doctor's name and contact information, their vital signs (blood pressure, pulse, respiration), baseline mental status, the resident representatives name and contact information, attachments of the care plan, MAR (medication administration record), TAR (treatment administration record), Doctor's orders, recent pertinent labs, face sheet, x-rays, copy of the DDNR (durable do not resuscitate order) advance	F 622		

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	49E084	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

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F 622	Continued From page 12 directive. It further documented if the resident was at risk for falls, skin breakdown, seizures, communicable disease, aspiration, high and low blood sugars and harm to self or others. The form also documented special conditions, wounds, immunization records, feeding assistance required, and if the resident had any infections. When asked if the facility keeps a copy of the form evidencing what information was sent to the hospital LPN #5 stated, "No, we don't keep a copy." An interview was conducted with administrative staff member (ASM) #3, the director of nursing on 11/28/18 at 3:30 p.m. When asked if the facility keeps a copy of the form that goes to the hospital upon a transfer evidencing what information was provided to the hospital, ASM #3 stated, the facility does not keep a copy of the form." ASM #1, the president/CEO (chief operating officer), ASM #2, the vice-president/COO (chief operations officer), and ASM #3, the director of nursing, were made aware of the above findings on 11/28/18 at 4:16 p.m. A review of the facility's policy, "Transfer of Residents to Hospitals", documents in part, "1. Transfer to Hospital: 1. The physician gives the order to send resident to the hospital to the supervisor. 2. The nursing office secretary arranges transportation ...if an emergency 911 is called. 4. The supervisor completes transfer form and copies necessary information from chart (including the comprehensive care plan). 7. The next of kin or legal guardian is notified by the nursing supervisor."	F 622		

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F 622	Continued From page 13 No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/multiplesclerosis.html 2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000754.htm 3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm 2. The facility staff failed to evidence documentation that Resident #36's comprehensive care plan goals were provided to the receiving provider for a facility initiated transfer on 10/19/18. Resident #36 was admitted to the facility on 4/30/2009 with a readmission date of 10/22/2018. Diagnoses included but were not limited to: diabetes, ulcerative pan colitis (1), hemiplegia (2), depression and hyperlipidemia (3). The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/6/18 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions. Review of Resident #36's clinical record revealed that he had been sent to the hospital on 10/19/18. A nursing note dated 10/19/18 at 9:00 a.m. documented, "Resident was assessed for c/o (complaint of) nausea and vomiting. It was noted that resident vomited about 50-100 ml (milliliters) of coffee ground material his abdomen was very distended (swollen) and he c/o (complained of)	F 622		

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F 622	Continued From page 14 abdominal pain. The M.D. (medical doctor) who was in the facility assessed the resident and ordered him to the ER (emergency room) for evaluation. The residents brother, POA (power of attorney) and emergency contact was notified of the residents illness and pending transfer out to the ER." There was no evidence in the clinical record that Resident #36's comprehensive care plan goals were sent to the receiving provider for this facility-initiated transfer dated 10/19/18. On 11/28/18 at approximately 2:24 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked what documentation is provided to the receiving provider for a facility initiated hospital transfer, LPN #3 stated, "We send their orders but really the supervisor does that. I stay with the resident until the rescue squad calls. The supervisor does all the paperwork." On 11/28/18 at approximately 2:34 p.m., an interview was conducted with LPN #5, the Supervisor. When asked what documentation is provided to the receiving provider for a facility initiated hospital transfer, LPN #5 stated, "We send a 'Transfer Form' and any attachments required: physician orders, labs (laboratory test results), the care plan, history and physical, nurses notes and face sheet." When asked if the facility had evidence, the receiving provider received a "Transfer Form" for Resident #36's facility initiated hospital transfer dated 10/19/18, LPN #5 replied, "No, we don't keep a copy." On 11/28/18 at approximately 2:36 p.m., LPN #5 provided a copy of the facility document titled	F 622		

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F 622	Continued From page 15 "Transfer Form." The "Transfer Form," documented in part, Residents' name, language spoken, code status, reason for transfer and actions taken prior to transfer. The "Transfer Form," documented the doctor's name and contact information, their vital signs (blood pressure, pulse, respiration), baseline mental status, the resident representatives name and contact information, attachments of the care plan, MAR (medication administration record), TAR (treatment administration record), Doctor's orders, Recent pertinent labs, face sheet, x-rays, copy of the DNR (durable do not resuscitate order) advance directive. It further documented if the resident was at risk for falls, skin breakdown, seizures, communicable disease, aspiration, high or low blood sugars and harm to self or others. The form also documented special conditions, wounds, immunization records, feeding assistance required, and if the resident had any infections. On 11/28/18 at approximately 3:30 p.m., an interview was conducted with administrative staff member (ASM) #3, the Director of Nursing. When asked if the facility keeps a copy of the form that goes to the hospital upon a transfer, ASM #3 stated, "The facility does not keep a copy of the form." On 11/28/18 at approximately 5:30 p.m., ASM #1, the president/CEO (chief operating officer), and ASM #2, the vice-president/COO (chief operations officer), were made aware of the findings. No further information was provided prior to exit.	F 622		

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F 622	Continued From page 16 1. Ulcerative colitis (UC) is a disease that causes inflammation and sores, called ulcers, in the lining of the rectum and colon. It is one of a group of diseases called inflammatory bowel disease. UC can happen at any age, but it usually starts between the ages of 15 and 30. It tends to run in families. The most common symptoms are pain in the abdomen and blood or pus in diarrhea. This information was obtained from the website: https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=ulcerative+colitis. 2. Hemiplegia or paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 3. Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm 3. The facility staff failed to evidence documentation of the documents sent to the hospital for Resident # 71's facility initiated transfer on 11/17/18. Resident #71 was admitted to the facility 7/18/16 with a recent readmission on 11/14/18 with	F 622		

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F 622	Continued From page 17 diagnoses, that included but were not limited to: cerebral palsy [loss or deficiency of muscle control due to permanent, nonprogressive brain damage occurring before or at the time of birth. (1)], osteoarthritis [Characterized by degenerative changes in the joints, pain, stiffness and swelling can develop after exercise. (2)]. high blood pressure, depression, chronic pain, and anxiety disorder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/11/18 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance for all of her activities of daily living. The nurse's note dated, 11/27/18 at 6:42 a.m. documented, "Was notified by nurse assigned resident having respiratory problems, and O2 (oxygen) was applied at 2L via N/C (nasal cannula). MD (medical doctor) was notified and N.O (new order) to send out to er (emergency room) to treat and evaluate." The physician order dated, 11/27/18 at 6:53 a.m. documented, "Send to er to eval (evaluation)." An interview was conducted with LPN (licensed practical nurse) #3 on 11/28/18 at 2:24 p.m., regarding what information is sent with residents transferred to the hospital. LPN #3 stated we send their orders but really, the supervisor does that. I stay with the resident until the rescue squad calls. The supervisor does all the paperwork."	F 622		

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F 622	Continued From page 18 An interview was conducted with LPN #5, the supervisor, on 11/28/18 at 2:34 p.m., regarding what paper work is sent to the hospital when a resident is transferred to the hospital. LPN #5 stated, the facility send a "Transfer Form" and any attachments required, physician orders, labs (laboratory test results), the care plan, history and physical, nurses notes and face sheet." LPN #5 provided this writer with a copy of the "Transfer Form." The "Transfer Form," documented in part, Residents' name, language spoken, code status, reason for transfer and actions taken prior to transfer. The "Transfer Form," documented the doctor's name and contact information, their vital signs (blood pressure, pulse, respiration), baseline mental status, the resident representatives name and contact information, attachments of the care plan, MAR (medication administration record), TAR (treatment administration record), Doctor's orders, recent pertinent labs, face sheet, x-rays, copy of the DDNR (durable do not resuscitate order) advance directive. It further documented if the resident was at risk for falls, skin breakdown, seizures, communicable disease, aspiration, high and low blood sugars and harm to self or others. The form also documented special conditions, wounds, immunization records, feeding assistance required, and if the resident had any infections. When asked if the facility keeps a copy of the form evidencing what information was sent to the hospital LPN #5 stated, "No, we don't keep a copy." An interview was conducted with administrative staff member (ASM) #3, the director of nursing on 11/28/18 at 3:30 p.m. When asked if the facility keeps a copy of the form that goes to the hospital upon a transfer, ASM #3 stated, the facility does	F 622		

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F 622	Continued From page 19 not keep a copy of the form." Administrative staff member (ASM) #1, the president, chief executive officer, ASM #2, the vice president, chief operating officer and ASM #3, the director of nursing, were made aware of the above findings on 11/28/18 at 4:20 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 422. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and	F 623	For those residents found to have been affected by the deficient practice, the facility reviewed the current census to note any planned or unplanned transfers to the hospital. At the time of the survey no current residents were identified as having the potential to be affected by the deficient practice. The nursing Supervisors were informed and educated by the DON on the requirement to notify the ombudsman if a resident was going to be transferred to the hospital. All residents sent to the hospital have the potential to affected by the deficient practise. The ombudsman will be notified of all residents transferred to	11/28/18 12/31/18

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F 623	Continued From page 20 (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;	F 623	the hospital by the Director of Restorative Services or designee on a monthly basis via fax. The facility plans to monitor its performance to ensure that solutions are sustained by a monthly audit of charts of residents transferred to the hospital. The Director of Restorative Services will be responsible for auditing and submitting data to the DON and QAPI (Quality Assurance and Performance Improvement) Committee Chair each month by the last day of the month. The following procedures/systemic changes will be implemented to ensure that the deficient practice does not recur: Education/in-service will be provided to Social Services staff by the Director of Restorative Services.	12/31/18 1/13/19 1/13/19

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F 623	Continued From page 21 (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide	F 623		

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F 623	Continued From page 22 written notification to the resident and/or resident representative, and ombudsman for facility initiated transfers to the hospital for two of 33 residents in the survey sample: Residents #105 and 36. 1. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman upon a facility initiated transfer to the hospital on 8/24/18 for Resident #105. 2. The facility staff failed to provide Resident #36 or the resident's representative (RP) and the ombudsman with written documentation of a facility initiated transfer dated 10/19/18. The findings include: 1. The facility staff failed to provide written documentation to the resident and/or resident representative and notify the ombudsman upon a facility initiated transfer to the hospital on 8/24/18 for Resident #105. Resident #105 was admitted to the facility on 6/20/2000, with a most recent readmission of 8/27/18, with diagnoses that included but were not limited to: multiple sclerosis (a nervous system disease that affects the brain and spinal cord, damaging the myelin sheath (the material that surrounds and protects the nerve cells). This damage slows down or blocks messages between the brain and the body) (1), chronic kidney disease, neurogenic bladder (lack of bladder control due to a brain, spinal cord, or nerve condition) (2), dementia, high blood pressure, diabetes, and low back pain.	F 623		

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F 623	Continued From page 23 Resident #105 was admitted to the facility on 6/20/2000, with a most recent readmission of 8/27/18, with diagnoses that included but were not limited to: multiple sclerosis [a nervous system disease that affects the brain and spinal cord, damaging the myelin sheath (the material that surrounds and protects the nerve cells). This damage slows down or blocks messages between the brain and the body. (1)], chronic kidney disease, neurogenic bladder [lack of bladder control due to a brain, spinal cord, or nerve condition. (2)], dementia, high blood pressure, diabetes, and low back pain. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/01/18, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she has moderate cognitive impairment for daily decision making. The nurse's note dated 8/24/18 at 2:36 p.m. documented in part, "Resident was seen by the MD (medical doctor) today for excessive drowsiness ...We will continue to monitor and follow up as needed." The nurse's note dated 8/24/18 at 6:59 p.m. documented in part, "Resident has been sleeping very soundly since the start of this shift. Currently unable to awaken her. Her current VS (vital signs) are stable. Will not respond to verbal or physical stimulus. Will notify MD and plan to transfer to [hospital's name] ER (emergency room) dept (department) for medical evaluation." The physician's order dated 8/24/18 at 7:05 p.m. documented in part, "Send to [hospital's name]	F 623		

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THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

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F 623	Continued From page 24 ER dept for evaluation of AMS (altered mental status), [a change in mental status such as confusion, memory loss, loss of alertness, and disorientation (3)]." An interview was conducted with LPN (licensed practical nurse) #5 on 11/28/18. When asked if the nurses play any role in notifying the ombudsman of resident transfers to the hospital, LPN #5 stated, "No, we don't have a role in that. Maybe the DON (director of nursing) or the ADON (assistant director of nursing) does that." An interview was conducted with ASM (administrative staff member) #3, the director of nursing, on 11/28/18 at 2:42 p.m. ASM #3 was asked if the resident and/or the resident representative are provided anything in writing as to why they were being sent out when residents' are transferred to the hospital, ASM #3 stated, "We call them. I don't believe we give them anything." When asked if she plays a role in notifying the ombudsman regarding a transfer to the hospital, ASM #3 stated, "I don't think they do." When asked who would do it, ASM #3 stated, 'Maybe the social worker does." An interview was conducted with ASM #2, the vice president, chief operating officer, on 11/28/18 at 2:59 p.m. When asked if the facility notifies the ombudsman when a resident is transferred to the hospital, ASM #2 stated, "I don't believe so." An interview was conducted with RN (registered nurse) #2, on 11/28/18 at 3:35 p.m. When asked if the facility notifies the ombudsman of a facility initiated transfer to the hospital, RN #2 stated the facility has a policy that all beds are held for the resident, so we don't need to notify the	F 623		

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F 623	Continued From page 25 ombudsman." She further stated, "In the beginning, we contacted the ombudsman and they told us it wasn't necessary for us to notify them because we take everyone back." ASM #1, the president/CEO (chief operating officer), ASM #2, and ASM #3 were made aware of the above findings on 11/28/18 at 4:16 p.m. No further information was provided prior to exit. 1) This information was obtained from the National Institutes of Health at https://medlineplus.gov/multiplesclerosis.html 2) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/000754.htm 3) This information was obtained from the National Institutes of Health at https://medlineplus.gov/ency/article/003205.htm 2. The facility staff failed to provide Resident #36 or the resident's representative (RP) and the ombudsman with written documentation of a facility initiated transfer dated 10/19/18. Resident #36 was admitted to the facility on 4/30/2009 with a readmission date of 10/22/2018. Diagnoses included but were not limited to: diabetes, ulcerative pan colitis (1), hemiplegia (2), depression and hyperlipidemia (3). The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 9/6/18 coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact to make daily decisions.	F 623		

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F 623	Continued From page 26 Review of Resident #36's clinical record revealed that he had been sent to the hospital on 10/19/18. A nursing note dated 10/19/18 at 9:00 a.m. documented, "Resident was assessed for c/o (complaint of) nausea and vomiting. It was noted that resident vomited about 50-100 ml (milliliters) of coffee ground material his abdomen was very distended (swollen) and he c/o abdominal pain. The M.D. (medical doctor) who was in the facility assessed the resident and ordered him to the ER (emergency room) for evaluation. The residents brother, POA (power of attorney) and emergency contact was notified of the residents illness and pending transfer out to the ER." The clinical record failed to evidence documentation that Resident #36, the RP or the Ombudsman were given written notice regarding the facility initiated transfer dated 10/19/18. On 11/28/18 at approximately 2:40 p.m., LPN (licensed practical nurse) #2. LPN #2 was asked if Resident #36 and/or the resident representative was provided anything in writing documenting why Resident #36 was transferred, to the hospital on 10/19/18, LPN #2 replied, "Nothing, to my knowledge." An interview was conducted with ASM (administrative staff member) #3, the director of nursing, on 11/28/18 at 2:42 p.m. ASM #3 was asked if the resident and/or the resident representative are provided anything in writing as to why they were being sent out when residents' are transferred to the hospital, ASM #3 stated, "We call them. I don't believe we give them anything." When asked if she plays a role in notifying the ombudsman regarding a transfer to	F 623		

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F 623	Continued From page 27 the hospital, ASM #3 stated, "I don't think they do." When asked who would do it, ASM #3 stated, 'Maybe the social worker does." An interview was conducted with ASM #2, the vice president, chief operating officer, on 11/28/18 at 2:59 p.m. When asked if the facility notifies the ombudsman when a resident is transferred to the hospital, ASM #2 stated, "I don't believe so." An interview was conducted with RN (registered nurse) #2, on 11/28/18 at 3:35 p.m. When asked if the facility notifies the ombudsman of a facility initiated transfer to the hospital, RN #2 stated the facility has a policy that all beds are held for the resident, so we don't need to notify the ombudsman." She further stated, "In the beginning, we contacted the ombudsman and they told us it wasn't necessary for us to notify them because we take everyone back." On 11/28/18 at approximately 5:30 p.m., ASM #1, the President and ASM #2, the Vice President and ASM #3, the Director of Nursing were made aware of the findings. No further information was provided prior to exit. 1. Ulcerative colitis (UC) is a disease that causes inflammation and sores, called ulcers, in the lining of the rectum and colon. It is one of a group of diseases called inflammatory bowel disease. UC can happen at any age, but it usually starts between the ages of 15 and 30. It tends to run in families. The most common symptoms are pain in the abdomen and blood or pus in diarrhea. This information was obtained from the website:	F 623		

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F 623	Continued From page 28 https://vsearch.nlm.nih.gov/vivisimo/cgi-bin/query-meta?v%3Aproject=medlineplus&v%3Asources=medlineplus-bundle&query=ulcerative+colitis. 2. Hemiplegia or paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 3. Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.	F 623		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it	F 695	For resident #66 who found to have been affected by the deficient practice, the nursing staff immediately covered the nebulizer in a clean plastic bag with a clean towel to cover it as it was not in use on the bedside table. As all residents with orders for nebulizers have the potential to be affected by the deficient practice, the facility will review all active orders for residents with respiratory care orders. The nurse Supervisor will check all	11/28/18 12/14/18

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F 695	Continued From page 29 was determined the facility staff failed to provide respiratory care and services consistent with professional standards of practice for one of 33 residents in the survey sample, Resident #66. The facility staff failed to store Resident #66's nebulizer mask in a sanitary manner. On multiple occasions during the survey, Resident #66's nebulizer mask was observed on her bedside table, without any cover and not in use by the resident. The findings include: Resident #66 was admitted to the facility on 3/21/1994. Diagnoses included but were not limited to: cerebral palsy (1), asthma (2), constipation, rash and wheezing (3). The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/11/18 coded the resident as having a score of 14 out of 15 on the BIMS (brief interview for mental status) indicating the resident was cognitively intact to make daily decisions. The physician order dated November 2018, documented "Ipratropium bromide 0.2 mg/ml (milligrams per milliliter) solution (4) 2.5 ml inhale orally via nebulizer two times a day for asthma." Review of the MAR (medication administration record) dated November 2018, for Resident #66 documented "Ipratropium bromide 0.2 mg/ml (milligrams per milliliter) solution. 2.5 ml inhale orally via nebulizer two times a day for asthma" was documented as being given. On 11/27/18 at approximately 11:20 a.m., an	F 695	respiratory equipment and the storage of such so that it complies with our policy for safe and clean handling of respiratory equipment. This measure that the facility will undergo using the Point Click Care (PCC) eMAR system and quality assurance checklist tool will ensure the deficient practice does not adversely affect additional residents. F 695 The following measures have been put into place to ensure the deficient practice will not recur: The L.P.N. Nursing staff will be educated/in-serviced on respiratory care needs with a focus on storage and care of equipment that is consistent with professional standards of practice. Additionally, a Charge Nurse on every floor with conduct a weekly audit of the proper storage of respiratory equipment. The documented audits will be submitted to the DON for review and necessary education and compliance review. Upon hire, new nursing staff will be oriented to the facility policy of Respiratory Equipment Care. F 695 To monitor its performance to make sure that solutions are sustained, the L.P.N. audits from each resident floor will be given to the DON as a monthly	12/14/18 1/10/19 1/10/19

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F 695	Continued From page 30 observation was made of Resident #66. Resident #66's nebulizer mask was observed on her bedside table, without any cover and not in use by the resident. On 11/27/18 at approximately 2:08 p.m., a second observation was made of Resident #66. Resident #66's nebulizer mask was observed on her bedside table, without any cover and not in use by the resident. On 11/27/18 at approximately 3:24 p.m., a third observation was made of Resident #66. Resident #66's nebulizer mask was observed on her bedside table, without any cover and not in use by the resident. On 11/28/18 at approximately 1:12 p.m., an interview was conducted with LPN (licensed practical nurse) #3, Charge Nurse. When asked how Resident #66's nebulizer mask should be stored when not in use, LPN #3 replied, "They are supposed to be covered with a towel or placed in a bag." On 11/28/18 at approximately 2:39 p.m., an interview was conducted with CNA (certified nursing assistant) #3. When asked how a nebulizer mask is supposed to be stored when not in use, CNA #3 replied, "We cover them with a towel." When asked why nebulizer masks are supposed to be covered, CNA #3 "To keep it clean." According to facility policy titled "Respiratory Equipment Care" with a revision date April 2017, documented "Keep nebulizer equipment covered with clean towel when not in use."	F 695	quality assurance report. The DON will report the results of the monthly audits of monitoring of respiratory equipment to the QAPI (Quality Assurance and Performance Improvement) monthly meeting for a period of 4 months.	1/10/19

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F 695	Continued From page 31 On 11/28/18 at approximately 5:30 p.m., ASM (administrative staff member) #1, the President and ASM #2, the Vice President and ASM #3, the Director of Nursing were made aware of the findings. No further information was provided prior to exit. 1. A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html. 2. A disease that causes the airways of the lungs to swell and narrow. It leads to wheezing, shortness of breath, chest tightness, and coughing. This information was obtained from the website: https://medlineplus.gov/ency/article/000141.htm. 3. Wheezing is a high-pitched whistling sound during breathing. It occurs when air moves through narrowed breathing tubes in the lungs. This information was obtained from the website: https://medlineplus.gov/ency/article/003070.htm 4. Ipratropium oral inhalation is used to prevent wheezing, shortness of breath, coughing, and chest tightness in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Ipratropium is in a class of medications called bronchodilators. It works by relaxing and opening the air passages to the	F 695		

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F 695	Continued From page 32 lungs to make breathing easier. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a695021.html.	F 695	RECEIVED DEC 20 2018 V.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, facility staff failed to prepare and serve food items in a safe and sanitary manner. Cold food items were being held above safe temperature prior to food service. The Findings Included:	F 812	For those residents found to have been affected by the deficient practice, the facility relocated the seafood cold plates to the coldest walk in refrigerator. The cold plates remained in the walk-in refrigerator until the salad temperature reached 37°F. The sheet pans of cold plates were then transferred back to the reach in refrigeration at the trayline. The trays of the residents who ordered cold plates were added to the trucks after the salads were chilled to 37°F. Salad temperatures were tested at 37°F prior to service. As all residents have the potential to be affected by the deficient practice the measures that the facility has taken will ensure the deficient practice does not adversely affect anyone.	11/27/18 1/10/19

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F 812	Continued From page 33 On 11/27/2018 at 11:30 a.m., a tour of the kitchen was conducted with Other Staff Member (OSM) #2, the Food Services Manager. Following the kitchen tour, observation of the tray line was conducted with OSM #1, a Dietary Aide. OSM #1 checked the temperatures of each food item. The "cold plate" meal, which consisted of "Seafood Salad" and assorted fruit, was temped twice, in the deepest part of the scoop of seafood salad. The observed temperatures were 48.6F and 47.3F. Upon seeing the temperatures, OSM #1 stated "I don't know why it is not cold enough, it should be cooler." When asked what temperature the food should be, OSM #1 replied "It should be 40 or below for cold plates." A review of the facility policy entitled "Administrative Policy #730.6 Food Temperatures" revealed the following: "Policy: The temperatures of all food items will be taken and properly recorder prior to the service of each meal. Procedure: ... 2. All cold food items must be stored and served at a temperature of 41 F or below." The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 11/28/2018. No further information was provided.	F 812	The following measures have been put into place to ensure the deficient practice will not recur. All cold salads shall be prepared from chilled products and refrigerated to below 41°F IMMEDIATELY after preparation: Meat/Poultry/Fish/Egg salads will be removed from refrigeration for plating in small batches. Each tray of six prepared plates will immediately be placed in a cold food reach-in unit and the door will remain closed until the tray line starts. The Supervisor and /or the Executive Chef will take temperatures periodically to assure cold food stays below 41°F during the service process.	1/10/19
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	F 812	To monitor its performance to make sure that solutions are sustained, the facility will add monitoring of cold food items to the monthly Quality Assurance form for Sanitation and Food Safety. The executive Chef will be directed to monitor production of cold foods including; dividing food into small batches for plating , checking temperatures periodically to assure cold food stays below 41°F during the service process and documenting on monthly Quality Assurance report to be submitted to QAPI committee.	1/10/19

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F 842	Continued From page 34 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; (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	F 842	For the one resident #113 in the 33 resident survey sample residents who was found to be affected by the deficient practice of failure to document non-pharmacological interventions offered prior to administration of pain medication, the ADON educated the L.P.N. nursing staff on the unit. The ADON reviewed with the nursing unit staff how to maintain a complete and accurate medical record as well as the non-pharmacological interventions as related to resident # 113. As all residents with PRN pain medications have the potential to be affected by the deficient practice, all nurses will be educated/in-serviced on documenting interventions prior to administration of pain medications by ADON or designee. In order to identify if any other resident was affected, the Assistant Director of Nursing obtained from PCC (Point Click Care-Electronic Medical Record in use) a list of all residents with active PRN Pain Medication orders. The following procedures/systemic changes will be implemented to ensure that the deficient practice does not recur: Random audits will be performed to ensure non-pharmacological interventions are documented.	12/12/18 12/12/18

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F 842	Continued From page 35 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; (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 resident interview, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for one of 33 residents in the survey sample, Resident #113. The facility staff failed to document non-pharmacological interventions that were offered to Resident #113 prior to administering as needed pain medication on multiple dates in October 2018 and November 2018. The findings include:	F 842	The facility plans to monitor its performance to ensure that solutions are sustained by a weekly audit times four weeks, monthly audit for 6 months, of Residents who received PRN pain medications and if non-pharmacological interventions were documented . The ADON or designee will check the PCC dashboard for residents receiving PRN Pain Medications weekly, then monthly and then random checks for all Resident with PRN pain medication orders and will verify that non-pharmacological interventions have been documented by checking for documentation in residents medical record in PCC. The ADON or designee will email finding to DON and QAPI Committee Chair each month by the last day of the month. If issues are found, the ADON or designee will immediately notify/consult with DON and Medical Director.	1/13/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E084	A. BUILDING _____ B. WING _____	11/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIA HOME	1101 HAMPTON ST RICHMOND, VA 23220

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F 842	Continued From page 36 Resident #113 was admitted to the facility on 10/17/89. Resident #113's diagnoses included but were not limited to high cholesterol, pain and obesity. Resident #113's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 11/8/18, coded the resident as being cognitively intact. Section J coded Resident #113 as reporting a pain score of eight on a scale from zero to ten during the past five days. Review of Resident #113's clinical record revealed a physician's order dated 8/30/18 for ibuprofen (1) 200 milligrams- two tablets by mouth every six hours as needed for back or hip pain. Review of Resident #113's October 2018 and November 2018 MARs (medication administration records) revealed the resident was administered as needed ibuprofen on the following dates (including but not limited to): 10/1/18 10/4/18 10/15/18 10/22/18 10/23/18 10/25/18 11/1/18 11/6/18 11/9/18 Further review of Resident #113's clinical record (including October 2018/November 2018 MARs and nurses' notes) failed to reveal non-pharmacological interventions were offered to Resident #113 prior to the administration of as needed ibuprofen on the above dates. (Note:	F 842		

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F 842	Continued From page 37 non-pharmacological interventions were documented as provided per physician's order on other dates in October 2018 and November 2018). Resident #113's comprehensive care plan dated 7/28/17 documented, "(Name of Resident #113) has chronic pain r/t (related to) headache and musculoskeletal pain right hip...Offer non-pharmacological interventions per MD (Medical Doctor) orders prior to the administration of PRN (as needed) medications." On 11/28/18 at 2:31 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (a nurse who administered as needed ibuprofen to Resident #113 on many of the above dates). LPN #4 was asked what should be done prior to administering as needed pain medication. LPN #4 stated, "Try to do an alternative. Put them in a quiet environment or depending on what it is. Find out the root of the problem." When asked if nurses should document the attempted non-pharmacological interventions, LPN #4 stated, "We have a thing on the MAR that comes up and it says non-pharmacological interventions and we put it there." LPN #4 stated she offers non-pharmacological interventions such as repositioning prior to administering as needed ibuprofen to Resident #113. When shown some of the above dates where there was no documentation of the attempted interventions, LPN #4 stated, "My mistake. There are times that I'll forget (to document). I write it on my paper then I forget to go back and document." On 11/28/18 at 2:55 p.m., an interview was conducted with Resident #113. The resident confirmed staff attempts non-pharmacological	F 842		

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F 842	Continued From page 38 interventions prior to the administration of as needed ibuprofen. On 11/28/18 at 4:24 p.m., ASM (administrative staff member) #1 (the president/chief executive officer), ASM #2 (the vice president/chief operating officer) and ASM #3 (the director of nursing) were made aware of the above concern. The facility policy titled, "Pain Management" documented, "(Name of facility) will routinely assess the pain of all residents upon admission and regularly thereafter. Pain will be managed by non-pharmacological and pharmacological interventions. Refer to physician orders for non-pharmacological interventions. Evaluation of interventions will be documented as applicable prior to administration of pharmacological interventions..." No further information was presented prior to exit. (1) Ibuprofen is used to relieve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682159.html	F 842		