VCU Health

Community
Memorial Hospital

The Hundley Center

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South Hill, VA 23970

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July 31, 2019

Nicole Keeney
LTC Supervisor
Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233

Dear Ms. Keeney,

Enclosed please find our completed plan of correction dated July 31, 2019, responding to our revisit that finished on July 24, 2019.

Our plan of correction should be considered to serve as our allegation of compliance to cited deficiencies. This plan of correction is being filed as a matter of compliance, but should not be construed as an admission to the validity of any of the cited concerns.

Community Memorial Hospital Hundley Center takes these cited deficiencies very seriously and have implemented the plan of correction. Please feel free to contact me with any questions or concerns that you may have at todd.howell@vcuhealth.org.

Sincerely,

A. Todd Howell, LNHA
Administrator

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495177	A. BUILDING _____ B. WING _____	R 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEMORIAL HOSPITAL HUNDLEY CENTER	125 BUENA VISTA CIRCLE SOUTH HILL, VA 23970

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E 000	Initial Comments	E 000		
{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the standard survey conducted 05/28/19 through 05/30/19, was conducted 07/23/19 through 07/24/19. No complaints were investigated. Corrections are required for compliance with the following Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. The census in this 140 certified bed facility was 91 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 101 through 116).	{F 000}	**F Tag 656** **Corrective Action:** **MDS nurses met with resident #109 to discuss individualized toileting program. Resident #109 provided input into an individualized toileting program on July 24, 2019. An individualized plan of care for incontinence has been developed for a toileting program meeting the needs/requests of resident. Staff has been educated on the care plan for resident #10's toileting program.** **Identification of others:** **A meeting was held with the clinical staff on each unit to identify other residents with special toileting needs/requests. All care plans were updated to reflect resident needs.** **System Changes:** **Education on resident-centered care plans was conducted with the IDT and other nurses who are involved in the development of care plans. This education included discussion of care planning for resident's specific needs. Education was completed July 31, 2019.** **Monitoring:** **6 care plans will be audited weekly per care plan schedule x 8 weeks to ensure that resident specific needs are addressed; QA Coordinator or designee will review, and will correct as necessary; Weekly audits will be submitted to DON for tracking/trending and analysis and will be reported monthly to QAPI Committee.**	7/31/19
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	{F 656}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Noell Howell, CNHA | TITLE: Administrator | (X6) DATE: 7/31/19

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 656}	Continued From page 1 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of 16 residents in the survey sample. Resident #109 had no individualized care plan about incontinence care. The findings include: Resident #109 was admitted to the facility on 4/25/17 with diagnoses that included high blood pressure, peripheral vascular disease, diabetes, arthritis, hypothyroidism, anxiety, depression and hyperlipidemia. The minimum data set (MDS)	{F 656}		

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{F 656}	Continued From page 2 dated 4/11/19 assessed Resident #109 as cognitively intact, frequently incontinent of bowel/bladder and to require the extensive of one person for toileting. On 7/24/19 at 7:45 a.m., Resident #109 was interviewed about any care concerns. Resident #109 stated she was no longer using an incontinence brief while in bed due to irritated skin under her belly and in her groin area. The resident stated the brief was rubbing her skin so she was now positioned on a white pad when in bed. Resident #109 stated the white pads were "like sandpaper" and felt rough on her skin. Resident #109 stated she requested a sheet over the white pads to make them more comfortable. The resident stated some staff members did not always place the sheet over the pad and she did not think all the staff were aware of the padding or the need for the sheet. Resident #109 stated she stopped using an incontinence brief in bed several weeks ago. Resident #109 was in bed at the time of this interview and voluntarily pulled back her bed covers. Resident #109 was positioned on a white pad with a sheet in place over the pad. The resident was not wearing an incontinence brief. Resident #109's plan of care (print date 7/24/19) included no individualized problems, goals and/or interventions regarding incontinence care. The plan of care listed the resident required extensive assistance with toileting. The only intervention listed about incontinence care was, "Provide incontinent care." There was no mention in the care plan about the resident's skin irritation from the incontinence brief, not using a brief when in bed or about the use of the white pad with a sheet.	{F 656}		

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{F 656}	Continued From page 3 On 7/24/19 at 9:45 a.m., the certified nurses' aide (CNA #2) caring for Resident #109 was interviewed about the resident's incontinence needs. CNA #2 stated the resident used "pull-ups" during the day when she was out of bed in her wheelchair. CNA #2 stated the resident no longer used briefs in bed because she had skin irritation under her belly area. CNA #2 stated a white pad was used under the resident when in bed. On 7/24/19 at 9:50 a.m., the licensed practical nurse (LPN #2) caring for Resident #109 was interviewed about incontinence care. LPN #2 stated Resident #109 had skin irritation under her belly and in the groin area thought to be caused by the incontinence brief rubbing against the skin. LPN #2 stated the resident used pull-ups when out of bed but the incontinence brief was not used in bed to prevent skin irritation. LPN #2 stated the irritated skin in the groin area started "about a month ago." LPN #2 stated the registered nurses were responsible for care plans. On 7/24/19 at 9:55 a.m., the registered nurse unit manager (RN #2) was interviewed about Resident #109's plan of care regarding incontinence. RN #2 stated the resident's skin irritation under the belly was an ongoing problem with prescription cream applied each day. On 7/24/19 at 10:20 a.m., RN #2 stated she reviewed Resident #109's plan of care and there were no resident specific interventions listed about bowel/bladder needs. RN #2 stated the care plan only listed the assistance required and there was "nothing person-centered" in the plan about the resident's incontinence care.	{F 656}		

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{F 656}	Continued From page 4 This finding was reviewed with the administrator and director of nursing during a meeting on 7/24/19 at 11:20 a.m.	{F 656}	**F Tag 684** **Corrective Action:** **Resident #111 removes and applies skin sleeves as desired. MD notified resident not consistently wearing skin sleeve. New order received: "Resident may wear skin sleeves to bilateral arms daily when up out of bed as tolerated." Care plan was updated on 7/26/19 to reflect resident removes skin sleeves as desired. When resident refuses to wear sleeves, she will use skin moisturizer.** **Identification of others:** **All other residents who have orders for Geri-sleeves have been reviewed. Residents will be reviewed and orders will be clarified. Orders and documentation of implementation of the orders for Geri-sleeves will be documented in Cerner.** **System Changes:** **The nursing facility staff met with IT on 7/31/19 and evaluated more direct ways of communicating physician's orders of care to nursing staff. The presence of skin sleeves will be documented in Cerner under IView, Skin Integrity Assessment-Intervention band. Clinical Coordinators will perform morning huddles with CNAs to convey residents with skin sleeves. Staff was educated on 7/31/19 on the new process for documenting skin sleeves. Daily validation of placement of skin sleeves will be conducted by Clinical Coordinator/QA for eight weeks. Daily audits to Director of Nursing for trends and analysis. Director of Nursing will submit a report monthly to QAPI.** **Monitoring:** **Clinical Coordinators will audit 4 X per week x 6 weeks for observation /documentation of Geri-sleeves as ordered; weekly findings will be reported to DON for tracking/trending and analysis and a report will be submitted to QAPI.**	7/31/19
{F 684} SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility failed to follow physician orders for protective sleeves, for one of 16 resident's, Resident #111. Findings include: Resident #111 was admitted to the facility on 6/22/18. Diagnoses for Resident #111 included; Diabetes, heart failure, osteoporosis, chronic pulmonary edema. The most current MDS (minimum data set) was an annual assessment with an ARD (assessment reference date) of 6/3/19. Resident #111 was assessed with a score of 11 indicating moderately cognitively impaired. On 7/23/19 Resident #111 physician orders were reviewed and revealed an order dated 7/9/19 that stated "skin sleeves to bi-lateral arms to be worn daily and checked for placement [...]."	{F 684}		

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{F 684}	Continued From page 5 On 7/23/19 Resident #111 was observed up in the wheelchair without protective sleeves in place. Resident #111's left arm had scattered older bruising and was without open areas. On 7/23/19 at 3:15 PM certified nursing assistant (CNA #1, aide assigned to Resident #111 on day shift) was interviewed concerning protective sleeves not being in place. CNA #1 stated that she was new and did not know that Resident #111 needed protective sleeves. CNA #1 also stated that the nurse would be the person to let the CNAs know if residents needed protective sleeves. On 7/23/19 at 3:20 PM license practical nurse (LPN #1, assigned to Resident #111) was interviewed concerning Resident #111's protective sleeves. LPN #1 stated that he was not aware of Resident #111's protective sleeves order. LPN #1 then reviewed Resident #111's physician order for the protective sleeves and stated that the facility's software system has no way of alerting nurses or CNAs of these type of needs for the residents, and the only way a nurse would know if a resident would need things, like protective sleeves, is to look at each resident's orders. On 07/24/19 at 11:30 AM, the above finding was presented to the director of nursing and administrator. No other information was presented prior to exit conference on 7/24/19.	{F 684}		