STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495188	A. BUILDING _____ B. WING _____	C 03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPOMATTOX HEALTH AND REHABILITATON CENTER	235 EVERGREEN AVE APPOMATTOX, VA 24522

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/05/19 through 03/07/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. One complaint was investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/5/19 through 3/7/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 14 current Resident reviews and 2 closed record reviews.	F 000		
F 550 SS=D	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.	F 550		3/18/19

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

Electronically Signed | 03/12/2019

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal 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 observations, clinical record review, and staff interview, the facility staff failed to ensure a dignified dining experience for one of 16 residents in the survey sample (Resident #45). Resident #45, who was identified as needing to be fed, was fed by a staff member who stood over the resident while feeding him. The findings include: Resident #45, was admitted to the facility on 11/8/17 and readmitted on 2/28/18. Diagnoses	F 550	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain incompliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.	

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F 550	Continued From page 2 included type 2 diabetes, hypertension, poly-osteoarthritis, hyperlipidemia, dementia with behavioral disturbance, difficulty walking, muscle weakness, lack of coordination, depression, mood disorder, bipolar disorder and benign prostatic hyperplasia (BPH). The most recent minimum data set (MDS) dated 2/8/19, was a significant change assessment and assessed Resident #45 as being severely cognitive impaired with a score of 0 out of 15. The MDS dated 2/8/19, under Section G (Functional Status), at item G0110 (H), Eating, assessed Resident #45 as requiring extensive assistance with one-person physical assistance for eating. A dining observation was conducted in the main dining room during lunch on 03/05/19 at approximately 11:55 a.m. During the lunch meal observation, Resident #45 was observed sitting in a geri-chair seated at table #11 in the main dining room. The resident's dining tray was brought to him by certified nursing assistant (CNA#1). CNA #1 was observed feeding Resident #45 and remained standing while she fed him. CNA #1 was observed standing and feeding the Resident for approximately 14 minutes until another staff member prompted her to sit down and feed Resident #45. On 03/05/19 at approximately 12:30 p.m., CNA #1 was interviewed regarding Resident #45's need for assistance at meals. CNA #1 stated the resident required feeding assistance at all meals. On 03/06/19, Resident #45's clinical record was reviewed. Resident #45's plan of care documented the following:	F 550	F550 1. Current staff are feeding Resident #45 while being seated. 2. An audit was conducted by the Director of Nursing to identify any current residents who require full assistance with meals to ensure staff are seated while feeding. Corrections were made as necessary. 3. Staff Development Coordinator will educate current trained staff that they will remain seated while feeding residents and will engage with residents during mealtime. DON or designee will observe meal times five times a week for 4 weeks to ensure staff is seated while feeding residents who require full assistance with meals. Any issues will be addressed immediately at the time of identification. 4. Process will be reviewed in QA committee X one quarter.	

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F 550	Continued From page 3 "Focus area: The resident has an ADL self-care performance deficit r/t Aggressive Behavior, Alzheimer's Confusion. Created on 11/08/2017, Revision on 02/25/18." "Goal - The resident will improve current level of function through the review data. Created on: 11/08/2017. Revision on 12/03/2018. Target Date: 05/20/19." "Interventions: - EATING: The resident needs assistance and cues. Created on 11/08/2017. Revision on: 02/18/2019." On 03/06/19 at approximately 2:25 p.m., the facility Administrator was interviewed regarding the expectation for a dignified dining experience. The Administrator stated she would expect staff to be seated and facing a resident while providing feeding assistance. These findings were discussed during a meeting on 03/06/19 at 3:20 p.m. with the Administrator, Director of Nursing and nurse consultant.	F 550		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to 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	F 684		3/18/19

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F 684	Continued From page 4 by: Based on staff interview, and clinical record review, the facility staff failed to follow physician's orders for two of 16 resident's, Resident's #2 and #37. 1. The facility did not make an orthopedic appointment as ordered by the physician for Resident #2. 2. Resident #37 was not administered calcium carbonate as ordered by the physician. The Findings Include: 1. Resident #2 was admitted to the facility on 6/28/18. Diagnoses for Resident #2 included: Muscle Weakness, rheumatoid arthritis, and difficulty walking. The most current MDS (minimum data set) was a significant change assessment with an ARD (assessment reference date) of 2/18/19. Resident #2 was assessed as being cognitively intact with a score of 15 of 15. On 03/05/19 at 2:21 PM, Resident #2 was interviewed. When asked about any concerns of pain, Resident #2 verbalized that she has pain to the right knee and it had been going on for quite some time. On 3/6/19 Resident #2's medical chart was reviewed. A physicians progress note dated 2/4/19 documented "[...] Reports her [Resident #2] right knee is still experiencing discomfort despite pain management attempts. Is requesting a appointment with orthopedic services for possible injection." The physician orders were also reviewed and	F 684	F684 1. Resident #2□s orthopedic appointment is scheduled for 05/23/2019 at 3:00PM. The physician was notified of Resident #37 receiving inadequate dose of Calcium Carbonate during the survey and the remaining dose was administered. 2. An audit was conducted by DON to identify any current residents that have orders for consults to ensure appointments have been set up and to identify any current residents with orders for Calcium Carbonate to ensure accurate doses were available for administration. Corrections were made as necessary. 3. Staff Development Coordinator will educate nurses that when entering an order for consults, the order will be scheduled for every shift to sign off until appointment has been made and nurses note entered stating the appointment date and time. The consult order will then be discontinued and a new order will be entered for the appointment date and time that will be signed off on the day of the appointment. Staff Development Coordinator will educate current licensed staff regarding the policy for medication administration to include The Five Rights. DON or Designee will monitor consult orders weekly for four weeks to ensure compliance and will perform medication pass observations with current charges nurses at different med pass times five times a week for four weeks. Any issues will be addressed immediately at the time of observation.	

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F 684	Continued From page 5 revealed an order dated 2/4/19 instructing to "consult with ortho-right knee discomfort [...]" On 3/6/19 at 10:30 AM, the director of nursing (DON) was asked who makes resident appointments. The DON verbalized that the discharge planner makes the appointments, but the discharge planner was no longer working at the facility, so the acting discharge planner and the administrator were taking on the task of getting appointments. On 03/06/19 at 10:41 AM, the acting discharge planner (other staff, OS #1) and administrator were interviewed regarding the order for consult with ortho. OS #1 verbalized that the discharge planner usually does appointments but no longer works at the facility. OS #1 verbalized that the order was in place when the discharge planner was working and doesn't know why the order wasn't carried out, but would look into it. On 03/06/19 at 11:33 AM, the DON verbalized that the previous discharge planner was working on it prior to leaving but was unable to pin down an appointment date due to messages left with the ortho clinic without a return call back. The DON showed evidence that attempts were made with messages left (to the ortho clinic) on 2/13/19 and 2/25/19. This surveyor verbalized that the order was still on the March 2019 physician order set and had not been completed. The DON verbalized uncertainty as to how it was missed with the only explanation being none of the staff caught it after the discharge planner had stop working at the facility. 03/06/19 04:02 PM the above information was	F 684	4. Process will be reviewed in QA for one quarter.	

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F 684	Continued From page 6	F 684		

again presented to the administrator and DON.

No other information was presented prior to exit conference on 3/7/19.
2. Resident #37 was admitted to the facility on 1/21/19 with diagnoses that included anemia, chronic kidney disease, high blood pressure, urinary tract infection and cognitive communication deficit. The minimum data set (MDS) dated 2/4/19 assessed Resident #37 with moderately impaired cognitive skills.

A medication pass was conducted on 3/6/19 at 7:45 a.m. with licensed practical nurse (LPN) #1 administering medications to Resident #37. During this observation, Resident #37 was administered two 500 mg tablets (1000 mg total) of calcium antacid (chewable).

Resident #37's clinical record documented a physician's order dated 1/21/19 for Calcium Carbonate tablet, 1200 mg to be given by mouth once per day for treatment of anemia/chronic kidney disease.

On 3/6/19 at 9:42 a.m., LPN #1 was interviewed about the administration of 1000 mg of calcium when the order required 1200 mg. LPN #1 reviewed the medication cart and pulled several bottles of bulk-supplied calcium. One bottle was the antacid calcium chewable (500 mg/tablet) administered to Resident #37 during the observed medication pass. There was also a bottle of oyster shell calcium (500 mg/tablet) and a bottle of calcium supplement tablets (600 mg/tablet). LPN #1 stated she was not sure which calcium was to be given. LPN #1 stated she would clarify the order with the physician.

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F 684	Continued From page 7 On 3/6/19 at 1:30 p.m., LPN #1 stated she clarified with the physician and the resident was supposed to get 1200 mg of calcium supplement each day as listed in the order. These findings were reviewed with the administrator and director of nursing during a meeting on 3/6/19 at 3:45 p.m.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to provide supervision for fall prevention for one of 16 residents in the survey sample. Resident #18, with cognitive impairment, poor safety awareness and need for extensive assistance with transfers, fell after being left unsupervised on the commode. The findings include: Resident #18 was admitted to the facility on 1/13/15 with a re-admission on 1/8/19. Diagnoses for Resident #18 included dementia, high blood pressure, glaucoma, right eye blindness, heart disease, anemia, anxiety and cerebral infarction. The minimum data set (MDS)	F 689	F689 1. Resident #18□s alarm device is currently in use and functioning properly. 2. An audit was conducted by Director of Nursing to identify any current residents who have alarms in use to ensure proper use and function of the devices. Corrections were made as necessary. 3. Staff Development Coordinator will educate current nursing staff on the use of alarms, the proper function and the purpose for the alarms. DON or designee will observe alarms five times a week for 4 weeks to ensure appropriate use and function of alarms. Any issues will be addressed immediately at the time of identification.	3/18/19

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F 689	Continued From page 8 dated 1/15/19 assessed Resident #18 with severely impaired cognitive skills. MDS assessments dated 1/15/19 and the previous assessment dated 10/17/18 indicated the resident had impaired vision and required the extensive assistance of one person for toileting. Resident #18's clinical record documented a nursing note dated 12/30/18 stating, "Resident had fall in bathroom while attempting to transfer self..." A post-fall assessment dated 12/30/18 listed the resident fell on 12/30/18 at 3:05 p.m. and documented, "She [Resident #18] was attempting to get from the toilet to the wheelchair." This assessment documented the resident had a history of falls, required assistance for transfers, attempted to rise/ambulate/transfer unsafely and had a chair alarm in place for fall prevention. A post-fall note dated 12/31/18 stated, "...pt [patient] fell attempting to transfer from toilet to w/c [wheelchair]...alert orient with confusion unaware of safety issues...no s/s [signs/symptoms] of injury no distress noted...redirect and educate to use cb [call bell] with adl [activities of daily living] and assistance with adl care, w/c alarm in place." (Sic) On 3/6/19 at 2:30 p.m., the certified nurses' aide (CNA) #1 routinely caring for Resident #18 was interviewed. CNA #1 stated that at the time of the fall, Resident #18 required assistance for all transfers including toileting. CNA #1 stated the resident was not able to independently transfer from the wheelchair to the commode and always required assistance for transfers and toilet use. CNA #1 stated she was not caring for Resident #18 at the time of the fall. On 3/6/19 at 2:37 p.m., the director of nursing	F 689	4. Process will be reviewed in QA committee X one quarter.	

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F 689	Continued From page 9	F 689		

(DON) was interviewed about how Resident #18 fell from the toilet and the status of the personal alarm at the time of the fall. The DON stated CNA #2 was assigned to Resident #18 at the time of the fall. The DON stated CNA #2 reported the resident requested to go to the bathroom. The DON stated CNA #2 removed the resident's personal alarm and then assisted the resident onto the commode. The DON stated CNA #2 did not stay with the resident while she was on the commode but was in the hallway outside of her room. The DON stated CNA #2 reported that he gave Resident #18 the call bell prior to leaving the restroom but the resident did not activate the call bell. The DON stated CNA #2 later heard the resident yell and when he went back found the resident in the floor. The DON stated Resident #18 required assistance from staff for safe transfers to/from the toilet.

Resident #18's plan of care (revised 1/20/19) listed the resident had a history of falls and was at risk for subsequent falls. Interventions in place at the time of the 12/30/18 fall included personal alarm, anticipating resident needs, bed and chair alarms, low bed with mats and call light within reach. The care plan documented, "The resident uses personal alarm. Ensure the device is in place as needed." The care plan also listed the resident required the assistance of one person for all transfers.

These findings were reviewed with the administrator and DON during a meeting on 12/6/19 at 3:45 p.m.