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

PRINTED 09/26/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495338	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRACE HEALTHCARE OF ABINGDON	600 WALDEN ROAD ABINGDON, VA 24210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 09/16/19 through 09/17/19. One Complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 82 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1, #2 and #4) and 1 closed record review (Resident #3).	F 000	**This Plan of Correction is submitted as required under State and Federal law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statements made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding taken.**	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657	**F-657 Care Plan Timing and Revision** **#1. Resident #3 no longer resides in the facility. She was discharged home from the facility on 9/9/19.** **#2. All residents could have the potential to be affected by the deficient practice. Nursing staff reviewed the care plans for all residents admitted within the last 30 days to ensure residents have a developed and accurate care plan and no issues regarding the resident care plans were noted.** **#3. In-service education will be provided to the interdisciplinary team and licensed nursing staff by the Director of Nursing or Designee, on the facility's policy and procedure for Comprehensive Care Plans including care plan updates and revisions. Education will be completed on or prior to 10/14/19. The Director of Nursing or Designee will review the care plan for each new resident with new orders or a significant change in condition at the daily clinical meeting to ensure the care plans have been updated.** **#4. The Director of Nursing or Designee will audit five (5) Comprehensive Care Plans to ensure all residents have a developed and accurate care plan including 1:1 care, use of alarm(s) and psychotropic**	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: James E. Ryle Jr. | TITLE: Administrator | (X6) DATE: 10/6/19

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 657	Continued From page 1 or as requested by the resident. (III)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the resident's comprehensive care plan for 1 of 4 residents. Resident #3. The findings included: The facility staff failed to review and revise the resident's CCP (Comprehensive Care Plan). The resident's CCP did not include the resident's 1:1 care, bed alarm, or the resident's psychotropic medication. This was a closed record review. The clinical record was reviewed on 09/17/19. The resident's face sheet revealed that Resident #3 had been admitted to the facility on 08/20/19. This face sheet included the diagnoses, cerebral infarct, hemiplegia, dementia, osteoarthritis, anxiety disorder, hypertension, dysphagia, muscle weakness, unsteadiness on feet, abnormalities of gait and mobility, anemia, and repeated falls. Section C (Cognitive Patterns) of the resident's admission MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 08/27/19 included a BIMS (Brief Interview for Mental Status) summary score of 7 out of a possible 15 points. Section N (Medications) was coded to indicate the Resident received	F 657	medications if applicable, weekly for one (1) month and then monthly for two months. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. All results and findings of the audits will be brought by DON and reviewed in the monthly facility QAPI meeting x 3 months or until compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director. Completion date: November 4, 2019	

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F 657	Continued From page 2	F 657		

antipsychotic medications. Section P (Alarms) was coded to indicate the Resident used a bed alarm daily.

A review of the resident's "Departmental Notes" revealed that the facility placed a 1:1 staff with this Resident on the date of admission (08/20/19) due to "...confusion and attempts to get out of the bed and attempt to stand..." These departmental notes revealed that Resident #3 had a 1:1 in place on 08/20, 08/21, 08/22, 08/23, and 08/28.

The clinical record included a physicians telephone order dated 08/22/19 for the antipsychotic medication "Seroquel 25 mg po (by mouth) BID (twice a day) prn (as needed) for anxiety x 7 days. Bed alarm while in bed for safety." The seroquel was changed to "Seroquel 60 mg po BID..." on 08/23/19.

A review of the resident's CCP revealed that the resident's care plan was not revised to include the 1:1, antipsychotic medication, or the bed alarm.

On 09/17/19 at 12:45 p.m., during an interview with the DON (Director of Nursing) and administrator. The DON verbalized to the surveyor that the resident's 1:1 care was a nursing intervention and there was not an order.

On 09/17/19 at 12:25 p.m., MDS nurse #1 reviewed the CCP with the surveyor and stated that she was not aware the Resident had a 1:1. In regards to the bed alarm and antipsychotic medication, MDS nurse #1 stated that these two items were "not there."

On 09/17/19 at 3:50 p.m., the administrator and DON were notified of the issue regarding the

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F 657	Continued From page 3 resident's care plan. No further information regarding this issue was provided to the surveyor prior to the exit conference on 09/17/19.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to 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 staff failed to ensure that a resident receive treatment and care by following a physician's order in regards to a surgical site for 1 of 4 Residents, Resident #2. The findings included: The facility staff failed to provide a protective dressing to a surgical site as ordered by the physician. The Residents face sheet revealed that Resident #2 had been admitted to the facility on 09/12/19 There was no completed MDS (minimum data set) assessment for this Resident. However, the Resident was alert and orientated to person, place, and time.	F 684	F-684 Quality of Care #1. The surgical site dressing for resident #2 was changed by the wound care nurse on 9/16/19 and no adverse effects were noted. #2. The wound care nurse completed wound care/treatments on 9/16/19 for all residents with orders for wound care / treatments and no other resident(s) were affected. The Assistant Director of Nursing audited all Treatment Administration records on 9/17/19 and no other issues were noted related to wound care/treatments. #3. In-service education will be provided to the licensed nursing staff by the Director of Nursing or Designee, on the facility's policy and procedure for Wound Care including physician's order, care plan, procedure and documentation. Education will be completed on or prior to 10/14/19. #4. The Director of Nursing, or Designee will audit five (5) residents receiving wound care including documentation weekly for one (1) month and then monthly for two (2) months to ensure residents receive treatment and care as ordered by the physician and that treatment is documented based on facility policy. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. All results and findings of the audits will be brought by DON and reviewed in the monthly facility QAPI meeting x 3 months or until	

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F 884	Continued From page 4 The facility provided the surveyor with a document titled "Diagnosis/History" that included the following diagnoses hypothyroidism, pressure ulcer stage 2, muscle weakness, fibromyalgia, osteoporosis, and fracture lower end of femur. The resident's clinical record was reviewed on 09/16 and 09/17/19. This clinical record included a physicians order to "CHANGE DRESSING (GAUZE AND ACE BANDAGE) ONCE DAILY EVERY OTHER DAY." The order date was documented as 08/12/19. This order had been transcribed to the TAR (treatment administration record) to be completed every other day at 7:00 a.m. A review of the TAR revealed that the nursing staff had not documented they had completed this treatment on 09/14 (Saturday). The resident's care plan included the problem area surgical wound. Approaches included, but were not limited to, treatment(s) as ordered by Physician. On 09/17/19 at approximately 9:25 a.m., during an interview with the wound care nurse, this nurse verbalized to the surveyor that she always initialed and dated her dressings. The wound care nurse then stated when she changed the dressing yesterday (09/16/19) the dressing was still in place from Thursday (09/12/19) and that the dressing should have been changed on Saturday (09/14/19). The dressing and ace bandage were observed to be in place when the surveyor observed wound	F 884	compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director. Completion date: November 4, 2019	

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F 684	Continued From page 5 care on 08/17/19 at 9:15 a.m. On 09/17/19 at 1:42 p.m., the wound care nurse verbalized to the surveyor that this was just a preventative dressing to protect the resident's sutures from her immobilizer. The DON (Director of Nursing) was notified of the issue regarding the resident's wound care on 09/17/19 at 8:40 a.m. On 09/17/19 at 2:50 p.m., the administrator and DON were notified of the issue regarding the resident's wound care. The nurse that would have been responsible for completing this treatment over the weekend was not working during the time of the survey and was not interviewed. No further information regarding this issue was provided to the surveyor prior to the exit conference on 09/17/19.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.26(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent w th professional standards of practice to	F 686	F-686 Treatment/Svcs. to Prevent/Heal Pressure Ulcer #1. The wound treatment for resident #2 was administered by the wound care nurse on 9/16/19 and no adverse effects were noted. #2. The wound care nurse completed wound care/treatments on 9/16/19 for all residents with orders for wound care / treatments and no other resident(s) were affected. The Assistant Director of Nursing audited all Treatment Administration records on 9/17/19 and no other issues were noted related to wound care/treatments.	

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F 686	Continued From page 6 promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, and clinical record review, the facility staff failed to ensure that necessary treatment and services were provided through physician ordered wound care for 1 of 4 residents, Resident #2. The findings included: The facility staff failed to provide a physician ordered wound treatment for a stage II pressure ulcer. The facility nursing staff failed to apply betadine to the resident's pressure ulcer. The resident's face sheet revealed that Resident #2 had been admitted to the facility on 09/12/19. The facility provided the surveyor with a document titled "Diagnosis/History" that included the following diagnoses hypothyroidism, pressure ulcer stage 2, muscle weakness, fibromyalgia, osteoporosis, and fracture lower end of femur. The resident's clinical record was reviewed on 09/16 and 09/17/19. There was no completed MDS (minimum data set) assessment for this resident. However, the resident was alert and orientated to person, place, and time. This clinical record included a physician's telephone order dated 09/13/19 to "Apply Betadine to Stage II on base of (R) thigh. Leave open to air."	F 686	#3. In-service education will be provided to the licensed nursing staff by the Director of Nursing or Designee, on the facility's policy and procedure for Wound Care including physician's order, care plan, procedure and documentation. Education will be completed on or prior to 10/14/19. #4. The Director of Nursing or Designee will audit five (5) residents receiving wound care including documentation, weekly for one (1) month and then monthly for two (2) months to ensure residents receive treatment and care as ordered by the physician and that treatment is documented based on facility policy. Findings will be reported to the Nursing Home Administrator (NHA) immediately when policy is not adhered to. All results and findings of the audits will be brought by DON and reviewed in the monthly facility QAPI meeting x 3 months or until compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Minimum Data Set Coordinator, Rehabilitation Coordinator, Medical Director, Environmental Services Director, Admissions Director, Dietary Manager, Social Services Director, Activity Director, Medical Records Director and Maintenance Director. Completion date: November 4, 2019	

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F 686	Continued From page 7	F 686		

This order had been transcribed to the TAR (treatment administration record) to be completed daily at 7:00 a.m. A review of the TAR revealed that the nursing staff had not documented they had completed this treatment on 09/14/19 (Saturday) and 09/15/19 (Sunday).

The resident's care plan included the problem area pressure ulcer stage II right thigh Approaches included, but were not limited to. treatment(s) as ordered by Physician.

During an interview with Resident #2 on 09/17/19 at 8:20 a.m., Resident #2 verbalized to the surveyor that she did not recall anyone putting betadine on her leg.

On 09/17/19 at 8:36 a.m., during an interview with the wound care nurse. The wound care nurse stated the order was in the process of being changed over to skin prep, she did not work weekends, and the floor nurses were responsible for the wound care on weekends.

The DON (director of nursing) was notified of the issue regarding the resident's wound care on 09/17/19 at 8:40 a.m.

Prior to observing wound care the order was changed to read, "APPLY SKIN PREP TO STAGE II TO BACK OF RIGHT LATERAL THIGH EVERYDAY UNTIL HEALED."

On 09/17/19 at 9:15 a.m., the surveyor observed the wound care nurse apply skin prep to the stage II pressure ulcer. This area was observed to be closed with no drainage.

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F 686	Continued From page 8 The nurse that would have been responsible for completing this treatment over the weekend was not working during the time of the survey and was not interviewed. On 09/17/19 at 2:50 p.m., the administrator and DON were notified of the issue regarding the resident's wound care. No further information regarding this issue was provided to the surveyor prior to the exit conference on 09/17/19	F 686		