STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 09/15/19 through 09/17/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of	E 018		10/21/19

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

Electronically Signed | 10/10/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 018	Continued From page 1 the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and	E 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 018	Continued From page 2 needs of the patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility record review the facility staff failed to develop emergency preparedness policy and procedure that fully addresses communication. The facility staff failed to address a system of tracking the location of on-duty staff and sheltered residents in the facility's care during an emergency. On 9/17/19 at approximately 2:30 PM an interview was conducted with the Maintenance Director who stated that in case of emergency they would gather the residents that were being sent out and take a head count and make an attendance sheet. He indicated that they would do the same for those sheltering in place. He stated "I don't have anything in writing about that but that is what we would do. We would also send the MAR (Medication Administration Record) and Face Sheet with the ones leaving. When asked how the facility would track where each Resident would go he stated "We would write it down." Facility could not show documentation of any formal tracking system in place at the present time.	E 018	This plan of correction is prepared and executed because it is required by the provisions of state and federal law not because Battlefield Park Healthcare Center admits or denies the validity of the allegations and citations listed on the pages of this Statement of Deficiencies. CommuniCare, Battlefield Park Healthcare Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit our capacity to render adequate care. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. E-018 1.) Facility has established system to track the location of on-duty staff and shelter patients in the facility□s care during an emergency. 2.) Current residents in facility at time of emergency have the potential to be affected. 3.) Divisional Facility Manger re-educated facility Maintenance Director on the Emergency Communications Policy (EM1015-00) and Evacuation Transport Checklist. Maintenance Director/ED will educate facility staff on the Emergency Preparedness Plan. 4.) Maintenance Director and/or designee will audit 3 staff members per audit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 018	Continued From page 3	E 018	regarding staff knowledge of Emergency Communications, Plan/Evacuation Transport Checklist daily 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based.	E 039		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 039	Continued From page 4 (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation the faculty staff failed to conduct exercises to test the emergency plan annually. The facility staff failed to produce evidence that they had participated in table top exercises and testing of the emergency plan since 11/9/17. On 9/17/19 approximately 2:45PM an interview	E 039	E-039 1.) The facility will conduct a table top exercise on 10/8/2019. 2.) Current residents in the facility have the potential to be affected 3.) Divisional Facilities Manager re-educated Maintenance Director. 100% of facility staff to be educated by Maintenance Director on table top	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 039	Continued From page 5 was conducted with the Maintenance Director. When asked to show documentation of participation in the table top exercises and testing of the emergency plan he stated that the facility had been through a lot of Administrative turnover. He said "We have had 4 Administrators in the past year." The Maintenance Director showed documentation of table top exercise conducted on 11/9/17 signed by a former Administrator. No further information was provided.	E 039	requirement/exercise related to a clinically relevant emergency scenario. 4.) Maintenance Director and/or designee will audit staff knowledge of 3 staff members related to the table top exercise 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9-15-19 through 9-17-19. Significant 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 survey sample consisted of 42 Residents.	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	F 550		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 550	Continued From page 6 individuality. The facility must protect and promote the rights of the resident. §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 observation, staff interviews, clinical record reviews, and facility documentation review, the facility staff failed to maintain dignity for 3 residents (Resident #31, Resident #87, Resident #70) in a sample size of 42 residents. The findings include: 1. For Resident #31, the facility staff observed he had food on his face, however, the facility staff	F 550	F-550 1.) Residents #31 dignity was honored with assistance in wiping his face. CNA #G counseled regarding Resident Rights policies/procedure. CNA #J & LPN #E re-educated on Resident Rights policies/procedure. Resident□s #87 and #70 dignity is currently maintained with staff knocking on resident room doors before entering.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 550	Continued From page 7 failed to assist him clean his face promptly. In addition, the facility staff left Resident #31's pants down while in bed. Resident #31, a 72-year old male, was admitted to the facility on 02/09/2019. Diagnoses included but not limited to dementia, dysphagia, and diabetes. Resident #31's most recent Minimum Data Set with an Assessment Reference Date of 07/15/2019 was coded as a quarterly assessment. Functional status for eating was coded as requiring a one-person physical assist and supervision (oversight, encouragement, or cueing) during meals. Personal hygiene was coded as total dependence on staff. On 09/16/2019 at approximately 5:05 PM, Certified Nursing Assistant H (CNA H), CNA I, and this surveyor entered the room of a resident, identified in the sample as Resident #31, to obtain a weight. Once the covers were removed, it was noted at that time that Resident #31 was fully dressed but his pants were pulled down to thigh level exposing his brief. On 09/17/2019 at 8:11 AM, Resident #31 was observed in bed with the head of the bed elevated approximately 60 degrees and his breakfast tray in front of him on the tray table. There was no staff in the room. There was a whole biscuit with gravy on the plate and a cup of orange juice. Resident #31 was picking off pieces of the biscuit with gravy with his right hand and feeding himself. Food remnants were on his face and chin. When asked if he needed assistance from staff, Resident #31 did not reply and kept eating in this fashion.	F 550	2.) Current residents that need assistance with ADL□s and resides in the facility reviewed to identify those that have the potential to be affected. 3.) DON educated all nursing staff on Resident Rights/Dignity and providing ADL care. 4.) Director of Nursing and/or designee will audit 5 licensed nursing staff regarding dignity/appropriate ADL care 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 550	Continued From page 8	F 550		

On 09/17/2019 at 8:15 AM, this surveyor alerted staff Resident #31 needed assistance. Certified Nursing Assistant G (CNA G) and this surveyor entered Resident #31's room and he was observed eating his breakfast with his hand and food remnants and gravy on his face and chin. CNA G reminded Resident #31 to use his fork and put the fork in his hand. CNA G then cut the whole biscuit up in small pieces. Resident #31 loaded his fork with food and fed himself. CNA G then left the room. She did not clean Resident #31's face.

On 09/17/2019 at 8:19 AM, this surveyor observed CNA G standing by a tray cart in the hall. When asked if [Resident #31] needed assistance washing the food off his face, she stated, "Yes" and walked away from the direction of Resident #31's room.

On 09/16/2019 at 6:55 PM, an interview with CNA J was conducted. CNA J verified she was assigned to care for Resident #70 and Resident #31. When informed about observation for Resident #31, CNA J stated that when she made her rounds at the beginning of her shift, she noticed [Resident #31]'s pants were down and just left them that way. When asked why, CNA J stated that "It's not a problem" to leave the pants halfway down. She went on to say, "We check to see if they're wet or dry, we don't want the family to think they're laying in bed all day or didn't get washed up."

On 09/17/2019 at 8:29 AM, Resident #31 was observed with food still on his face. A staff member entered his room, washed the food off his face and hands, and took the tray away.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 550	Continued From page 9	F 550		

Resident #31 had eaten all of his breakfast.

On 09/17/2019 at 8:45 AM, the DON was notified of concerns and she stated that the aide should have "wiped his face" before leaving the room.

On 09/17/2019, a copy of facility policy on dignity was requested and the facility staff provided a policy entitled, "Routine Resident Care." In Section 3 Part (b) it is documented, "Routine care by a certified nursing assistant includes but is not limited to the following:" Item (i) under Section 3(b) documented, "Assisting or provides for personal care 1. Bathing 2. Dressing 3. Eating and hydration 4. Toileting."

On 09/17/2019 at approximately 7:00 PM, the administrator and DON had no further information or documentation to offer.

2. For Resident #87, the facility staff failed to knock before entering the room and failed to maintain his dignity. From the hall, Resident #87 was observed with his pants down and brief exposed while lying in his bed.

Resident #87, a 49-year old male, was admitted to the facility on 01/14/2016.
Diagnoses included but not limited to Huntington's disease, anxiety, and depression.

Resident #87's most recent Minimum Data Set with an Assessment Reference Date of 08/29/2019 was coded as a significant change in status assessment. The Brief Interview for Mental Status was coded as "7 " out of possible "15" indicative of severe cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 550	Continued From page 10	F 550		

Functional status for bed mobility. Transferring, toileting, eating, dressing, personal hygiene were coded as requiring extensive assistance from staff. Urinary and bowel continence were coded as always incontinent.

On 09/15/2019 at 12:45 PM, Resident #87 was observed lying in bed awake. He had no covers on and was wearing a yellow shirt with pants on that pulled down to thigh level and exposing his brief. Resident #87's room door was open and he was visible from the hall. This surveyor alerted Licensed Practical Nurse E (LPN E). LPN E then entered Resident #87's room without knocking and pulled Resident #87's pants up. After exiting the room, LPN E was asked about the importance of knocking before entering and she stated she was sorry and that she should've knocked. When asked why, she stated, "For privacy."

On 09/17/2019 at 8:45 AM, the DON was notified of findings and she stated [Resident #87] should have had his pants pulled up. When asked why, she stated, It's a dignity issue."

On 09/17/2019, a copy of facility policy on dignity was requested and the facility staff provided a policy entitled, "Routine Resident Care." In Section 3 Part (b) it is documented, "Routine care by a certified nursing assistant includes but is not limited to the following:" Item (i) under Section 3(b) documented, "Assisting or provides for personal care 1. Bathing 2. Dressing 3. Eating and hydration 4. Toileting."

On 09/17/2019 at approximately 7:00 PM, the administrator and the DON had no further information or documentation to offer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 550	Continued From page 11	F 550		

3. For Resident #70, the facility staff left him seated by the door of his room and his pants were down to thigh level.

Resident #70, a 93 -year old male, was admitted to the facility on 07/23/2019. Diagnoses included but not limited to dementia and generalized muscle weakness.

Resident #70's most recent Minimum Data Set with an Assessment Reference Date of 07/30/2019 was coded as an admission assessment. The Brief Interview for Mental Status was not assessed. Functional status for bed mobility. transferring, toileting, eating, dressing, and personal hygiene was coded as requiring extensive assistance from staff. Urinary and bowel continence were coded as frequently incontinent. Resident #70's PPS 14-day scheduled assessment coded the Brief Interview for Mental Status as "00 " out of possible "15" indicative of severe cognitive impairment.

On 09/16/2019 at 5:17 PM, CNA H, CNA I, and this surveyor entered Resident #70's room to obtain a weight. He was dressed and seated in his wheelchair. It was noted at that time Resident #70's pants were pulled down to his thighs. CNA H and CNA I assisted him to stand and pulled his pants up. After exiting the room, CNA I was asked why Resident #70's pants were down and she stated she didn't know, she was not assigned to care for Resident #70.

On 09/16/2019 at 6:55 PM, an interview with CNA J was conducted. When informed about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 550	Continued From page 12 observation for Resident #70, CNA J stated she checked on [Resident #70] during her rounds and didn't notice his pants were down. When asked if it was acceptable to leave his pants down, she stated, "No, not when they're in the wheelchair but it's not a problem if they're in bed." On 09/17/2019 at 8:45 AM, the DON was notified of findings and she stated that their pants should have been up. When asked why, the DON stated that it's a dignity issue. On 09/17/2019, a copy of facility policy on dignity was requested and the facility staff provided a policy entitled, "Routine Resident Care." In Section 3 Part (b) it is documented, "Routine care by a certified nursing assistant includes but is not limited to the following:" Item (i) under Section 3(b) documented, "Assisting or provides for personal care 1. Bathing 2. Dressing 3. Eating and hydration 4. Toileting." On 09/17/2019 at approximately 7:00 PM, the administrator and DON had no further information or documentation to offer.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review the facility staff failed to assess, to determine if a Resident was safe to self administer medications,	F 554	F-554 1.) Upon notification from surveyor the medication at bedside was removed for Resident #104.	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 554	Continued From page 13 for one Resident (Resident #104) in a survey sample of 42 Residents. The findings included: Resident #104 was admitted to the facility on 8/25/14, with a most recent readmission on 10/21/18. Resident #104's diagnoses included but were not limited to: unspecified convulsions, muscle weakness, chronic pain, and type 2 diabetes. Resident #104's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 9/5/19 was coded as an annual assessment. Resident #104 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. The Resident was also coded as requiring extensive assistance of staff with dressing, eating, personal hygiene, bed mobility and toileting. For bathing, Resident #104 was totally dependent upon staff. During a resident interview with Resident #104, on 9/15/19 at 12:44 PM, it was observed that on the top of the chest of drawers, there was a medicine cup with a white cream in it. When Resident #104 was asked what it was, Resident #104 stated, "cream for my behind". Resident #104 was asked who applies the cream and he stated, "the nurse". On 9/15/19 at 12:53 PM, LPN E was in the hallway and was asked to accompany the surveyor into the room of Resident #104. LPN E was asked what the cup of cream is and LPN E stated, "honestly this is not my hall, I can ask the nurse, this is her hall and her resident".	F 554	2.) Current residents who have treatment orders to be administered by licensed nurses reviewed to identify those that have the potential to be affected. 3.) Director of Nursing educated licensed nursing staff on self-administration policy. 4.) Assistant Director of Nursing and/or designee will audit 3 resident rooms per audit to ensure no medications at bedside 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 554	Continued From page 14 On 9/15/19 at 12:55 PM, an interview was conducted with LPN A. When asked about the cream in the cup, which was observed in Resident #104's room, LPN A stated, "it is cream for itching, I know he gets it a fair amount". When asked if it should be left in his room, LPN A stated, "no ma'am". Review of Resident #104's entire clinical record, to include but not limited to: physician orders, careplan, nursing notes, assessments, and interdisciplinary team meeting notes there was no indication that Resident #104 had been assessed for and/or determined to be safe to self-administer medications. On 9/15/19 a request was made of nursing administration for any self-administration of medication assessments for Resident #104. They returned and indicated they had no assessments of self-administration for Resident #104. Review of the facility policy titled, "Resident Self-Administration of Medications" with a review date of 5/29/19 read, "the facility will periodically review the ability to self-administer medication based upon change in status. On admission, the facility will assess the resident for safety through an IDT care planning team prior to the resident exercising their right of self-administration of drugs within 7 days after the comprehensive assessment is completed as required by regulations. " No further information was provided.	F 554		
F 558	Reasonable Accommodations Needs/Preferences	F 558		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 558 SS=D	Continued From page 15 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, Resident interview, the facility staff failed to provide reasonable accommodation of needs for 1 Resident (#30) in survey sample of 42 Residents. The findings included; For Resident #30 the facility staff failed to accommodate the residents's needs as evidenced by failure to provide an operational hospital bed. Resident #30's most recent re-admission to the facility was on 2/12/19. The Resident's diagnoses included but were not limited to: end stage renal disease and hyperlipidemia. Resident #30's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 7/17/19 was coded as a quarterly assessment. Resident #30 was not assessed for cognitive functioning on this assessment. Resident #30 was coded as being independent with dressing, eating and bathing. He was also coded as having had required supervision of one staff person for transfers, toileting and personal hygiene. On 9/15/19 at 12:50 PM, during an interview with	F 558	F-558 1.) Resident #30□s bed was replaced. 2.) Current resident□s rooms audited to identify those that have the potential to be affected. 3.) Divisional Facilities Manager re-educated Maintenance Director regarding work orders/requests. Director of Nursing educated nursing staff on work orders/requests. 4.) Admissions Director and/or designee will audit 5 beds in resident rooms 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 558	Continued From page 16	F 558		

Resident #30, the Resident stated this his bed did not work, and had not worked for 2 weeks. The Resident stated he had reported multiple times to staff but nothing had been done.

On 9/15/19 at 12:52 PM, LPN E came into the room of Resident #30, she was asked to use the remote controller for the bed to adjust it and stated, "it isn't working". The elevation of the bed was not able to be adjusted to change the height from the floor to make it easier for Resident #30 to transfer out of bed, nor was the head of the bed able to elevated. LPN E then went into the hall, , and told Resident #30's assigned nurse, LPN A, "[Resident #30's name redacted] bed isn't working, he said he's been asking for 2 weeks so I'm going to go put it in for maintenance in TELS [computerized system for maintenance work orders]".

On 9/16/19 at approximately 9:00 AM, an interview was conducted with Resident #30. The Resident stated his bed still was not working and used the remote control and demonstrated that it was not operational.

On 9/16/19 at 5:03 PM, Employee F, the maintenance director accompanied this writer to the room of Resident #30. When he attempted to move the bed using the hand controller he stated "it isn't working". Employee F continued looking at the bed and stated, "the motors are bad, the gears on the motor, I'm waiting on some parts to come in, I can get that corrected". When the maintenance director was asked how he would be made aware of such equipment failure, he stated, "nursing or housekeeping will report when they find something and nursing will put it in TELS. Only a person with computer access can

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 558	Continued From page 17	F 558		

put in the work orders". Employee F reported that he checks the functioning of beds monthly.

On 9/16/19 a request for all maintenance work orders involving Resident #30's room was requested. This revealed that on 9/3/19 a maintenance work order had been entered into the TELS system and was "set to closed" on 9/5/19 with a note "replaced". On 9/5/19 another work order was entered into TELS that stated, "HiLO [sic] motor bad duplicate [sic]" and this work order was "set to closed" by the maintenance director on 9/9/19.

On 9/17/19 at 3:50 PM during environmental rounds the bed of Resident #30 was observed to still not be working.

On 9/17/19 at 5:31 PM, during an end of day meeting, the facility Administrator (Employee A) was asked if the facility was at 100% occupancy. The facility administrator stated, "no". The administrator was asked why it was identified on 9/15/19 that Resident #30's bed was not operational, maintenance confirmed this on 9/16/19 and as of 3:50 PM on 9/17/19 Resident #30 remained in a broken bed. The facility Administrator stated he was not able to answer that question.

Review of the facility policy titled "maintenance work request system" it read, "corrective maintenance can be defined as those actions required to restore equipment, buildings and grounds to normal condition and operation. The department director will assign work requests to personnel and daily review completed work orders for completeness and correctness of repairs and/or the need for purchases or outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 558	Continued From page 18 assistance". The Administrator and Director of Nursing were made aware of the facility staff's failure to accommodate the needs of Resident #30 during an end of day meeting on 9/17/19 at 5:31 PM. No further information was provided.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the	F 561		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 561	Continued From page 19 facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed for one Resident (Resident #28) in a survey sample of 42 residents, to facilitate a preference to interact with community members who live in the facility by sharing a community dining experience due to the dining room was closed for breakfast, lunch and dinner on the weekends The findings included; Resident #28 was a 67 year old who was admitted to the facility on 4/12/19. Resident #28's diagnoses included Diabetes Mellitus Type 2, Muscle Weakness, and Hypertension. The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 4/22/19 was reviewed. Resident #28 was coded with a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. He was also coded as requiring set up assistance with meals, and being able to ambulate independently with his wheelchair. On 9/16/19 a review was conducted of Resident #28's clinical record, revealing the following diet order: "4/22/19. Renal diet. Regular texture, Large Portions, Sandwich 3 times a day at meals." On 9/15/19 at 12:45 P.M. a tour was conducted of the facility. There were no residents in the dining room, or the activity room. A Certified Nursing Assistant (CNA M) was asked why the residents	F 561	F-561 1.) Resident #28 (reported as #60) educated that main dining room currently open during all meals including weekends. 2.) Current residents who wish to attend meals in main dining room reviewed to identify those that have the potential to be affected. 3.) Director of Nurses re-educated all current facility staff on providing access for residents to dining area for all meals. 4.) Food Service Director and/or designee to audit dining area access for all residents to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 561	Continued From page 20 weren't eating in the dining room, or the activity room. She stated, "The dining and activity rooms are closed. They are closed for breakfast, lunch and dinner on the weekends due to a staff shortage." When asked how long had the rooms been closed, CNA M stated that the rooms were closed on weekends for several months. She stated that during the week, residents who did not require feeding assistance ate in the dining room, and those who required feeding assistance ate in the activity room. On 9/15/19 at 1:40 P.M. an interview was conducted with Resident #28 in his room. His lunch had not been served. He stated that he wanted to be allowed to eat with his neighbors in the dining room. He stated that he did not want to eat in his bedroom. He further stated that the dining room was closed all day on weekends. On 9/16/19 at approximately 5:00 P.M., an interview was conducted with the Director of Nursing (DON Employee B). When asked why Resident #28 was unable to eat in the dining room along with other residents, the DON did not answer. She stated that a "Huddle meeting had been conducted with the CNA's about that." She submitted the Meeting Notes. An excerpt read, "9/15/19 at 3 P.M. & 9/16/19 at 3:30 P.M. Passing trays at meal times, Assisting Feeders, Documenting on Amounts Eaten." The document was signed by only 6 CNA's, and did not address ensuring the dining room would be used as appropriate. No further information was received.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 582	Continued From page 21	F 582		

§483.10(g)(17) The facility must--
(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-
(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 582	Continued From page 22 deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation the facility staff failed to ensure correct completion of the Advance Beneficiary Notice of Non-Coverage, for 1 Resident (#71) in a survey sample of 42 Residents. The findings include: The facility failed to ensure Resident #50 was given a choice and checked the one of three options box on the ABN form. On 9/17/19 at approximately 4:30 PM the business office manager was given the names of the client records for ABN notices to pull. She returned with Resident #50's ABN notice dated 6/7/19. Page 1 had Resident # 50's name and "Effective Date Coverage of Your Current Skilled Nursing Facility Services Will End: 6/10/19". (Patient number was left blank) Page 2 read " If you miss the deadline to request	F 582	F-582 1.) Resident #50 was explained the process and options in receiving NOMNC notice. 2.) Current residents no longer actively receiving Medicare A benefits have the potential to be affected. 3.) Facility Administrator will educate Social Worker on correct/timely completion of the ABN notice and resident rights. 4.) Administrator and/or designee will audit all discharged residents on ABN/NOMNC completion/delivery to ensure compliance weekly x3 weeks then monthly x 3 month with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 582	Continued From page 23	F 582		

an immediate appeal you may have other appeal rights:
If you have original Medicare call QUITO listed on page 1.
If you belong to a Medicare health plan call your plan at the number given below:
(Space left blank)
Additional information optional: Telephone Notification: On 6/7/19 at (time) [left blank] telephone notification was made with resident representative [name redacted] to explain notice of non-coverage and appeal rights. Made aware of skilled service will end (effective date) 6/10/19 and financial liability will begin (date) 6/11/12 [sic] informed that a request for immediate appeal should be made as soon as possible but no later than noon on the day before the effective date. Provided number to contact [company name redacted] for appeal at 1-888-396-4646. TTY 1-888-985-2660. Received verbal confirmation that resident representative understood all information as explained.
Facility Representative Signature [name redacted] BOM (Business Office Manager)

It was signed by the Resident on 6/10/19

Last page titled "Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN)
Beginning on 6/11/19 you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs.
CARE:
Skilled Care

Reason Medicare May Not Pay:
No longer meets skilled criteria

Estimated Cost:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 582	Continued From page 24 $213.09 a day OPTIONS: CHECK ONLY one box. We can't chose a box for you. Option 1 - I want the care listed above. I want Medicare to be billed for an official decision on payment. Which will be sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I'm responsible for paying, I can appeal to Medicare by following the directions on MSN. Option 2 - I want the care listed above, but don't bill Medicare. I understand that I may be billed now because I am responsible for payment of the care. I cannot appeal because Medicare won't be billed. Option 3 - I don't want the care listed above. I understand that I'm not responsible for paying, and I can't appeal to see if Medicare would pay. However, no options were checked. On 9/18/19 during the end of day meeting when asked about the ABN notice not being filled out completely and Resident not making a choice out of the three options the Administrator stated he would look into it. At approximately 6:45 PM the facility stated they had no further documentation.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean,	F 584		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 584	Continued From page 25	F 584		

comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide-
§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.
(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.
(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 584	Continued From page 26 Based on observation, resident interview and staff interview, the facility staff failed for 1 resident (resident #67) of 42 resident and for 2 of 61 resident rooms to provide a clean, comfortable, home-like environment. The findings include: For Resident #67 the facility staff failed to maintain a safe and homelike environment for a visually impaired resident, as evidenced by a broken cabinet with 2 drawer faces/covers missing. Resident #67 was admitted to the facility on 3/21/14. The diagnoses for Resident #67 included but were not limited to: blindness, dementia, difficulty walking, and major depressive disorder. On 9/15/19 at approximately 12:40 PM, during an interview with Resident #67 it was observed that his bedside table had 2 drawers with the faces/covers missing. The drawer covers were observed propped beside the cabinet. Resident #67 is visually impaired but was asked how long it has been broken and he stated "not too long". On 9/16/19 at 5:03 PM the maintenance director was asked if he was aware of or had any outstanding issues in the room of Resident #67. The maintenance director stated, "no". He was shown the cabinet in Resident #67's room. The maintenance director stated, "yeah, I'm gonna have to replace that. I missed it this morning, I was in here checking call bells". Review of the facility policy titled "maintenance work request systems" stated, "policy: to establish	F 584	F-584 1.) Maintenance Director to repair dresser drawers for Resident #67 and completed patching in rooms 213/231. 2.) Current resident□s rooms audited to identify those that have the potential to be affected. 3.) Divisional Facilities Manager educated Maintenance Director on timely repairs of furniture/equipment. Director of Nurses re-educated staff on work orders/requests. 4.) ED and /or designee to audit 5 rooms to ensure furniture/walls in good condition to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 584	Continued From page 27	F 584		

an effective means of requesting, coordinating, and completing maintenance of a corrective nature. The department director will assign work requests to personnel and daily review completed work orders for completeness and correctness of repairs and/or the need for purchases or outside assistance."

No further information was provided.

2. The facility staff failed to maintain the building in good repair, and create a homelike environment in rooms 213 and 231.

On 9/17/19 from 3:30 PM until 4:30 PM in the course of environmental rounds it was observed that 2 Resident rooms (Rooms 213 and Room 231) had significant holes in the wall.

Room 213 had a hole in the wall behind the head of the bed that measured approximately 12 inches in width by 8 inches in height.

Room 231 was observed to have a hole in the wall that was located to the right of the p-tac (heating/air unit) in the wall and extended behind the cove base. The hole was observed to have broken pieces of sheet rock in the hole. The damage was approximately 1 ft in height and extended 1 1/2- 2 feet in width. Two CNA's (certified nursing assistants) were in the room and were asked about the damage. When asked how long it had been like that, CNA C stated, "a couple of months". CNA D stated, "I've been on leave for 2 months, it was like that before I left".

On 9/17/19 at 4:40 PM the maintenance director (employee F) was shown the hole in the wall in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 584	Continued From page 28 room 231. The maintenance director stated, "that's probably from a wheelchair or bedside table". Review of the facility policy titled "maintenance work request systems" stated, "policy: to establish an effective means of requesting, coordinating, and completing maintenance of a corrective nature. The department director will assign work requests to personnel and daily review completed work orders for completeness and correctness of repairs and/or the need for purchases or outside assistance." No further information was provided.	F 584		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, facility documentation review, and in the course of a	F 600	F-600 1.) Resident #37 has discharged from the facility. Resident #43 continues on 1:1	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 29 complaint investigation, the facility staff failed to ensure 3 residents were free from abuse and/or neglect (Residents #37 and 93, who was abused by Resident #43) in a survey sample of 42 residents. This resulted in harm for Resident #37. The findings included: 1. For Resident #37, the facility staff neglected to provide goods and services to prevent continuing significant weight loss, resulting in severe malnutrition, and an unstageable pressure sore not identified by staff until the wound was first identified with eschar, and unstageable, all resulting in harm. Resident #37 was admitted to the facility on 4-15-19. Diagnoses included: hypertension, anemia, arthritis, chronic kidney disease moderate, high cholesterol, heart disease, seizures, and a history of dysphagia. The most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 9-9-19. Resident #37 was coded with a Brief Interview of Mental Status score of 11 indicating mild to no cognitive impairment and the Resident required extensive assistance, to complete dependence, on staff for all activities of daily living. This included extensive assistance of 1 staff member's physical assistance to eat. The Resident was coded with no aberrant behaviors, and no refusals of care or assistance from staff. This MDS was compared to the previous MDS with an ARD of 7-12-19 which was a 90 day assessment, and the comparison is as below:	F 600	supervision. Resident #37 was receiving TwoCal per MD orders BID given by licensed nurse. 2.) Current residents with noted behaviors reviewed to identify those that have the potential to be affected. 3.) Director of Nurses re-educated staff on abuse/neglect reporting and policies/procedures. All licensed nursing staff re-educated on MD weight change notification, appropriate interventions/care planning for significant weight loss, timely delivery of meal tray to resident room, proper assistance with feeding and compliance, and meal consumption accuracy. DON re-educated licensed nurses on identifying resident behavior and appropriate interventions. 4.) Administrator and/or designee to audit 100% of incident reports regarding abuse reporting, policies/procedures to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 30	F 600		

MDS 7-12-19 - BIMS = 11, at risk for wounds, no current wounds, no preventative measures for wounds, no weight loss, mechanically altered diet, Bed mobility extensive assistance needed, eating extensive assistance needed.

MDS 9-9-19 - BIMS =11, at risk for wounds, one current "vascular" (incorrect identification) wound, pressure reduction devices for chair and bed, for wounds, ointments and dressings for the wound, nutrition management, significant weight loss, mechanically altered diet, Bed mobility extensive assistance needed, eating extensive assistance needed.

On 4-15-19, Resident #37 was admitted on a "Regular diet with low potassium, regular texture, thin liquids." On 6-25-19 the Resident's diet was changed to "Dysphagia ground texture, thin consistency low potassium diet". On 9-11-19 the Resident's diet was again changed to "Regular diet puree texture, nectar consistency, for dysphagia." The Resident's diet card was requested from the kitchen and stated the pureed diet with nectar thickened liquids was being served. No mention of the supplement (2 cal supplement 240 ml (milliliters) three times per day, was on the tray card.

On 9-15-19 at 12:00 noon, observations and interviews were conducted with the Resident. After introduction, the Resident was asked if we could help him with anything while we were there, and he complained of hunger, and stated he wanted something to eat. He stated his family brought him things and he enjoyed that food.

The lunch meal tray did not arrive at the bedside until 12:45 p.m., and at 2:30 p.m., no staff had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 31	F 600		

entered the room to assist the Resident to eat. Surveyor A, and this surveyor looked at the tray which was uncovered, and untouched. We then went to the nursing station to enquire as to how long it would be for the Resident to be fed. The staff stated they were very understaffed, and were unable to use the dining room, and had to close it as they were unable to staff it, so the "feeders" who would normally be fed there had to be fed in their rooms. They stated that Resident #37 "was a self feeder, and independent."

At 2:30 p.m., the Resident was again observed and was sitting in bed falling over onto his left side with a small Styrofoam or paper cup containing "magic cup" supplement, which was an ice cream like substance in his hand. The Resident was licking the inside of the cup to obtain the contents, and the surveyor asked him if he was able to hold the spoon that was on his tray, and he stated "not too good, I am so weak now, I just don't have the strength". The Resident picked up the spoon and tried to use it, however, the small amount he was able to get onto the spoon after much effort, fell down onto the bed linens. The rest of the tray was untouched, and no 2 cal supplement was on the tray.

At 2:45 p.m., the HR (human resources) Director entered the Resident room to feed him. The surveyors returned at 3:30 pm to find the tray had been left there and the thick pudding consistency portions of food had approximately 2 spoonfuls missing from 2 of the 3 scoops of pureed food. Each of the scoops measured approximately 3 inches by 3 inches circular, and 1/2 inch depth, and had spread out into each other on the plate. The Resident stated "I can't eat that stuff, it's awful like cold wet bread." He went on to say "I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 32	F 600		

told them when I got here that I can't eat that stuff, and I don't have any trouble eating if I like the food, but they don't listen."

On 9-16-19 at 10:00 a.m., another observation was conducted for this Resident by Surveyor C. Surveyor C reported that for the breakfast meal the tray was followed and went into the Resident's room, left uncovered, and removed from the room untouched and returned to the kitchen. On 9-16-19 at 3:00 p.m., the Resident's lunch meal tray was again left untouched, and the Resident was not fed. No supplement was in the room for either meal

The ADL (activities of daily living) report was requested and received. The report documented that the Resident was independent with eating for breakfast and lunch every day in September, for 20 of the 32 breakfast and lunch meal opportunities. The 12 meal exceptions where the staff assisted the Resident occurred on the following days;

9-1-19 dependant (fed) for both meals, and consumed nothing for breakfast and 51-75% for lunch.
9-5-19 dependant (fed) for both meals, and consumed 51-75% for both meals.
9-7-19 limited assistance (not fed) for both meals, and consumed nothing for both meals.
9-8-19 limited assistance (not fed) for breakfast, and consumed 26-50%.
9-10-19 limited assistance (not fed) for lunch, and consumed nothing.

The behavior portion of the ADL record was also reviewed and revealed at no time did the Resident refuse assistance or care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 33	F 600		

The other 20 opportunities for staff support with feeding, and the Resident was not fed, occurred on the following days;

9-2-19 The Resident consumed 51-75% both meals
9-3-19 The Resident consumed 26-50% both meals
9-4-19 The Resident consumed 26-50% both meals
9-6-19 The Resident consumed 26-50% at breakfast, and 76-100% at lunch
9-8-19 The Resident consumed 26-50% at lunch
9-9-19 The Resident consumed 76-100% both meals
9-10-19 The Resident consumed nothing for breakfast
9-11-19 The Resident consumed nothing for breakfast, and 76-100% at lunch
9-12-19 The Resident consumed nothing both meals
9-13-19 The Resident consumed 26-50% both meals
9-14-19 The Resident consumed 26-50% breakfast, and 75-100% at lunch
9-15-19 The Resident consumed nothing both meals
9-16-19 The Resident consumed 26-50% for breakfast, nothing for lunch

It is notable to mention that on 9-16-19 the Resident's breakfast tray was followed by Surveyor C from delivery by CNA N, to discard, and it was not disturbed, nor did the Resident attempt to consume it. No staff member attempted to assist with the meal, and the tray was simply removed from the room, untouched, and discarded. CNA O documented 26-50%

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 34	F 600		

consumed.

CNA N (certified nursing assistant) was interviewed, and stated "he ate a little of his sherbet cup so I said he ate 25%", however, CNA N did not sign the ADL document, another staff member, CNA O was documented as having fed Resident #37 his breakfast. CNA N was asked if she fed the Resident, and she stated "no he can feed himself." CNA N was asked if she had been trained on how to calculate the amount of a meal that a resident consumes, and she stated "no." CNA O stated that she only removed the tray, and did not feed the Resident.

During this 16 day period from 9-1-19 through 9-16-19, nine different staff members signed the meal consumption record, only 3 of which delivered the meal to the Resident consistently more than one day in the 16 days.

The Resident's weight record was requested and revealed that from 7-3-19 until the time of survey on 9-16-19, the Resident had lost 23.4 pounds of weight in less than 12 weeks. Those weights follow:

4-15-19 - On admit 122.4 lbs (pounds)
4-23-19 - 119.2
5-1-19 - 115.2 - weight loss of 7 pounds after admission for 2 weeks.
5-22-19 - 120.2 - weight gain of 5 pounds and stabilizes after 3 more weeks.
6-25-19 - diet modified to ground texture begun, and significant weight loss begins.
6-26-19 - 119.0
7-3-19 - 119.0
7-24-19 - 117.0
7-31-19 - 117.0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 35	F 600		

8-26-19 - 108.0
9-1-19 - 103.0
9-9-19 - 101.8
9-11-19 - diet modified to pureed texture begun after significant weight loss of 17.2 pounds from 7-3-19 to 9-9-19.
9-16-19 - 95.6 - significant weight loss increased in less than 12 weeks to 23.4 pounds, equaling 20% of the Resident's entire body weight, and 26.8 pounds, since admission.

On 9-16-19 at 3:00 p.m., an interview was conducted with the Director of Nursing (DON), and "Unit manager" RN (registered nurse) D, by surveyors in the conference room. They stated that they were talking to the family, and there were "lots of family dynamics,...we want to have a care plan meeting with him and his family, wife, son or brother, that is our next step with him I am aware he is loosing weight."

They were asked why it had taken 5 months to get a plan going, and they stated "At first his family was bringing in food that he was eating, he doesn't like the pureed texture or the nectar thick liquids." "Therapy had been working with him, and he had a "FEES" study on 9-10-19 that he failed. We have talked with his wife, and his son and brother. He has biological children, a wife and a stepson. He had to go to the hospital for a blood transfusion, and at the hospital his wife refused it. He is his own RP (responsible party). The hospital sent him back to us, and his biological children were upset... Our social worker (name) Employee O was working with him, and his son and daughter got involved and we sent him back, to the hospital, the spouse didn't have his best interest."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 36	F 600		

They were asked why the physician had not talked with the Resident himself and decide a course of action? They stated "We discussed the doctor talking to him (the Resident), and we didn't have a social worker as Employee O has been gone about a month and a half ago, and he has lost weight since that." The DON stated "I see we need to make a decision and talk to him to see if he wants a peg tube because he doesn't like the pureed texture to maintain his BMI (Body Mass Index)."

The DON and unit manager continued with, "Speech therapy did a swallowing eval, and he didn't do well." They were asked when that occurred as no therapy notes were found in the clinical record. She stated, I don't know, I will get those for you." "The family brings in McDonalds, and that he eats." She was asked if he had ever aspirated or been hospitalized, or treated for aspiration pneumonia, or had any respiratory problems, and they stated "no." They were asked why the Resident was not being fed by staff who thought he was independent, when his MDS showed he needed extensive assistance from staff to eat since the 7-12-19 MDS which included a seven day look back to 7-5-19. They responded "He should be fed."

On 9-16-19 at 3:15 p.m., Employee E, the speech language pathologist (ST/SLP) entered the interview in progress in the conference room with surveyors, and with the unit manager and DON. She stated "he was on ground meat with pureed solids and the Resident didn't like it so the family requested an upgrade so he would eat, and then the FEES study was ordered on 9-10-19." I asked if there was no problem, or outcome with the regular diet that the family brought in that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 37	F 600		

Resident did eat, why the change. She stated "he needs positioning and encouragement to not aspirate, he is at risk for silent aspiration". She continued "he wasn't really eating the ground texture, or anything off of the pureed tray but pudding, oatmeal, and cream of wheat, and that's why the FEES study was done." "A bedside swallowing evaluation was done by another speech therapist who was full time here. I am not typically treating most of the time. Her last day was weeks ago, I don't remember how many, we have a new one starting today. Between the last one and this one we have had PRN (as needed) staff and I have been helping treat as well." She was asked if she had assessed or treated Resident #37, and she stated "no." The ST notes were again requested.

The "FEES" ("Dysphagia systems test") study was requested at 3:15 p.m., during the interview with Employee E, and received at 4:00 p.m. The study documented no diagnoses linked to dysphagia, and documented that the Resident took his medications whole. The document describes the "Potential risks" to the Resident, and documents that the Resident is at "Potential risk" for aspiration. Any and all ST notes from Resident #37's time of admission to today were requested again.

On 9-16-19 at 4:00 p.m., the Registered Dietician (RD), and Assistant Director of Nursing (ADON) were interviewed by surveyors in the conference room. The current RD stated there had been "a lot of turnover in the department and there had been one RD from April to may 2019, and then travel and consultant RD's had come in as needed until mid August 2019 during his significant weight loss", and she herself

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 38	F 600		

(employee G) "started work in the facility in mid august, and had been there just under a month."

Physician's progress notes were reviewed and indicated no weights on the assessments conducted by the physicians. The area in the form for "weight" were all left blank. There is no indication that the physician's were aware of the significant weight loss from 6-25-10 to 8-29-19.

A review of the physician's orders, was conducted from the time of admission to the time of survey. They revealed the following timeline of interventions;

4-15-19 - admission regular diet with thin liquids. - weight 122.4.

4-16-19 - ST, TO (occupational therapy), PT (physical therapy) all evaluate and treat as necessary order entered.

5-2-19 - 2 Cal supplement 120 ml (milliliters) drink twice per day at 8:00 a.m., and 5:00 p.m. - weight 115.2.

6-25-19 - Weight 119.0, which had rebounded from initial admission loss, proving the Resident had no difficulty gaining weight back (for the 2 months and 10 days since admission) while eating a regular diet, and taking a small amount of supplement. During this time there were no problems associated with aspiration.

6-25-19 The diet change to dysphagia ground diet with thin liquids, which the Resident did not like.

No other interventions occurred to prevent significant weight loss from 5-2-19 until 8-28-19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 39	F 600		

when the new RD arrived, and the significant weight loss had already occurred. - weight 108.0 (14.4 pound (10%) weight loss since admission, and an 11 pound weight loss in 2 months.)

7-25-19 through 7-29-19 the Resident had symptoms of illness, and had laboratory blood tests drawn. As a result of those tests it was revealed that the Resident had become dehydrated. Resident #37 then was ordered to receive IV (intravenous) normal saline fluids for dehydration. The infusion was started initially through a peripheral IV in his left wrist, however, the IV was not positioned well and had to be removed, and the staff was unable to replace it, so a specialist nurse was brought in to insert a "mid line" PICC (peripherally inserted central line catheter) to infuse the fluids.

7-26-19 - Physician's orders, laboratory reports, and nursing/physician progress notes revealed that ADON was aware that the "Resident need for help with ADL's has increased. Resident recently ended PT, TO, and ST services. Will continue to monitor for further decline and have therapy screen as needed."

8-27-19 - RD progress note revealed "Weight not stable, Spoke with Resident who says that he doesn't like the ordered texture of his food. He reports that he feels like he's lost weight and does feel hungry throughout the day and at bedtime. He is agreeable to drinking 2 cal and trying snacks between meals and at bedtime...." Orders are then initiated and follow below.

8-29-19 - 2 Cal supplement increased to 240 ml (milliliters) drink twice per day at 8:00 a.m., and 5:00 p.m., magic cup twice per day with lunch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 40	F 600		

and supper, yogurt and apple sauce between meals and at bedtime, were all started - weight 108.0.

9-2-19 - Resident found to have a pressure ulcer to his right lateral ankle directly over the bone, and it was first identified with eschar (Black,dead, necrotic, hard tissue) covering the entire cap over the ankle bone. - weight 103.0.

9-3-19 - Resident lab test resulted for pre-albumin (measures recent dietary intake). Pro-stat protein supplement for wound healing was ordered.

9-9-19 - FEES study (Dysphagia systems test) completed. - weight 101.8.

9-11-19 - Diet changed to pureed with nectar thickened liquids, increase to 2 cal supplement to 3 times per day, and med pass liquid supplement was added for 60 ml three times per day.

9-16-19 - at the time of survey weight was - 95.6.

On 9-17-19 at 12:32 p.m., the physician was called on the telephone and asked for an interview. He stated he would come to the facility and look at the chart and let surveyors know about Resident #37. The physician arrived and stated he had looked at the chart, and said "the Resident is severely malnourished and doesn't like the texture of the diet."

He stated "We had speech look at the patient, and they said he isn't able to eat regular food. The family said no to a PEG (Per Endoscopic Gastrostomy) tube, there is nothing else to do." The doctor was asked why was speech therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 41	F 600		

was consulted, if the Resident had no signs of aspiration, was not hospitalized or ever suffered from any respiratory illness associated with aspiration, and had been here in the facility for 5 months. He stated that "the family was concerned."

The doctor was asked why the family was allowed to make decisions for the Resident when the staff made surveyors aware that the family did not have the Resident's best interest at heart. Further, for a Resident, who was alert and oriented, could make his needs known, and was his own Responsible Party (RP). The Resident had not been deemed incompetent, and had the right to make his own decisions. The doctor responded "I was not aware of that, and if we let him eat whatever he wants, that's how we get sued."

The doctor was then asked why the wound on the Resident's ankle was being called a "Vascular ulcer", and he stated "it's a pressure sore, and most likely the result of the patient's severe malnutrition." He was asked if he was aware that the RD, ST, and social worker had all been multiple different people (on an as needed basis) with no regular consistency, from June through August in the facility, and that the social worker had been gone for 6 weeks, and a new one was starting that day. He stated "no."

On 9-17-19 at 5:00 p.m., a "Summary Report of Meeting" document for the last 2 days of staff "huddle" meetings was presented to surveyors by the DON. The document described the subject of the meetings to be in regard to "Passing trays at meal times, assisting feeders, documenting on amounts eaten." and was signed by those in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 42	F 600		

attendance. This was evidence of training begun by the facility to rectify deficient practice in the meal delivery and assistance system.

The comprehensive care plan was reviewed in it's entirety and revealed the following interventions for the weight loss and pressure sore. There were no interventions for hydration, and it was simply placed in with the nutrition (weight loss) hydration plan below;

(Weight loss) FOCUS: (name) Resident #37 has the potential for nutrition/hydration imbalance related to hypertension, anemia, chronic kidney disease, history of hyperkalemia, diagnosis of dysphagia. Resident does not like puree texture food. initiated on 4-19-19, revised on 5-5-19, 6-25-19, and 9-13-19.
GOAL: Resident will remain adequate nutritional status as evidenced by maintaining weight with no significant weight changes through review date.
INTERVENTIONS: (all created and initiated on 4-19-19 immediately after admission) Administer medications as ordered. Monitor/document for side effects and effectiveness. Provide/serve diet as ordered, honoring resident preferences. Monitor intake and record every meal. RD to monitor and follow up per protocol. Weigh per facility protocol. (initiated 6-25-19) No hot liquids for safety.

No changes were made to any interventions after the Resident suffered a significant weight loss. The significant weight loss was not care planned, none of the interventions that were initiated for the weight loss were care planned, none of the supplements were care planned, none of the diet changes were care planned, and the need of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 43	F 600		

Resident to be fed by extensive assistance of staff was not care planned. Most goals are not measurable, and the Residents preferences were not honored.

(Pressure sore) FOCUS: (name) Resident #37's pressure ulcer was documented on the care plan on 9-2-19 when the ulcer was identified as a "pressure ulcer to right outer heel related to decreased mobility and altered nutrition". On 9-4-19 it was changed to "vascular ulcer to the right outer heel". On 9-12-19 it was changed again to "vascular ulcer right outer ankle".
GOAL: Wound will be free from infection through review date.
INTERVENTIONS: (all created and initiated on 9-2-19 at identification) Air mattress. Heel lift boots as tolerated. Resident/family education as needed. (initiated 9-12-19) Supplements as ordered for wound healing (10 days after identification).

There was no Hydration care plan initiated, even after the Resident suffered from dehydration requiring IV fluid infusions on 7-25-19.

The doctor, and nursing staff identified the wound as a pressure ulcer. None of the supplements for healing are care planned, the heel lift boots application is not measurable and has no guidance for use. No interventions for wound development prevention were present prior to the development of an unstageable pressure ulcer found with eschar upon identification, and likely caused by the Resident's malnutrition, as stated, and diagnosed by the doctor.

A wound Observation was conducted on 9-17-19 at 9:30 a.m. with LPN H. The Resident was alert

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 44	F 600		

and oriented to person, place, time, and situation. Both legs and the right ankle were exposed, as the Resident was laying partially on his left side, revealing cool, smooth leg skin, with no lesions, scars, scratches, scales nor brawny appearance. There was hair on both legs, no edema, or erythema in either extremity, and the Resident had palpable popliteal (behind the knee), dorsalis pedis (top of foot), and tibial (behind the ankle bone) pulses. The Resident had a brisk capillary refill when the toe nails were depressed, and at less that 1 second blood return. The Resident had no wounds on his heels or shins, and exhibited only 1 wound which was directly on top of the right lateral ankle bone (lateral malleolus). The depth of the pressure ulcer could not be ascertained as the wound was covered by black dead thick necrotic tissue with only the outer circumference beefy red, as the de-vitalized tissue was shrinking leaving an open thin boarder around the circular necrotic wound. There was no slough visible, and no drainage, nor odor to indicate infection. The wound was clean and had a minuscule amount of serosanguineous clear drainage making the edges around the wound shiny. The wound was approximately the size of a 1/2 dollar coin.

A "Skin Grid Pressure" initial assessment document was completed by RN E on 9-2-19 at initial identification of the wound. The document was reviewed and revealed that the wound was a "new pressure area, house acquired, risk factors impaired mobility and altered nutrition, unstageable pressure wound, right outer ankle, measured 2.5 cm (centimeters) x 2.2 cm, edges not clearly visible, granulation and eschar present, color red and necrotic, small amount of serous drainage, no odor, peri wound black or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 45	F 600		

hyper-pigmented, no pain, question, "does the Resident have a turning and repositioning program in place?" answer, "no".

5 Physician orders all issued on 9-2-19 after the pressure ulcer was identified, were reviewed and revealed the following:

1. L Elemental Arginine packet for wound healing once per day for 7 days, and was completed at the time of survey.
2. Multivitamin for wound healing one time per day.
3. Pro-stat protein supplement 30 ml one time per day.
4. Zinc Sulfate 220 mg (milligrams) one tablet 1 time per day for wound healing.
5. Cleanse right outer ankle with normal saline, pat dry, apply skin prep to peri-wound, medihoney and calcium (Softens hard dead tissue, and inhibits bacterial growth while absorbing drainage) alginate to wound bed, cover with dry dressing until resolved. Every day shift for wound care.

On 9-11-19 a new order was obtained for Santyl collagenase ointment 250 unit/GM (gram) apply to right outer ankle topically every day shift for wound for 14 days. (Enzymatic debriding agent for the removal of dead necrotic tissue), was currently being used during survey.

Abuse, neglect policies were requested and received. They revealed that the facility policy described neglect as, "failure to provide timely and consistent services, treatment or care to a resident .....to obtain or maintain a resident's health, safety to comfort: or a failure to provide timely and consistent goods and services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 46	F 600		

necessary to avoid physical harm, mental anguish.....". The document goes on to say; "Examples of neglect include but are not limited to: Failure to provide adequate nutrition and fluids". Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials.....". ".....(within 2 hours for serious injury or within 24 hours if no serious injury)."

On 9-17-19 at 5:00 p.m., the DON was again asked for ST notes, and none were supplied. At that time, the facility Administrator and Director of nursing were made aware of findings at the end of day meeting. The facility stated they had no further information to provide.

COMPLAINT DEFICIENCY

2. For Resident #93, the facility staff failed to ensure that she was not abused by Resident #43.

Resident #43 was a 82 year old who was admitted to the facility on 2/7/18. Resident #43's diagnoses upon admission included Cardiovascular Disease, Anxiety Disorder, Vascular Dementia with Behavioral Disturbance, Unspecified Psychosis, and Diabetes Mellitus -Type 2. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 5/15/19 was reviewed. Resident #43 was coded as having a Brief Interview of Mental Status Score of 8, indicating moderately impaired cognition. In addition, he was coded as requiring 1 person for physical assistance to ambulate.

Resident #93 was a 93 year old who was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 47	F 600		

admitted to the facility on 6/18/18. Resident #93's diagnoses included Unspecified Dementia, Muscle Weakness, and Hypertension. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 9/4/19 was reviewed. Resident #93 was coded as having a Brief Interview of Mental Status Score of 4, indicating severely impaired cognition.

On 9/15/19 at 3:15 P.M., an observation was conducted of Resident #43 in his room. He was lying awake on his bed. A Certified Nursing Assistant (CNA L) was providing 1:1 supervision. She stated that Resident #43 was doing well and did not exhibit any inappropriate behaviors.

On 9/16/19 at 12:00 P.M., a second observation was conducted of Resident #43. He was sitting in the dining room with CNA L. There were 2 other residents at his table. He sat quietly and did not interact with anyone.

On 9/15/19 a review was conducted of facility documentation, revealing a Facility Reported Incident dated 11/28/18. An excerpt read, "(Resident #43) was noted by a dietary staff member holding [Resident # 93] with her hands behind her back and stating 'I am not gonna let you go, I'm going to twist your arm off.' Staff intervened and separated them. There were no injuries or further incidents." According to the nursing progress notes, the incident occurred at about 7:30 P.M.

The facility submitted a follow-up report on 11/30/18. An excerpt read, "(Resident #43) was observed by a dietary staff member who was leaving the kitchen, holding [Resident #93] with her hands behind her back and yelling 'I am not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 48	F 600		

gonna let you go, I am going to twist your arm off." The dietary staff member alerted nursing staff and the two were separated." Both residents were assessed for injuries. There were no injuries noted. Their physician's and Responsible Party's were notified. Resident #43 was seen by the facility's Psychiatric Nurse Practitioner for aggression, and Resident #93 was seen for emotional support by the Psychiatric Nurse Practitioner.

On 9/16/19 a review was conducted of Resident #43's clinical record, revealing a care plan. An excerpt read, "4/12/18. Psychosis with auditory hallucinations and paranoia. Behaviors include, but not limited to: resisting care, physical aggression, verbal abuse, talking to self. Monitor/record occurrence of target behavior symptoms...violence/aggression towards staff/others.

After the incident on 11/28/18, the care plan was updated. An excerpt read: "11/28/18. [Resident #43] is/has potential to demonstrate abusive behaviors towards staff and residents r/t (related to) dementia. Assess and anticipate needs. Assess coping skills and support system, give as many choices as possible." In addition, Resident #43 was placed on 1:1 supervision at that time.

Resident #43's clinical record contained a report by a Licensed Clinical Psychologist. Resident #43 was seen in December 2018, and on 8/23/19. An excerpt read, "(Resident #43's) statements regarding his belief that he needs to use violence to defend himself, his paranoid/unrealistic thought process regarding the motivations and intentions of others, and his history of becoming verbally and physically aggressive with residents and staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 600	Continued From page 49 suggests that [Resident #43] may not be appropriate for this current setting. He needs significant focus on his psychiatric concerns at this time." According to the nursing progress notes, there were multiple preceding incidents earlier in the afternoon on 11/28/18. At approximately 3:30 P.M. Resident #43 was noted to use profane language at staff, including making sexual comments. He also threatened other residents when they walked past him in the hallway, attempting to trip them with his walker or hit them with his belt. Attempted redirection was unsuccessful, and Resident #43 refused to take his medications. During the month of November, 2018, Resident #43 had refused to take his medications about 50% of the time. He was care-planned for refusing to take his medications on 4/17/18. After the incident with Resident #43 on 11/28/18, facility staff monitored her. Resident #93 did not exhibit any physical, mood, or behavioral changes. There had been no further incidents with Resident #43, or any other residents. No further information was received.	F 600		
F 607 SS=E	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 607	Continued From page 50 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to implement their abuse policy for 1 resident (Resident #38) in a survey sample of 42 Residents. The findings included: 1. For Resident #38, the facility staff failed to implement their abuse policy by not notifying the state agency timely after a serious injury, and failing to file an accurate 5 day follow up report to the state agency of the results of their internal investigation. Resident #38 was most recently admitted to the facility on 11-30-17. Diagnoses included: hypertension, anemia, contractures of the right and left knees, dementia without behavioral disturbances, quadriplegia, peripheral vascular disease, gastrostomy tube for feeding, and high cholesterol. The closest Minimum Data Set (MDS) assessment to the time period associated with the event that injured Resident #38, was a significant change assessment with an assessment reference date (ARD) of 3-18-19. Resident #38 was coded with a Brief Interview of Mental Status score of "0" indicating severe	F 607	F-607 1.) The facility filed a Facility Reportable Incident for Resident #38 on 3/4/2019. 2.) Current residents have the potential to be affected. 3.) Regional Director of Clinical Operations re-educated Administration regarding timely reporting of abuse and abuse policies/procedures. DON re-educated all staff on timely abuse reporting and policies/procedures. 4.) Administrator or designee to audit 100% of incident reports regarding abuse reporting, policies/procedures to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 607	Continued From page 51	F 607		

cognitive impairment and the Resident required extensive assistance of 2 staff for bed mobility, and extensive to complete dependence, on staff for all activities of daily living. The Resident was coded with no aberrant behaviors. This MDS was compared to the previous MDS with an ARD of 12-19-18 which was a quarterly assessment. and the Resident was coded as extensive assistance of 2 staff for bed mobility in that assessment as well. The Resident was not interviewable.

An initial "facility reported incident" (FRI) was received in the Virginia Department of Health, Office of Licensure and Certification (VDH/OLC) on 3-4-19 in regard to Resident #38 having a fractured and lacerated finger requiring emergency room hospitalization on 3-3-19 from an "injury of unknown origin".

Nursing progress notes were reviewed, and revealed the following course of events;

On 3-3-19 at 4:10 p.m. LPN (I) was called to the Resident's room by CNA (T). The LPN found the Resident to have a deep laceration to her left pinky finger which measured approximately 1 inch in length, and it was bleeding, and a pressure dressing was applied, and the Resident was sent out to the hospital emergency room via stretcher at 4:50 p.m.

On 3-4-19 at 12:50 a.m., the Resident returned with diagnoses of "hematoma to right forehead", after a computed tomography (CT) radiology examination , and a bandaged left pinky finger with 8 stitches, also requiring Keflex antibiotic four times a day for 7 days to prevent infection, and a follow up appointment with an orthopedic doctor in 1-2 days.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 607	Continued From page 52	F 607		

On 3-4-19 at 4:18 p.m., the first report (FRI) of the incident, which was identified as an "injury of unknown origin", was sent to the VDH/OLC, Late. The Facility staff were aware of the incident and serious injury 24 hours before this report was sent, and the federal regulation requires a 2 hour report time, after the serious injury is known, when there is a serious injury.

3-3-19 the investigation began before the incident was reported. On 3-3-19, 3-4-19, and 3-5-19, residents were checked for injuries that could not be explained. On 3-3-19, and 3-4-19 witness statements were obtained verbally and in written form. The Residents room mate stated that Resident #38 had fallen from bed and CNA (T) and 2 other staff members had picked her up and taken her out of the room. CNA (T) called for LPN (I), who responded to the room, and LPN (I) then called LPN (J) to assist her. The 2 LPN's arrived in the room to assess the injuries. LPN (J) documented that the laceration to the finger was "down to the bone/tendon, nail still intact." The other CNA's working with CNA (T) that evening denied being present or any knowledge of the incident. CNA (T) could not name any other staff assisting him when the Resident fell from the bed.

On 3-4-19 the "Summary of Alleged Incident" was completed by the DON (Director of Nursing). The timeline in the document describes that on 3-3-19 at 3:00 p.m. the Resident had no injury. At 4:10 p.m., according to statements LPN (I) was called to Resident #38's room by CNA (T) where she found the Resident with the injury. At 4:50 the Resident was sent to the hospital by stretcher. On 3-4-19 at 12:45 a.m., the Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 607	Continued From page 53	F 607		

returned by ambulance with a negative head CT for injury, and 8 sutures to the fractured and lacerated finger which was bandaged now. The summary "Conclusion," documented that the injuries were the result of a fall for Resident #38, and the employee (CNA (T) was terminated. It was determined that CNA (T) was in the room providing care for Resident #38 alone when the resident was turned by the CNA toward the window and the Resident fell out of the bed. After the Resident was injured other staff were called into the room by CNA (T) to pick up the Resident and send her out to the hospital for treatment of a serious injury.

However, on 3-7-19 the facility sent a follow up report of the investigation, which included their conclusions. The document stated "The cause of the injury is unable to be substantiated.", and it is still being classified by them as an injury of unknown origin. Even though CNA (T)'s employment was terminated.

Abuse, neglect policies were requested and received. They revealed that the facility policy described neglect as, "failure to provide timely and consistent services, treatment or care to a resident .....to obtain or maintain a resident's health, safety to comfort: or a failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish.....". The document goes on to say; "Examples of neglect include but are not limited to: Failure to take precautionary measures to protect the health and safety of the Resident." Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials"....."(within 2 hours for serious injury or within 24 hours if no serious injury)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 607	Continued From page 54 On 9-17-19 at 5:00 p.m., the facility Administrator and Director of nursing were made aware of findings, at the end of day meeting. The facility stated they had no further information to provide.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:	F 609		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 609	Continued From page 55 Based on observation, staff interview, resident interview, clinical record review, facility documentation review, and in the course of a complaint investigation the facility staff failed to report allegations of abuse, and neglect, to the state agency timely for one resident (Residents #38) of 42 residents in the survey sample. The findings included: 1. For Resident #38, the facility staff failed to notify the state agency timely. Resident #38 was most recently admitted to the facility on 11-30-17. Diagnoses included: hypertension, anemia, contractures of the right and left knees, dementia without behavioral disturbances, quadriplegia, peripheral vascular disease, gastrostomy tube for feeding, and high cholesterol. The closest Minimum Data Set (MDS) assessment to the time period associated with the event that injured Resident #38, was a significant change assessment with an assessment reference date (ARD) of 3-18-19. Resident #38 was coded with a Brief Interview of Mental Status score of "0" indicating severe cognitive impairment and the Resident required extensive assistance of 2 staff for bed mobility, and extensive to complete dependence, on staff for all activities of daily living. The Resident was coded with no aberrant behaviors. This MDS was compared to the previous MDS with an ARD of 12-19-18 which was a quarterly assessment. and the Resident was coded as extensive assistance of 2 staff for bed mobility in that assessment as well. The Resident was not interviewable.	F 609	F-609 1.) The facility filed a Facility Reportable Incident for Resident #38 on 3/4/2019. 2.) Current residents have the potential to be affected. 3.) Regional Director of Clinical Operations re-educated Administration regarding timely reporting of abuse and abuse policies/procedures. DON re-educated all staff on timely abuse reporting and policies/procedures. 4.) Administrator and/or designee to audit 100% of incident reports regarding abuse reporting, policies/procedures to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 609	Continued From page 56	F 609		

An initial "facility reported incident" (FRI) was received in the Virginia Department of Health, Office of Licensure and Certification (VDH/OLC) on 3-4-19 in regard to Resident #38 having a fractured and lacerated finger requiring emergency room hospitalization on 3-3-19 from an "injury of unknown origin".

Nursing progress notes were reviewed, and revealed the following course of events;

On 3-3-19 at 4:10 p.m. LPN (I) was called to the Resident's room by CNA (T). The LPN found the Resident to have a deep laceration to her left pinky finger which measured approximately 1 inch in length, and it was bleeding, and a pressure dressing was applied, and the Resident was sent out to the hospital emergency room via stretcher at 4:50 p.m.

On 3-4-19 at 12:50 a.m., the Resident returned with diagnoses of "hematoma to right forehead", after a computed tomography (CT) radiology examination , and a bandaged left pinky finger with 8 stitches, also requiring Keflex antibiotic four times a day for 7 days to prevent infection, and a follow up appointment with an orthopedic doctor in 1-2 days. Neurological checks were begun in the facility due to the head injury.

On 3-4-19 at 11:15 a.m., the nurse practitioner wrote a progress note after evaluating the Resident which stated "Left pinky open fracture with stitches, on Keflex".

The Investigation file for this incident was reviewed and revealed the following:

3-3-19 Resident #38 experienced a fall with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 609	Continued From page 57 contusion to the brain and an open fracture of the finger requiring hospitalization for CT of the head and sutures and splint to the severely fractured finger. 3-4-19 at 4:18 p.m., the first report (FRI) of the incident, which was identified as an "injury of unknown origin", was sent to the VDH/OLC, Late. The Facility staff were aware on 3-4-19 at 12:50 a.m., of the fracture. Abuse, neglect policies were requested and received. They revealed that the facility policy described neglect as, "failure to provide timely and consistent services, treatment or care to a resident .....to obtain or maintain a resident's health, safety to comfort: or a failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish.....". The document goes on to say; "Examples of neglect include but are not limited to: Failure to take precautionary measures to protect the health and safety of the Resident." Accurate and timely reporting of incidents, both alleged and substantiated, will be sent to officials"....."(within 2 hours for serious injury or within 24 hours if no serious injury)." On 9-17-19 at 5:00 p.m., the facility Administrator and Director of nursing were made aware of findings, at the end of day meeting. The facility stated they had no further information to provide.	F 609		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 637		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 637	Continued From page 58 resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, and facility document review, the facility staff failed to complete a significant change MDS (minimum data set) assessment (SCSA) within 14 days of a significant change for one Resident (Resident #37) in a survey sample of the 42 Residents. The findings included; For Resident #37, the facility staff failed to complete a SCSA after significant weight loss, with pressure sore formation occurring from 7-3-19 to 9-2-19. Resident #37 was admitted to the facility on 4-15-19. Diagnoses included: hypertension, anemia, arthritis, chronic kidney disease moderate, high cholesterol, heart disease, seizures, and a history of dysphagia. The most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 9-9-19. This assessment had a seven day "look back" period to obtain data about the Resident's current	F 637	F-637 1.) Resident #37 discharged from the facility. 2.) To identify residents with potential to be affected, Resident Assessment Coordinator and/or designee to audit current residents with newly identified significant weight loss or newly identified wounds within the last thirty days. 3.) Regional Resident Care Coordinator educated MDS staff on RAI manual related to requirements related to significant change in resident condition. 4.) Regional Resident Care Coordinator and/or designee will audit all residents identified with significant weight loss and/or newly identified wounds to determine if these changes meet the criteria for significant change assessments per the RAI guidelines weekly x 3 weeks then monthly x 3 months and presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 637	Continued From page 59	F 637		

clinical condition from 9-3-19 to 9-9-19. At this time the Resident's significant weight loss and pressure sore were known to staff, and should have triggered a significant change assessment.

Resident #37 was coded with a Brief Interview of Mental Status score of 11 indicating mild to no cognitive impairment and the Resident required extensive assistance, to complete dependence, on staff for all activities of daily living. This included extensive assistance of 1 staff member's physical assistance to eat. The Resident was coded with no aberrant behaviors, and no refusals of care or assistance from staff. This MDS was compared to the previous MDS with an ARD of 7-12-19 which was a 90 day assessment, and the comparison is as below:

MDS 7-12-19 - BIMS = 11, at risk for wounds, no current wounds, no preventative measures for wounds, no weight loss, mechanically altered diet, Bed mobility extensive assistance needed, eating extensive assistance needed.

MDS 9-9-19 - BIMS =11, at risk for wounds, one current "vascular" (incorrect identification) wound, pressure reduction devices for chair and bed, for wounds, ointments and dressings for the wound, nutrition management, significant weight loss, mechanically altered diet, Bed mobility extensive assistance needed, eating extensive assistance needed.

On 4-15-19, Resident #37 was admitted on a "Regular diet with low potassium, regular texture, thin liquids." On 6-25-19 the Resident's diet was changed to "Dysphagia ground texture, thin consistency low potassium diet". On 9-11-19 the Resident's diet was again changed to "Regular

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 637	Continued From page 60 diet puree texture, nectar consistency, for dysphagia." The Resident's diet card was requested from the kitchen and stated the pureed diet with nectar thickened liquids was being served. No mention of the supplement (2 cal supplement 240 ml (milliliters) three times per day, was on the tray card. The Resident's weight record was requested and revealed 7-3-19 - 119.0 7-24-19 - 117.0 7-31-19 - 117.0 8-26-19 - 108.0 9-1-19 - 103.0 9-9-19 - 101.8 The residents record revealed: 9-2-19 - Resident found to have a pressure ulcer to his right lateral ankle directly over the bone, and it was first identified with eschar (Black,dead, necrotic, hard tissue) covering the entire cap over the ankle bone. - weight 103.0. On 9-17-19 at 5:00 p.m., the facility Administrator and Director of nursing were made aware of findings at the end of day meeting. The facility stated they had no further information to provide.	F 637		
F 641 SS=D	COMPLAINT DEFICIENCY Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 641	Continued From page 61 Based on staff interview, facility documentation review and clinical record review the facility staff failed to accurately code an MDS (minimum data set) assessment for two Residents (Resident #109, Resident #30) in a survey sample of 42 Residents. The findings included: 1. For Resident #109 the facility staff failed to assess the Resident's cognitive functioning. Resident #109 was admitted to the facility on 6/21/19 with a readmission date of 7/1/19. Resident #109's diagnoses included but were not limited to: Hypertension, diabetes mellitus with unspecified complications, end stage renal disease and altered mental status. Resident #109's most recent MDS assessment with an ARD (assessment reference date) of 6/25/19 was coded as an admission assessment. Resident #109 had not been assessed for cognitive skills and daily decision making on this assessment. The Resident was coded as being totally dependent upon staff for transfers, toilet use, personal hygiene and bathing. Review of Resident #109's MDS with an ARD of 6/25/19 revealed that in section C, items C0100-C0500, the Resident interview had not been conducted and a dash (-) had been entered. Review of section C, questions C0600-C1000, also had a dash (-) entered. Questions C0600-C1000 are in regards to a staff assessment for mental status. Review of Resident #109's same MDS, also revealed that the Resident was coded as able to	F 641	F-641 1.) Resident #109 and #30 cognitive patterns to be evaluated and if changes identified then care plan revision(s) to follow. 2.) MDS Coordinator/designee to review current resident□s most recent assessments. If any resident assessments identified with dashes in Section C, resident□s cognitive pattern will be evaluated. 3.) Regional Resident Care Coordinator re-educated MDS staff on the timely completion of interviews in Section C per the RAI manual. 4.) Resident Assessment Coordinator and/or designee to audit Section C of ten MDS assessments x 3 weeks then ten MDS Section C assessments monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility'□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 641	Continued From page 62	F 641		

make himself understood without any impairments, and was able to understand others adequately as indicated on page 6, in response to the questions in section B.

2. For Resident #30 the facility staff failed to assess the Resident's cognitive functioning.

Resident #30's most recent re-admission to the facility was on 2/12/19. The Resident's diagnoses included but were not limited to: end stage renal disease and hyperlipidemia.

Resident #30's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 7/17/19 was coded as a quarterly assessment. Resident #30 was not assessed for cognitive functioning on this assessment. Resident #30 was coded as being independent with dressing, eating and bathing. He was also coded as having had required supervision of one staff person for transfers, toileting and personal hygiene.

Review of Resident #30's MDS with an ARD of 7/17/19 revealed that in section C, items C0100-C0500, the Resident interview had not been conducted and a dash (-) had been entered. Review of section C, questions C0600-C1000, also had a dash (-) entered. Questions C0600-C1000 are in regards to a staff assessment for mental status.

Review of Resident #30's same MDS, also revealed that the Resident was coded as able to make himself understood without any impairments, and was able to understand others

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 641	Continued From page 63	F 641		

adequately as indicated on page 6, in response to the questions in section B.

On 9/17/19 at 11:55 AM an interview was conducted with Employee H, the RN MDS Coordinator. The RN MDS Coordinator was asked who completes sections B and C of the MDS, she stated "here at this facility we do, the MDS do it." She was asked what a dash (-) means, Employee H stated, "not completed". She was asked to review the MDS of another Resident with the same coding as Resident #30 and stated, "they didn't do it correctly, someone missed doing the interview".

On 9/17/19 at 11:55 AM during an interview, Employee H, the RN MDS Coordinator was requested to provide the facility policy regarding MDS completion. Employee H stated, "we use the RAI Manual".

On 9/17/19 at approximately 12:15 PM, Employee H returned to the conference room and stated "we do use the RAI manual but also have this policy" and provided the policy titled "MDS Responsibilities".

Review of the facility policy titled "MDS Responsibilities" read on pages 2 and 4: "the interdisciplinary [IDT] assessment shall be completed for all resident [sic] utilizing the Resident Assessment Instrument (RAI)- Minimum data set 3.0 (MDS) based upon oral or written communication, resident, family interview and assessments provided by the IDT team members. Each individual who completes a portion of the assessment (RAI) must certify the accuracy of that portion by signing and dating in the appropriate location".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 641	Continued From page 64 Review of CMS's RAI Version 3.0 Manual CH 3: Overview of Guide to MDS Items page 3-4 read, "Almost all MDS 3.0 items allow a dash (-) value to be entered and submitted to the MDS QIES ASAP system. - A dash value indicates that an item was not assessed. This most often occurs when a resident is discharged before the item could be assessed." CMS's RAI Version 3.0 Manual CH 3: Overview of Guide to MDS Items page C2 read, "Coding Tips: Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD) and is not contingent upon item B0700, Makes Self Understood. the resident interview was not conducted within the look-back period (preferably the day before or the day of) the ARD, item C0100 must be coded 1, Yes, and the standard "no information" code (a dash "-") entered in the resident interview items. Do not complete the Staff Assessment for Mental Status items (C0700-C1000) if the resident interview should have been conducted, but was not done." No further information was provided.	F 641		
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	F 656		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 656	Continued From page 65 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 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 observations, resident interviews, staff interviews, clinical record reviews, and facility documentation review, the facility staff failed to implement the comprehensive care plan for one resident (Resident #78) in a sample size of 42	F 656	F-656 1.) Upon notification from surveyor the PICC dressing care plan was implemented for Resident #78. 2.) All residents requiring PICC dressing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 656	Continued From page 66 residents. The findings include: 1. For Resident #78, the facility staff failed to implement her care plan for dressing changes to her peripherally inserted central catheter (PICC) for intravenous access (IV). Resident #78, a 50 year old female, was admitted to the facility on 8/27/2019 for IV (intravenous) antibiotic treatment and wound care following recent abdominal surgery. Her diagnoses included, but are not limited to sepsis. On 9/15/2019 at approximately 1:10 PM, Resident #78 was interviewed and stated that she was getting IV (intravenous) antibiotics and wound care for a couple of weeks and she would be returning home. A double lumen PICC line (peripherally inserted central catheter/line with two access ports) covered with a semipermeable dressing at the insertion site dated 9/3/19 was observed to her right upper arm. Resident #78 stated that the dressing had only been changed once since her admission date of 8/27/2019. On 9/15/2019 at approximately 4:30 PM, a second observation revealed that the PICC dressing had been changed and had been dated 9/15/19. Resident #78 confirmed that her nurse, RN A, had just performed a dressing change shortly after our initial interview. A staff interview was conducted with RN A at approximately 4:40 PM. RN A confirmed that she had changed the PICC dressing and stated, "I looked at the date on the dressing and noticed it had not been changed since the third [9/3/19], so I went ahead and did it, it should have been done on the	F 656	changes reviewed to identify those that have the potential to be affected. 3.) Director of Nursing re-educated all nursing staff following resident□s care plan. 4.) Director of Nursing and/or designee to audit care plan implementation for all residents with PICC line dressing changes to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 656	Continued From page 67 10th....if it is not changed as ordered, she can get an infection directly into her bloodstream, she could get septic and die--I've seen it happen before to a person with a PICC line". On 9/16/2019, Resident #78's care plan was reviewed. An excerpt from the care plan read, "Potential for infection related to catheter direct access to blood, PICC IV, date initiated 8/30/2019" and "Interventions/Tasks: Change sterile transparent dressing 24 hours after insertion and then at least every week and PRN [as needed] contamination, date initiated 8/30/2019".	F 656		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident	F 661		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 661	Continued From page 68 representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, the facility staff failed to ensure a discharge summary was written after discharge on 6/30/2018 for one resident (Resident #108) in a survey sample of 42 residents. The findings include: Resident #108 was a 55 year old male admitted to the facility on 3/20/2018, with diagnoses of but not limited to: Gastrostomy, contracture, history of traumatic brain injury, tracheostomy, pressure ulcer of sacral region, flaccid hemiplegia, Diabetes, Pneumonia and Hypertension. The most recent Minimum Data Set (MDS) Assessment was a Quarterly assessment with an Assessment Reference Date (ARD) of 6/15/2018. Under Section B 0100, the MDS coded Resident # 108 with being Comatose with Persistent vegetative state. The assessment also coded Resident # 108 as requiring total assistance of two staff persons with activities of daily living; and frequently incontinent of bowel and always incontinent of bladder. Review of the electronic clinical record and paper clinical record was conducted on 9/15/2019 and 9/16/2019.	F 661	F-661 1.) Facility was unable to correct deficiency. Residents who are discharged from facility in the last thirty days have been reviewed to ensure discharge summary was completed. 2.) All residents who discharge from the facility have the potential to be affected. 3.) Regional Director of Clinical Operations will educate Medical Records and physician services on discharge summary process and compliance. 4.) Medical Records Director and/or designee to audit discharge summary completion on all discharged residents to ensure compliance weekly x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 661	Continued From page 69 Review of the clinical record revealed no discharge summary for the discharge on 6/30/2018. There were discharge summaries for three other dates when Resident # 108 had been discharged to hospitals and subsequently readmitted to the facility. On 9/16/2019 at 11 AM, an interview was conducted with the Assistant Director of Nursing who stated she would look in the clinical record again to be sure but she did not see a discharge summary for the date of 6/30/18. On 9/16/2019 at 4 PM, the Assistant Director of Nursing stated she did not find a discharge summary for the discharge on 6/30/18. 09/17/19 01:07 PM, the physician arrived onsite and came into the conference room with all of the surveyors. The physician stated that a discharge summary was not completed for Resident # 108 after he left AMA (against medical advice) on 6/30/2018. During the end of day debriefing, the Administrator and Director of Nursing were informed of the findings of no discharge summary after the discharge on 6/30/2018. No further information was provided.	F 661		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident-	F 685		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 685	Continued From page 70 §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility record review and clinical record review, the facility staff failed to ensure a resident received assistive devices for vision for one Resident (Resident #54) in a survey sample of 42 Residents. The findings included: Resident #54 was admitted to the facility on 1/10/19. Diagnoses for Resident #54 included, but were not limited to: complete traumatic amputation at level between knee and ankle, right lower leg, peripheral vascular disease, and type 2 diabetes. Resident #54's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 7/16/19 was coded as a quarterly assessment. Resident #54 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. Resident #54 was coded as having required extensive assistance of 2 staff persons for transfers, dressing, personal hygiene and toileting. During an interview with Resident #54 on 9/15/19, it was observed that his eye glasses were broken	F 685	F-685 1.) Resident #54 was re-scheduled for follow-up vision consult and map adjustment re-sent to Petersburg DSS. Facility initiated purchasing process for Resident #54□s prescription eyeglasses. 2.) All residents with assistive devices for vision have the potential to be affected. 3.) Executive Director educated the Social Services Director on timely referral/follow-up regarding assistive devices for vision. 4.) Executive Director and/or designee to audit all referrals to ensure timeliness of follow-up related to assistive devices for vision to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 685	Continued From page 71	F 685		

and the stem on the right side was completely absent. Resident #54 reported that his glasses had been broken since February 2019. Resident #54 further reported, that he had seen an eye doctor, received a new prescription for glasses but had yet to receive the glasses. Resident #54 reported that it is difficult to try to keep the glasses on with the stem missing.

A review of Resident #54's clinical record revealed that on 2/12/19 an entry was made in the Social Services notes that indicated the Resident signed the consent form for vision services with the vision care provider of the facility. A signed consent form revealed Resident #54 signed the form on 2/13/19 and facility staff signed the same form on 2/18/19.

Resident #54's careplan revealed an entry dated 7/2/19 that read, "[Resident #54's name redacted] is resistive to care and often refuses to comply with treatment/care plan. On several occasions he has refused to remove broken eyeglasses after being encouraged by staff to do so after being made aware eyeglasses were causing indentations across the bridge of his nose". Resident #54 was interviewed regarding this entry, Resident #54 reports he can not see without his glasses, he can't watch TV, read, or anything without the use of his glasses and therefore did refuse to remove them. Resident #54 reported the facility staff provided him a pair of reading glasses but he has an astigmatism and they didn't work.

Resident #54's clinical record revealed a prescription for eye glasses dated 5/17/19. Nursing notes revealed an entry on 6/30/19 that read, "Resident noted with his old glasses on that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 685	Continued From page 72	F 685		

caused open wounds on both sides of the bridge of his nose. Resident stated that someone had brought him another pair and he didn't want to wear them, he rather keep his old ones on. When resident took glasses off he had deep indentation on both sides of the bridge of his nose". An entry dated 7/1/19 read, "deep indentation remain [sic] on both sides of the bridge of his nose. Resident continues to refuse to remove broken glasses".

On 9/17/19 at 9:11 AM, an interview was conducted with RN D, the unit manager. The unit manager stated she was unaware that Resident #54's eye glasses were broken. The unit manager stated she thinks he was seen by the eye doctor, she reviewed the progress notes of Resident #54 and stated, "on 7/2/19 I called [name of optometry company redacted] to follow-up on his eye glasses. Then on 7/5/19 I spoke with them and they sent an invoice. I think it is waiting on the business office".

On 9/17/19 at 9:17 AM an interview was conducted with Employee N, the business office manager (BOM). The BOM stated, she had sent the information to the department of social services for an adjustment of Resident #54's patient liability to pay for the glasses. The BOM provided the surveyor copies of what she had submitted. This revealed that despite the Resident being seen 5/17/19 information for payment was not submitted until 7/10/19 and was sent again on 9/16/19.

On 9/17/19 at 9:40 AM, the facility administrator accompanied the surveyor to the room of Resident #54. The Administrator observed the glasses of Resident #54 being broken. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 685	Continued From page 73	F 685		

#54 reported to the facility Administrator that they had been broken since February 2019. The facility Administrator stated, "I think this is something we need to follow-up on and see why there has been a fairly significant lapse. I will be glad to follow-up on it".

The facility Administrator was shown the information, which included:
* Resident #54 authorizing vision services 2/12/19 per social services notes.
* Resident seeing eye doctor 5/17/19 per the prescription
* Information for payment not being submitted to the department of social services for payment until 7/10/19

The facility Administrator was asked why such a delay in services for Resident #54 to receive replacement glasses when his glasses are broken and as of this survey, 9/17/19 the Resident is still wearing broken glasses, without any resolution. The facility Administrator stated, "I don't understand the delay, I agree with you". .

Review of the facility policy titled "Care of visually impaired" read, "it is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of residents". Page 2 of this policy stated, in section I.a.i.: "eyewear is kept clean". Section I.c.i. read, "consider ophthalmology and medical consults".

The Mayo Clinic defines astigmatism as: "Astigmatism (uh-STIG-muh-tiz-um) is a common and generally treatable imperfection in the curvature of your eye that causes blurred distance and near vision. Astigmatism occurs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 685	Continued From page 74 when either the front surface of your eye (cornea) or the lens, inside your eye, has mismatched curves. Instead of having one curve like a round ball, the surface is egg shaped. This causes blurred vision at all distances." accessed online at: https://www.mayoclinic.org/diseases-conditions/astigmatism/symptoms-causes/syc-20353835 The Mayo Clinic goes on to stated, "The goal of treating astigmatism is to improve vision clarity and eye comfort. Treatments are corrective lenses". accessed online at: https://www.mayoclinic.org/diseases-conditions/astigmatism/diagnosis-treatment/drc-20353838 The facility Administrator and Director of Nursing were made ware of the facility staff's failure to ensure a resident received assistive devices for vision during the end of day meeting on 09/17/19 at 05:31 PM. No further information was provided.	F 685		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(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 with professional standards of practice, to	F 686		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 686	Continued From page 75 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, clinical record review, and facility document review, and in the course of a complaint investigation, the facility staff failed to provide treatment and services to prevent and heal pressure sores for one Resident (Residents #37) in a survey sample of 42 Residents, resulting in harm for Resident #37. The findings included; 1. For Resident #37, the facility staff failed to provide adequate nutrition, and preventive devices, and care, for a Resident at risk of developing pressure sores, leading to the development of a pressure sore first identified as an unstageable ulcer with eschar, resulting in harm. Resident #37 was admitted to the facility on 4-15-19. Diagnoses included: hypertension, anemia, arthritis, chronic kidney disease moderate, high cholesterol, heart disease, seizures, and a history of dysphagia. The most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 9-9-19. Resident #37 was coded with a Brief Interview of Mental Status score of 11 indicating mild to no cognitive impairment and the Resident required extensive assistance, to complete dependence, on staff for all activities of daily living. This included extensive assistance of 1 staff member's physical assistance to eat. The Resident was	F 686	F-686 1.) Resident #37 has discharged from the facility. 2.) Current resident□s Braden score reviewed to identify residents at risk of developing pressure sores that have the potential to be affected. 3.) Director of Nursing re-educated all nursing staff on pressure ulcer prevention and treatment. 4.) Director of Nursing and/or designee to audit 5 weekly skin grids, 5 shift rounds, 5 turning/re-positioning, 5 incontinent care and 5 supportive surfaces to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 686	Continued From page 76	F 686		

coded with no aberrant behaviors, and no refusals of care or assistance from staff. This MDS was compared to the previous MDS with an ARD of 7-12-19 which was a 90 day assessment, and the comparison is as below:

MDS 7-12-19 - BIMS = 11, at risk for wounds, no current wounds, no preventative measures for wounds, no weight loss, mechanically altered diet, Bed mobility extensive assistance needed, eating extensive assistance needed.

MDS 9-9-19 - BIMS =11, at risk for wounds, one current "vascular" (incorrect identification) wound, pressure reduction devices for chair and bed, for wounds, ointments and dressings for the wound, nutrition management, significant weight loss, mechanically altered diet, Bed mobility extensive assistance needed, eating extensive assistance needed.

On 4-15-19, Resident #37 was admitted on a "Regular diet with low potassium, regular texture, thin liquids." On 6-25-19 the Resident's diet was changed to "Dysphagia ground texture, thin consistency low potassium diet". On 9-11-19 the Resident's diet was again changed to "Regular diet puree texture, nectar consistency, for dysphagia." .

A review of the physician's orders, was conducted from the time of admission to the time of survey. They revealed the following timeline of interventions;

5-2-19 - 2 Cal supplement 120 ml (milliliters) drink twice per day at 8:00 a.m., and 5:00 p.m. - weight 115.2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 686	Continued From page 77	F 686		

8-27-19 - RD progress note revealed "Weight not stable, Spoke with Resident who says that he doesn't like the ordered texture of his food. He reports that he feels like he's lost weight and does feel hungry throughout the day and at bedtime. He is agreeable to drinking 2 cal and trying snacks between meals and at bedtime...." Orders are then initiated and follow below.

8-29-19 - 2 Cal supplement increased to 240 ml (milliliters) drink twice per day at 8:00 a.m., and 5:00 p.m., magic cup twice per day with lunch and supper, yogurt and apple sauce between meals and at bedtime, were all started - weight 108.0.

9-2-19 - Resident found to have a pressure ulcer to his right lateral ankle directly over the bone, and it was first identified with eschar (Black,dead, necrotic, hard tissue) covering the entire cap over the ankle bone. - weight 103.0.

9-11-19 - Diet changed to pureed with nectar thickened liquids, increase to 2 cal supplement to 3 times per day, and med pass liquid supplement was added for 60 ml three times per day.

The Resident's diet card was requested from the kitchen and stated the pureed diet with nectar thickened liquids was being served. No mention of the supplement (2 cal supplement 240 ml (milliliters) three times per day, was on the tray card

On 9-17-19 at 12:32 p.m., the physician was called on the telephone and asked for an interview. He stated he would come to the facility and look at the chart and let surveyors know about Resident #37. The physician arrived and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 686	Continued From page 78	F 686		

stated he had looked at the chart, and said "the Resident is severely malnourished and doesn't like the texture of the diet."

The doctor was then asked why the wound on the Resident's ankle was being called a "Vascular ulcer", and he stated "it's a pressure sore, and most likely the result of the patient's severe malnutrition."

The comprehensive care plan was reviewed in it's entirety and revealed the following interventions for the pressure sore.

(Pressure sore) FOCUS: (name) Resident #37's pressure ulcer was documented on the care plan on 9-2-19 when the ulcer was identified as a "pressure ulcer to right outer heel related to decreased mobility and altered nutrition". On 9-4-19 it was changed to "vascular ulcer to the right outer heel". On 9-12-19 it was changed again to "vascular ulcer right outer ankle".
GOAL: Wound will be free from infection through review date.
INTERVENTIONS: (all created and initiated on 9-2-19 at identification) Air mattress. Heel lift boots as tolerated. Resident/family education as needed. (initiated 9-12-19) Supplements as ordered for wound healing (10 days after identification).

No interventions for wound development prevention were present prior to the development of an unstageable pressure ulcer found with eschar upon identification..

A wound Observation was conducted on 9-17-19 at 9:30 a.m. with LPN H. The Resident was alert and oriented to person, place, time, and situation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 686	Continued From page 79	F 686		

Both legs and the right ankle were exposed, as the Resident was laying partially on his left side, revealing cool, smooth leg skin, with no lesions, scars, scratches, scales nor brawny appearance. There was hair on both legs, no edema, or erythema in either extremity, and the Resident had palpable popliteal (behind the knee), dorsalis pedis (top of foot), and tibial (behind the ankle bone) pulses. The Resident had a brisk capillary refill when the toe nails were depressed, and at less that 1 second blood return. The Resident had no wounds on his heels or shins, and exhibited only 1 wound which was directly on top of the right lateral ankle bone (lateral malleolus). The depth of the pressure ulcer could not be ascertained as the wound was covered by black dead thick necrotic tissue with only the outer circumference beefy red, as the de-vitalized tissue was shrinking leaving an open thin boarder around the circular necrotic wound. There was no slough visible, and no drainage, nor odor to indicate infection. The wound was clean and had a minuscule amount of serosanguineous clear drainage making the edges around the wound shiny. The wound was approximately the size of a 1/2 dollar coin.

A "Skin Grid Pressure" initial assessment document was completed by RN E on 9-2-19 at initial identification of the wound. The document was reviewed and revealed that the wound was a "new pressure area, house acquired, risk factors impaired mobility and altered nutrition, unstageable pressure wound, right outer ankle, measured 2.5 cm (centimeters) x 2.2 cm, edges not clearly visible, granulation and eschar present, color red and necrotic, small amount of serous drainage, no odor, peri wound black or hyper-pigmented, no pain, question, "does the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 686	Continued From page 80 Resident have a turning and repositioning program in place?" answer, "no". 5 Physician orders all issued on 9-2-19 after the pressure ulcer was identified, were reviewed and revealed the following: 1. L Elemental Arginine packet for wound healing once per day for 7 days, and was completed at the time of survey. 2. Multivitamin for wound healing one time per day. 3. Pro-stat protein supplement 30 ml one time per day. 4. Zinc Sulfate 220 mg (milligrams) one tablet 1 time per day for wound healing. 5. Cleanse right outer ankle with normal saline, pat dry, apply skin prep to peri-wound, medihoney and calcium (Softens hard dead tissue, and inhibits bacterial growth while absorbing drainage) alginate to wound bed, cover with dry dressing until resolved. Every day shift for wound care. On 9-11-19 a new order was obtained for Santyl collagenase ointment 250 unit/GM (gram) apply to right outer ankle topically every day shift for wound for 14 days. (Enzymatic debriding agent for the removal of dead necrotic tissue), was currently being used during survey. On 9-17-19 at 5:00 p.m., the facility Administrator and Director of nursing were made aware of findings at the end of day meeting. The facility stated they had no further information to provide.	F 686		
F 689	COMPLAINT DEFICIENCY Free of Accident Hazards/Supervision/Devices	F 689		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689 SS=G	Continued From page 81 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 observation, staff interview, resident interview, clinical record review, and facility documentation review facility staff failed to ensure Residents were free from accidents and hazards, for 2 residents (Residents #38, and #31) of 42 residents in the survey sample, resulting in harm for Resident #38. In addition, the facility staff failed to maintain water temperatures in a range to prevent burns, scalding and other injuries on 2 of 2 nursing units. The findings included: 1. For Resident #38, the facility staff failed provide the 2 needed staff members for ADL (Activities of Daily Living) care leading to a fall, fracture, and head injury, resulting in harm. Resident #38 was most recently admitted to the facility on 11-30-17. Diagnoses included: hypertension, anemia, contractures of the right and left knees, dementia without behavioral disturbances, quadriplegia, peripheral vascular disease, gastrostomy tube for feeding, and high cholesterol. The closest Minimum Data Set (MDS)	F 689	F-689 1. Resident #38 has been receiving assistance with care per care plan. Maintenance Director counseled on proper water temperature guidelines. All temperatures were audited and within range. 2. Current resident□s bed mobility reviewed to identify residents coded as two-person assist that have the potential to be affected. 3. DON re-educated all nursing staff on proper ADL care related to residents coded as two-person assist and proper technique via mechanical lift guidelines. DON conducted mechanical lift competencies with licensed nursing staff. ED educated Maintenance Director on proper water temperature guidelines. 4. Director of Nursing and/or designee to audit 5 residents requiring ADL care related to two-person assist to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. ED audited the water temperature to ensure within range 3x a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689	Continued From page 82 assessment to the time period associated with the event that injured Resident #38, was a significant change assessment with an assessment reference date (ARD) of 3-18-19. Resident #38 was coded with a Brief Interview of Mental Status score of "0" indicating severe cognitive impairment and the Resident required extensive assistance of 2 staff for bed mobility, and extensive to complete dependence, on staff for all activities of daily living. The Resident was coded with no aberrant behaviors. This MDS was compared to the previous MDS with an ARD of 12-19-18 which was a quarterly assessment. and the Resident was coded as extensive assistance of 2 staff for bed mobility in that assessment as well. The Resident was not interviewable. An initial "facility reported incident" (FRI) was received in the Virginia Department of Health, Office of Licensure and Certification (VDH/OLC) on 3-4-19 in regard to Resident #38 having a fractured and lacerated finger requiring emergency room hospitalization on 3-3-19. Nursing progress notes were reviewed, and revealed the following course of events; On 3-3-19 at 4:10 p.m. Licensed Practical Nurse (LPN) (I) was called to the Resident's room by Certified Nursing Assistant (CNA) (T). The LPN found the Resident to have a deep laceration to her left pinky finger which measured approximately 1 inch in length, and it was bleeding, and a pressure dressing was applied, and the Resident was sent out to the hospital emergency room via stretcher at 4:50 p.m. On 3-4-19 at 12:50 a.m., the Resident returned with diagnoses of "hematoma to right forehead",	F 689	week x 3 weeks then monthly x 3 months with results presented to QAPI. 5. The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689	Continued From page 83	F 689		

after a computed tomography (CT) radiology examination , and a bandaged left pinky finger with 8 stitches, also requiring Keflex antibiotic four times a day for 7 days to prevent infection, and a follow up appointment with an orthopedic doctor in 1-2 days. Neurological checks were begun in the facility due to the head injury.

Hospital records, and orthopedic follow up documents were reviewed and indicated that the Resident had experienced a "head contusion injury (bruised brain) bleeding in the brain which can cause swelling" from a fall which also produced an "open fracture (bone visible) of the distal phalanx of the little finger."

The Resident's care plan was reviewed and revealed a focus for "fracture of left pinky finger related to a fall" on "3-3-19".

The director of nursing was requested to bring all investigation records for March 2019 involving Resident #38. The investigation information was provided, and revealed the following:

3-3-19 Resident #38 experienced a fall with contusion to the brain and an open fracture of the finger requiring hospitalization for CT of the head and sutures and splint to the severely fractured finger.

On 3-3-19, and 3-4-19 witness statements were obtained verbally and in written form. The Residents room mate stated that Resident #38 had fallen from bed and CNA (T) and 2 other staff members had picked her up and taken her out of the room. CNA (T) called for LPN (I), who responded to the room, and LPN (I) then called LPN (J) to assist her. The 2 LPN's arrived in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689	Continued From page 84	F 689		

room to assess the injuries. LPN (J) documented that the laceration to the finger was "down to the bone/tendon, nail still intact." The other CNA's working with CNA (T) that evening denied being present or any knowledge of the incident. CNA (T) could not name any other staff assisting him when the Resident fell from the bed.

On 3-4-19 the "Summary of Alleged Incident" was completed by the DON (Director of Nursing). The timeline in the document describes that on 3-3-19 at 3:00 p.m. the Resident had no injury. At 4:10 p.m., according to statements LPN (I) was called to Resident #38's room by CNA (T) where she found the Resident with the injury. At 4:50 pm the Resident was sent to the hospital by stretcher. On 3-4-19 at 12:45 a.m., the Resident returned by ambulance with a negative head CT for injury, and 8 sutures to the fractured and lacerated finger which was bandaged now. The summary "Conclusion," documented that the injuries were the result of a fall for Resident #38, and the employee (CNA (T) was terminated.

The "Summary of Alleged Incident" report determined that CNA (T) was in the room providing care for Resident #38 alone when the resident was turned by the CNA toward the window and the Resident fell out of the bed. After the Resident was injured other staff were called into the room by CNA (T) to pick up the Resident and send her out to the hospital for treatment of a serious injury.

On 9-16-19 the Employee record for CNA (T) was reviewed and revealed documents that described on 1-28-19 the CNA had been counseled for "abandoning his post" without replacement, and he was terminated on 3-7-19 for "injuring a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689	Continued From page 85	F 689		

Resident".

On 9-17-19 at 5:00 p.m., the facility Administrator and Director of nursing were made aware of findings, at the end of day meeting. The facility stated they had no further information to provide.

2. For Resident #31, the facility staff failed to demonstrate safe use of the mechanical lift while obtaining a weight on 09/16/2019.

Resident #31, a 72-year old male, was admitted to the facility on 02/09/2019. Diagnoses included but not limited to dementia, dysphagia, and diabetes.

Resident #31's most recent Minimum Data Set with an Assessment Reference Date of 07/15/2019 was coded as a quarterly assessment. Functional status for eating was coded as requiring a one-person physical assist and supervision (oversight, encouragement, or cueing) during meals. Functional status for bed mobility was coded as requiring extensive assistance from staff. Transferring between surfaces was coded as requiring limited assistance from staff. Walking in room was coded as requiring supervision (oversight, encouragement, or cueing) from staff. Mobility devices selected were walker and wheelchair.

On 09/16/2019 after 4:52 PM, CNA H, CNA I, and this surveyor entered the room of Resident #31 with the mechanical lift. CNA H and CNA I removed the sling (pad) from the handle bar of the mechanical lift and placed it under Resident #31. CNA H began to raise Resident #31 in the lift. Resident #31's shoulders remained on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689	Continued From page 86	F 689		

bed while his lower torso was being elevated in the sling. This surveyor told CNA H to stop and lower Resident #31 to the bed. CNA H did so and then CNA H and CNA I readjusted the sling under Resident #31, attempting to raise it up further under his back toward the shoulders. CNA H began to raise Resident #31 in the sling and as the sling elevated just above the bed, Resident #31's eyes darted around and he turned his head to the right and reached his right arm out to grab the side rail of the bed. This surveyor told the CNA's to stop and lower Resident #31 to the bed. After completing care for Resident #31 and exiting the room, CNA H stated residents don't have their own pad. CNA I stated she didn't think the pad didn't fit correctly for [Resident #31] but it was the only one she could find. CNA H stated that "We don't normally do weights, restorative does it."

On 09/17/2019 at 10:44 AM, the DON was notified that this surveyor had to prompt [CNA H and CNA I] to stop when Resident #31 was being raised via mechanical lift for a weight. The DON stated that each resident should have their own pad and that they come in different sizes. The DON also stated that the CNA's should have stopped and readjusted before continuing. When asked why, the DON stated we "Don't want him to fall out of the lift."

The facility staff provided their policy entitled, "Mechanical Lifts and Transfer." The last sentence under the header entitled, "Policy" documented, "Follow manufacturer's recommendations for specific mechanical lift equipment."

The facility staff provided the manufacturer's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689	Continued From page 87	F 689		

instructions for the mechanical lift. Under the header entitled, "Slings" it was documented, "All slings are size-coded with different colored edge binding or attachment strap coloring ...always refer to the label on the sling being used to make sure of its actual safe working load."

On 09/17/2019 at approximately 7:00 PM, the administrator and DON had no further information or documentation to offer.

3. The facility staff failed to maintain water temperatures in a range to prevent burns, scalding and other injuries on 2 of 2 nursing units.

On 9/17/19 at 4:22 PM, surveyor F went to the office of the maintenance director. The maintenance director was asked if he checks water temperatures and the maintenance director stated, he checks temperatures daily. Review of his water temperature logs revealed that temperatures are only checked in the kitchen, laundry, lobby and shower rooms. No Resident rooms are checked.

When the maintenance director was asked how often he calibrates the thermometer he uses to check temperatures, the maintenance director stated, "I haven't ever calibrated it".

When the maintenance director was asked about water temperatures he indicated he likes the temperatures to be "110-115, 110 is safe for Residents and 115 stops any bacteria or growth". The maintenance director was asked what temperature is too hot, he stated, "anything over 125 degrees" when asked the risks, he stated, "you risk scalding, especially for Residents".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689	Continued From page 88	F 689		

On 9/17/19 at approximately 4:30 PM, surveyor F and the Maintenance Director met with the dietary manager, (Employee D). Employee D stated she calibrates the kitchen thermometers daily. Employee D provided surveyor F with one of her calibrated thermometers.

The maintenance director and surveyor F then checked water temperatures using the maintenance thermometer and the kitchen's calibrated thermometer and found the following:
* Resident room 102: 124 degrees Fahrenheit using the kitchen thermometer and 122.2 degrees Fahrenheit using the maintenance thermometer. The maintenance director stated, "it's hot" when asked to touch the water with his hand.
* Resident room 111: 123.6 degrees Fahrenheit using the kitchen thermometer and 121.8 degrees Fahrenheit using the maintenance thermometer. The maintenance director stated, "it's time for me to get a new thermometer". The maintenance director then asked, "does usage effect it? This time of day they are not using a lot of water".
* Station 1 shower room: 125.4 degrees Fahrenheit using the kitchen thermometer and 124 degrees Fahrenheit using the maintenance thermometer. When the maintenance director was asked how long it takes for a Resident to get scalded he stated, "less than a minute".
* Resident room 128: 124.7 degrees Fahrenheit using the kitchen thermometer and 123.5 degrees Fahrenheit using the maintenance thermometer.
* Resident room 223: 125.4 degrees Fahrenheit using the kitchen thermometer and 123.6 degrees Fahrenheit using the maintenance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689	Continued From page 89	F 689		

thermometer.
*Resident room 231: 111 degrees Fahrenheit using the kitchen thermometer and 109 degrees Fahrenheit using the maintenance thermometer.
*Resident room 201: 125.2 degrees Fahrenheit using the kitchen thermometer and 123.8 degrees Fahrenheit using the maintenance thermometer.

On 9/17/19 at approximately 5:00 PM the facility Administrator and Director of Nursing were made aware of the concern regarding water temperatures.

On 9/17/19 at 5:31 PM, during the end of day meeting the facility administrator advised the survey team that the water temperatures had cooled down, they have notified the vendor, had initiated water temperatures and had drained the boiler.

Review of the water temperature logs revealed that the water temperatures in the Resident shower rooms and bath rooms ranged temperatures of 112 degrees to 114 degrees from 7/22/19-9/17/19, with the exception of 9/12/19 all of the temperatures were recorded at 100 degrees.

Review of the facility policy titled "water management plan" revealed only information about maintaining temperatures in excess of 108 degrees to prevent the growth and spread of microorganisms such as Legionella. This policy made no reference to acceptable water temperature ranges for Resident use.

Access to water at 124 degrees, which was noted in 5 of the areas observed, for 3 minutes can

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 689	Continued From page 90 cause 3rd degree burns, according to Moritz, A.R., Henriques F.C. Jr. (1947). Studies of Thermal Injury: 11. The Relative Importance of Time and Surface temperatures in the Causation of Cutaneous Burns. Am J Pathology, 23, 695-720,. No further information was provided.	F 689		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, and facility documentation review, the facility staff failed to ensure the nutrition and hydration status of 3	F 692	F-692 1.) Resident #37 has discharged from the facility. Regarding Resident #60 the facility dining room is open for all meal	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 91 residents, (Residents #37, 28, and 31) in a survey sample of 42 residents, resulting in harm for Resident #37. The findings included; 1. For Resident #37, the facility staff neglected to ensure the resident was free from malnutrition and dehydration, resulting in harm. Resident #37 was admitted to the facility on 4-15-19. Diagnoses included: hypertension, anemia, arthritis, chronic kidney disease moderate, high cholesterol, heart disease, seizures, and a history of dysphagia. The most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 9-9-19. Resident #37 was coded with a Brief Interview of Mental Status score of 11 indicating mild to no cognitive impairment and the Resident required extensive assistance, to complete dependence, on staff for all activities of daily living. This included extensive assistance of 1 staff member's physical assistance to eat. The Resident was coded with no aberrant behaviors, and no refusals of care or assistance from staff. This MDS was compared to the previous MDS with an ARD of 7-12-19 which was a 90 day assessment, and the comparison is as below: MDS 7-12-19 - BIMS = 11, at risk for wounds, no current wounds, no preventative measures for wounds, no weight loss, mechanically altered diet, Bed mobility extensive assistance needed, eating extensive assistance needed. MDS 9-9-19 - BIMS =11, at risk for wounds, one	F 692	periods every day of the week. Resident #31 has been assessed by Registered Dietitian and physician with interventions documented and noted weight gain. 2.) Current resident□s weights reviewed to identify those with significant weight loss and/or dehydration have the potential to be affected. 3.) DON re-educated all licensed nursing staff on ensuring the nutrition and hydration needs of current residents are met via appropriate interventions. DON re-educated all licensed staff on weight policy. DON educated licensed nursing staff regarding timely delivery of meal tray to resident room, proper assistance with feeding and compliance, and documentation of meal consumption accuracy. Regional Dietitian will re-educate Registered Dietitian regarding care plan requirements related to weight loss and hydration. 4.) Director of Nursing, and/or designee to audit nutrition and hydration needs of 5 current residents are met via appropriate interventions. DON and/or designee will audit 5 licensed nursing staff on compliance with weight policy weekly x 3 weeks then monthly x 3 months. Regional Dietitian and/or designee will audit care plan requirements related to weight loss and hydration for 5 residents to ensure compliance weekly x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 92	F 692		

current "vascular" (incorrect identification) wound, pressure reduction devices for chair and bed, for wounds, ointments and dressings for the wound, nutrition management, significant weight loss, mechanically altered diet, Bed mobility extensive assistance needed, eating extensive assistance needed.

On 4-15-19, Resident #37 was admitted on a "Regular diet with low potassium, regular texture, thin liquids." On 6-25-19 the Resident's diet was changed to "Dysphagia ground texture, thin consistency low potassium diet". On 9-11-19 the Resident's diet was again changed to "Regular diet puree texture, nectar consistency, for dysphagia."

On 9-15-19 at 12:00 noon, observations and interviews were conducted with the Resident. After introduction, the Resident was asked if we could help him with anything while we were there, and he complained of hunger, and stated he wanted something to eat. He stated his family brought him things and he enjoyed that food.

The lunch meal tray did not arrive at the bedside until 12:45 p.m., and at 2:30 p.m., no staff had entered the room to assist the Resident to eat. Surveyor A, and this surveyor looked at the tray which was uncovered, and untouched. We went to the nursing station to enquire as to how long it would be for the Resident to be fed. The staff stated they were very understaffed, and were unable to use the dining room, and had to close it as they were unable to staff it, so the "feeders" who would normally be fed there had to be fed in their rooms. They stated that Resident #37 "was a self feeder, and independent."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 93	F 692		

At 2:30 p.m., the Resident was again observed and was sitting in bed falling over onto his left side with a small styrofoam or paper cup containing "magic cup" supplement, which was an ice cream like substance in his hand. The Resident was licking the inside of the cup to obtain the contents, and the surveyor asked him if he was able to hold the spoon that was on his tray, and he stated "not too good, I am so weak now, I just don't have the strength". The Resident picked up the spoon and tried to use it, however, the small amount he was able to get onto the spoon after much effort, fell down onto the bed linens. The rest of the tray was untouched, and no 2 cal supplement was on the tray.

At 2:45 p.m., the HR (human resources) Director entered the Resident room to feed him. The surveyors returned at 3:30pm to find the tray had been left there and the thick pudding consistency portions of food had approximately 2 spoonfuls missing from 2 of the 3 scoops of pureed food. Each of the scoops measured approximately 3 inches by 3 inches circular, and 1/2 inch depth, and had spread out into each other on the plate. The Resident stated "I can't eat that stuff, it's awful like cold wet bread." He went on to say "I told them when I got here that I can't eat that stuff, and I don't have any trouble eating if I like the food, but they don't listen."

On 9-16-19 at 10:00 a.m., another observation was conducted for this Resident by Surveyor C. Surveyor C reported that for the breakfast meal the tray was followed and went into the Resident's room, left uncovered, and removed from the room untouched and returned to the kitchen. On 9-16-19 at 3:00 p.m., the Resident's lunch meal tray was again left untouched, and the Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 94	F 692		

was not fed. No supplement was in the room for either meal.

It is notable to mention that on 9-16-19 the Resident's breakfast tray was followed by Surveyor C from delivery by CNA N, to discard, and it was not disturbed, nor did the Resident attempt to consume it. No staff member attempted to assist with the meal, and the tray was simply removed from the room, untouched, and discarded. CNA O documented 26-50% consumed.

CNA N (certified nursing assistant) was interviewed, and stated "he ate a little of his sherbet cup so I said he ate 25%", however, CNA N did not sign the ADL document, another staff member, CNA O was documented as having fed Resident #37 his breakfast. CNA N was asked if she fed the Resident, and she stated "no he can feed himself." CNA N was asked if she had been trained on how to calculate the amount of a meal that a resident consumes, and she stated "no." CNA O stated that she only removed the tray, and did not feed the Resident.

The ADL (activities of daily living) report was requested and received. The report documented that the Resident was independent with eating for breakfast and lunch every day in September, for 20 of the 32 breakfast and lunch meal opportunities. The 12 meal exceptions where the staff assisted the Resident occurred on the following days;

9-1-19 dependant (fed) for both meals, and consumed nothing for breakfast and 51-75% for lunch.
9-5-19 dependant (fed) for both meals, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 95	F 692		

consumed 51-75% for both meals.
9-7-19 limited assistance (not fed) for both meals, and consumed nothing for both meals.
9-8-19 limited assistance (not fed) for breakfast, and consumed 26-50%.
9-10-19 limited assistance (not fed) for lunch, and consumed nothing.

The behavior portion of the ADL record was also reviewed and revealed at no time did the Resident refuse assistance or care.

The other 20 opportunities for staff support with feeding, and the Resident was not fed, occurred on the following days;

9-2-19 The Resident consumed 51-75% both meals
9-3-19 The Resident consumed 26-50% both meals
9-4-19 The Resident consumed 26-50% both meals
9-6-19 The Resident consumed 26-50% at breakfast, and 76-100% at lunch
9-8-19 The Resident consumed 26-50% at Lunch
9-9-19 The Resident consumed 76-100% both meals
9-10-19 The Resident consumed nothing for breakfast
9-11-19 The Resident consumed nothing for breakfast, and 76-100% at lunch
9-12-19 The Resident consumed nothing both meals
9-13-19 The Resident consumed 26-50% both meals
9-14-19 The Resident consumed 26-50% breakfast, and 75-100% at lunch
9-15-19 The Resident consumed nothing both meals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 96	F 692		

9-16-19 The Resident consumed 26-50% for breakfast, nothing for lunch

During this 16 day period from 9-1-19 through 9-16-19, nine different staff members signed the meal consumption record, only 3 of which delivered the meal to the Resident consistently more than one day in the 16 days.

The Resident's weight record was requested and revealed that from 7-3-19 until the time of survey on 9-16-19, the Resident had lost 23.4 pounds of weight in less than 12 weeks. Those weights follow:

4-15-19 - On admit 122.4 lbs (pounds)
4-23-19 - 119.2
5-1-19 - 115.2 - weight loss of 7 pounds after admission for 2 weeks.
5-22-19 - 120.2 - weight gain of 5 pounds and stabilizes after 3 more weeks.
6-25-19 - diet modified to ground texture begun, and significant weight loss begins.
6-26-19 - 119.0
7-3-19 - 119.0
7-24-19 - 117.0
7-31-19 - 117.0
8-26-19 - 108.0
9-1-19 - 103.0
9-9-19 - 101.8
9-11-19 - diet modified to pureed texture begun after significant weight loss of 17.2 pounds from 7-3-19 to 9-9-19.
9-16-19 - 95.6 - significant weight loss increased in less than 12 weeks to 23.4 pounds, equaling 20% of the Resident's entire body weight, and 26.8 pounds, since admission.

On 9-16-19 at 3:00 p.m., an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 97	F 692		

conducted with the Director of Nursing (DON), and "Unit manager" RN (registered nurse) D, by surveyors in the conference room. They stated we want to have a care plan meeting with him and his family, wife, son or brother, that is our next step with him I am aware he is loosing weight."

They were asked why it had taken 5 months to get a plan going, and they stated "At first his family was bringing in food that he was eating, he doesn't like the pureed texture or the nectar thick liquids." "Therapy had been working with him, and he had a "FEES" study on 9-10-19 that he failed.

They were asked why the physician had not talked with the Resident himself and decide a course of action? They stated "We discussed the doctor talking to him (the Resident), and we didn't have a social worker as Employee O has been gone about a month and a half ago, and he has lost weight since that." The DON stated "I see we need to make a decision and talk to him to see if he wants a peg tube because he doesn't like the pureed texture to maintain his BMI (Body Mass Index)."

The DON and unit manager continued with, "Speech therapy did a swallowing eval, and he didn't do well." They were asked when that occurred as no therapy notes were found in the clinical record. She stated, I don't know, I will get those for you." "The family brings in McDonalds, and that he eats." She was asked if he had ever aspirated or been hospitalized, or treated for aspiration pneumonia, or had any respiratory problems, and they stated "no." They were asked why the Resident was not being fed by staff who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 98	F 692		

thought he was independent, when his MDS showed he needed extensive assistance from staff to eat since the 7-12-19 MDS which included a seven day look back to 7-5-19. They responded "He should be fed."

On 9-16-19 at 3:15 p.m., Employee E, the speech language pathologist (ST/SLP) entered the interview in progress in the conference room with surveyors, and with the unit manager and DON. She stated "he was on ground meat with pureed solids and the Resident didn't like it so the family requested an upgrade so he would eat, and then the FEES study was ordered on 9-10-19." I asked if there was no problem, or outcome with the regular diet that the family brought in that the Resident did eat, why the change. She stated "he needs positioning and encouragement to not aspirate, he is at risk for silent aspiration". She continued "he wasn't really eating the ground texture, or anything off of the pureed tray but pudding, oatmeal, and cream of wheat, and that's why the FEES study was done." "A bedside swallowing evaluation was done by another speech therapist who was full time here. I am not typically treating most of the time. Her last day was weeks ago, I don't remember how many, we have a new one starting today. Between the last one and this one we have had PRN (as needed) staff and I have been helping treat as well." She was asked if she had assessed or treated Resident #37, and she stated "no." The ST notes were again requested.

The "FEES" ("Dysphagia systems test") study was requested at 3:15 p.m., during the interview with Employee E, and received at 4:00 p.m. The study documented no diagnoses linked to dysphagia, and documented that the Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 99	F 692		

took his medications whole. The document describes the "Potential risks" to the Resident, and documents that the Resident is at "Potential risk" for aspiration. Any and all ST notes from Resident #37's time of admission to today were requested again.

On 9-16-19 at 4:00 p.m., the Registered Dietician (RD), and Assistant Director of Nursing (ADON) were interviewed by surveyors in the conference room. The current RD stated there had been "a lot of turnover in the department and there had been one RD from April to may 2019, and then travel and consultant RD's had come in as needed until mid August 2019 during his significant weight loss", and she herself (employee G) "started work in the facility in mid august, and had been there just under a month."

Physician's progress notes were reviewed and indicated no weights on the assessments conducted by the physicians. The area in the form for "weight" were all left blank. There is no indication that the physician's were aware of the significant weight loss from 6-25-10 to 8-29-19.

A review of the physician's orders, was conducted from the time of admission to the time of survey. They revealed the following timeline of interventions;

4-15-19 - admission regular diet with thin liquids. - weight 122.4.

4-16-19 - ST, OT (occupational therapy), PT (physical therapy) all evaluate and treat as necessary order entered.

5-2-19 - 2 Cal supplement 120 ml (milliliters)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 100	F 692		

drink twice per day at 8:00 a.m., and 5:00 p.m. - weight 115.2.

6-25-19 - Weight 119.0, which had rebounded from initial admission loss, proving the Resident had no difficulty gaining weight back (for the 2 months and 10 days since admission) while eating a regular diet, and taking a small amount of supplement. During this time there were no problems associated with aspiration.

6-25-19 The diet change to dysphagia ground diet with thin liquids, which the Resident did not like.

No other interventions occurred to prevent significant weight loss from 5-2-19 until 8-28-19 when the new RD arrived, and the significant weight loss had already occurred. - weight 108.0 (14.4 pound (10%) weight loss since admission, and an 11 pound weight loss in 2 months.)

7-25-19 through 7-29-19 the Resident had symptoms of illness, and had laboratory blood tests drawn. As a result of those tests it was revealed that the Resident had become dehydrated. Resident #37 then was ordered to receive IV (intravenous) normal saline fluids for dehydration. The infusion was started initially through a peripheral IV in his left wrist, however, the IV was not positioned well and had to be removed, and the staff was unable to replace it, so a specialist nurse was brought in to insert a "mid line" PICC (peripherally inserted central line catheter) to infuse the fluids.

7-26-19 - Physician's orders, laboratory reports, and nursing/physician progress notes revealed that ADON was aware that the "Resident need for help with ADL's has increased. Resident recently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 101	F 692		

ended PT, OT, and ST services. Will continue to monitor for further decline and have therapy screen as needed."

8-27-19 - RD progress note revealed "Weight not stable, Spoke with Resident who says that he doesn't like the ordered texture of his food. He reports that he feels like he's lost weight and does feel hungry throughout the day and at bedtime. He is agreeable to drinking 2 cal and trying snacks between meals and at bedtime...." Orders are then initiated and follow below.

8-29-19 - 2 Cal supplement increased to 240 ml (milliliters) drink twice per day at 8:00 a.m., and 5:00 p.m., magic cup twice per day with lunch and supper, yogurt and apple sauce between meals and at bedtime, were all started - weight 108.0.

9-3-19 - Resident lab test resulted for pre-albumin (measures recent dietary intake). Pro-stat protein supplement for wound healing was ordered.

9-9-19 - FEES study (Dysphagia systems test) completed. - weight 101.8.

9-11-19 - Diet changed to pureed with nectar thickened liquids, increase to 2 cal supplement to 3 times per day, and med pass liquid supplement was added for 60 ml three times per day.

9-16-19 - at the time of survey weight was - 95.6.

The Resident's diet card was requested from the kitchen and stated the pureed diet with nectar thickened liquids was being served. No mention of the supplement (2 cal supplement 240 ml

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 102	F 692		

(milliliters) three times per day, was on the tray card.

On 9-17-19 at 12:32 p.m., the physician was called on the telephone and asked for an interview. He stated he would come to the facility and look at the chart and let surveyors know about Resident #37. The physician arrived and stated he had looked at the chart, and said "the Resident is severely malnourished and doesn't like the texture of the diet."

He stated "We had speech look at the patient, and they said he isn't able to eat regular food. The family said no to a PEG (Per Endoscopic Gastrostomy) tube, there is nothing else to do." The doctor was asked why was speech therapy was consulted, if the Resident had no signs of aspiration, was not hospitalized or ever suffered from any respiratory illness associated with aspiration, and had been here in the facility for 5 months. He stated that "the family was concerned."

The doctor was asked why the family was allowed to make decisions for a Resident, who was alert and oriented, could make his needs known, and was his own Responsible Party (RP). The Resident had not been deemed incompetent, and had the right to make his own decisions. The doctor responded "I was not aware of that, and if we let him eat whatever he wants, that's how we get sued."

On 9-17-19 at 5:00 p.m., a "Summary Report of Meeting" document for the last 2 days of staff "huddle" meetings was presented to surveyors by the DON. The document described the subject of the meetings to be in regard to "Passing trays at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 103	F 692		

meal times, assisting feeders, documenting on amounts eaten." and was signed by those in attendance. This was evidence of training begun by the facility to rectify deficient practice in the meal delivery and assistance system.

The comprehensive care plan was reviewed in it's entirety and revealed the following interventions for the weight loss and pressure sore. There were no interventions for hydration, and it was simply placed in with the nutrition (weight loss) hydration plan below;

(Weight loss) FOCUS: (name) Resident #37 has the potential for nutrition/hydration imbalance related to hypertension, anemia, chronic kidney disease, history of hyperkalemia, diagnosis of dysphagia. Resident does not like puree texture food. initiated on 4-19-19, revised on 5-5-19, 6-25-19, and 9-13-19.
GOAL: Resident will remain adequate nutritional status as evidenced by maintaining weight with no significant weight changes through review date.
INTERVENTIONS: (all created and initiated on 4-19-19 immediately after admission) Administer medications as ordered. Monitor/document for side effects and effectiveness. Provide/serve diet as ordered, honoring resident preferences. Monitor intake and record every meal. RD to monitor and follow up per protocol. Weigh per facility protocol. (initiated 6-25-19) No hot liquids for safety.

No changes were made to any interventions after the Resident suffered a significant weight loss. The significant weight loss was not care planned, none of the interventions that were initiated for the weight loss were care planned, none of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 104	F 692		

supplements were care planned, none of the diet changes were care planned, and the need of the Resident to be fed by extensive assistance of staff was not care planned. Most goals are not measurable, and the Residents preferences were not honored.

There was no Hydration care plan initiated, even after the Resident suffered from dehydration requiring IV fluid infusions on 7-25-19.

On 9-17-19 at 5:00 p.m., the DON was again asked for ST notes, and none were supplied. At that time, the facility Administrator and Director of nursing were made aware of findings at the end of day meeting. The facility stated they had no further information to provide.

2. For Resident #28, the facility failed to ensure that he was offered adequate hydration.

Resident #28 was a 67 year old who was admitted to the facility on 4/12/19. Resident #28's diagnoses included Diabetes Mellitus Type 2, Muscle Weakness, and Hypertension.

The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 4/22/19 was reviewed. Resident #28 was coded with a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. He was also coded as requiring set up assistance with meals, and being able to ambulate independently with his wheelchair.

On 9/16/19 a review was conducted of Resident #28's clinical record, revealing the following diet order: "4/22/19. Renal diet. Regular texture,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 105	F 692		

Large Portions, Sandwich 3 times a day at meals."

On 9/15/19 at 1:40 P.M. an interview was conducted with Resident #28 in his room. His lunch had not been served. He stated that he wanted some apple juice, or something other than water to drink. Other than water there were no beverages in his room. He further stated that the dining room was closed all day on weekends. He complained that his food was late on a daily basis. He had not received an additional beverage to drink because the food tray was always late, and the facility did not ensure that preferred sources of hydration was available between meals.

On 9/16/19 at approximately 5:00 P.M., an interview was conducted with the Director of Nursing (DON Employee B). When asked why Resident #28 was unable to receive other sources of hydration, the DON said that the facility had a "hydration cart that passed out ice".

No further information was received.

3. For Resident #31, the facility staff failed to recognize and evaluate a 8.06% weight loss over a 4-day period.

Resident #31, a 72-year old male, was admitted to the facility on 02/09/2019. Diagnoses included but not limited to dementia, dysphagia, and diabetes.

Resident #31's most recent Minimum Data Set with an Assessment Reference Date of 07/15/2019 was coded as a quarterly

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 106	F 692		

assessment. Functional status for eating was coded as requiring a one-person physical assist and supervision (oversight, encouragement, or cueing) during meals.

On 09/16/2019, the clinical record was reviewed. According to the weight summary, Resident #31 weighed 172 pounds on admission (02/09/2019), 177 pounds on 06/26/2019, 171.2 pounds on 08/28/2019 and 157.4 pounds on 09/01/2019 which indicated an 8.06% weight loss over a 4-day timeframe.

An active physician's order with a start date of 07/19/2019 documented, "Mechanical soft texture, thin consistency, NO STRAWS. MONITOR FOR SIZE AND RATE DURING INTAKE for aphasia [sic]." Aphagia refers to the inability or refusal to swallow. There were no orders for protein/carbohydrate/ high-caloric supplements or fortified foods.

The progress notes from 08/01/2019 through 09/09/2019 were reviewed. There were no notes by any service addressing the weight loss documented in the weight summary on 09/01/2019.

The care plan was reviewed.

A focus entitled " [Resident #31] has the potential for nutrition/hydration imbalance r/t [related to] dementia, DM2 [diabetes mellitus 2], dysphagia dx [diagnosis], need for mechanically altered texture diet." A goal associated with this focus initiated on 02/18/2019 and revised on 09/16/2019 documented "[Resident #31] will maintain adequate nutritional status as evidenced by maintaining weight with no significant weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 107	F 692		

changes through the review date."

Interventions associated with this focus are as follows: Administer medications as ordered. Monitor/document for side effects and effectiveness.
Provide/serve diet as ordered and per resident preference. Monitor intake and record q [every] meal.

RD [registered dietitian] to monitor and f/u [follow up] per protocol
Weigh per facility protocol."

The interventions did not include monitoring for size and rate during intake as indicated in the physician's orders.

There was not a focus on the care plan for an actual significant weight loss.

On 09/16/2019 at 4:30 PM, an interview with Licensed Practical Nurse F (LPN F) was conducted. When asked about the process when a resident presents with weight loss, she stated, "I would re-weigh." She then stated that if it was true weight loss, she would notify the physician, the dietician, and the responsible party. When asked how much weight loss constitutes notifying the physician, she stated, "Five to ten pounds."

On 09/17/2019 at 10;23 AM, this surveyor observed a restorative aide that routinely weighs residents weigh Resident #31 via wheelchair on the scale and his weight was 158.8 pounds indicative of an overall 7.24% weight loss since 08/28/2019.

On 09/17/2019 at 1:34 PM, the medical director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 108	F 692		

was asked if he was aware of Resident #31's significant weight loss. He stated, "We discuss it every week in meeting so yes, I think so." When told there were no provider progress notes addressing it, the medical director stated, "I will look at it then" "I have to look at it and exactly the reason, he was doing so well and all of a sudden ...I will definitely look at him and get back to you."

On 09/17/2019 at 2:45 PM, an interview with Employee G, a registered dietician, was conducted. When asked if she was aware of Resident #31's significant weight loss, she stated she was aware. She went on to explain her process of obtaining a printout of all the residents and their weights. She stated she highlights the residents that need to be re-weighed but Resident #31 was not on the list. Employee G stated, "I talked to the nurse about that today." Employee G also stated that she will put in new recommendations for him. When asked what the recommendations would be, she stated that Resident #31 likes milk and ice cream "so I was going to add both of those." She stated she would also add juice to the breakfast meal and stated that his wife and daughter bring him snacks as well.

The facility staff provided a copy of their policy entitled, "Resident Weight." In Section 2 entitled, "Weight Procedure" it was documented in Part (c) "Compare weight to previous weight obtained. If a variance of 5 pounds or more is noted, reweigh resident to verify weight." In Section 6 entitled, "Reweight Parameters" it was documented, "a) A plus/minus of 5 pounds of weight in one week will result in: i) reweight within 24 hours(1) validation with nurse for accurate weight (2) notify IDT [interdisciplinary team]/doctor/family, if indicated."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 692	Continued From page 109 On 09/17/2019 at approximately 7:00 PM, the administrator and DON had no further information or documentation to offer.	F 692		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to administer physician ordered enteral feeding and water flushes for one resident (#101) in a survey sample of 42 residents.	F 693	F-693 1.) Medication error form completed for resident #101 with RP and MD notification of omitted signatures in MAR. Resident experienced no adverse effects. 2.) Current residents requiring tube feeding administration reviewed to identify	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 693	Continued From page 110 The Findings included: For Resident #101, the facility staff failed to provide physician ordered PEG tube water flushes, and tube feeding. Resident #101 is a 55 year old who was admitted to the facility on 11/8/18. Resident #101's diagnoses include Pancreatitis, Atrial Fibrillation, Muscle Weakness, and Major Depressive Disorder. The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 9/5/19 was reviewed. Resident #101 was coded as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. Resident #101's signed physician order read: "8/1/19. Enteral Feed Order every shift Flush PEG tube with 30 ml H 2 O before and after each med pass." According to the Medication Administration Record for August, 2019. On 8/2/19 during the evening shift, and 8/5/19 during the night shift, the water flushes were not documented as having been administered. In addition, there was an order for Enteral Feeding Jevity 1.5 cal @40 ml/hr x 10 hours to provide 400 ml tubefeeding and 600 kcal per day. According to the Medication Administration Record, the tubefeeding was not documented as having been administered on 8/2/19 during the evening shift. On 9/16/19 a review was conducted of facility	F 693	those that have the potential to be affected. 3.) All licensed nurses re-educated on timely/accurate med admin documentation. 4.) Director of Nursing and/or designee to audit MARs on 5 residents regarding tube feeding to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 693	Continued From page 111 documentation, revealing a Nursing Policy dated 4/6/16. An excerpt read: "Maintain nursing skills for appropriate areas of care management including but not limited to: tube feedings" On 9/16/19 at approximately 5:05 P.M., an interview was conducted with the Director of Nursing (DON Employee B). She was unable to state why tubefeeding orders had not been implemented. No further information was received.	F 693		
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, clinical record review, and facility record review, the facility staff failed to administer respiratory treatments as ordered by a physician for one Resident (Resident #13) in a survey sample of 42 residents. The findings included; For Resident # 13 the facility staff failed to remain with Resident during nebulizer treatment.	F 695	F-695 1.) Resident #13 currently receiving nebulizer treatment with licensed nurse monitoring at bedside. 2.) Current residents with ordered nebulizer treatments reviewed to identify those that have the potential to be affected. 3.) DON re-educated all licensed nurses on proper med administration of nebulizer treatments. 4.) Director of Nursing and/or designee to	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 695	Continued From page 112 Resident #13, an 82 year old woman admitted to the facility on 1/12/16 with diagnoses of but not limited to hypertension, Dementia, abnormalities of heart beat, difficulty walking, Anxiety disorder, type 2 diabetes, GERD. Pacemaker, glaucoma, and arthritis. Resident #90's most recent MDS (Minimum Data Set) with and ARD (Assessment Reference Date) 6/28/19 coded as a Quarterly Assessment has Resident #90 listed as having a BIMS (Brief Interview of Mental Status) score of 12 indicating moderate impairment. Resident #13 is coded as requiring supervision and over site with 1 person physical assistance for bed mobility and dressing, transfers, meals, bathing and hygiene. The MDS also codes Resident as able to ambulate with assistance and uses a wheel chair for locomotion on and off unit. On 9/16/19 at approximately 6:33 PM surveyor A and this surveyor were walking down the hall and observed Resident #13 asleep in her room, in her wheelchair, head and neck hyper-extended with the nebulizer mask in place and machine running. The nebulizer was not emitting any mist which indicated that the treatment was completed. Upon closer inspection it was observed that the nebulizer cup which holds the medication was empty. LPN A was standing at the nurse's station and when she saw this surveyor and surveyor A standing outside the Resident's doorway she began walking up the hall. She walked past and went into the room and said " [Resident name redacted] you were supposed to wait for me to come back remember I said wait for me?" She	F 695	audit administration of nebulizer treatments to 5 residents ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 695	Continued From page 113 then said "She must have turned it on by herself." LPN A was asked if she is supposed to leave a Resident alone with a nebulizer treatment running and she stated that she had told the resident to wait until she returned but the resident must have started it before she got back. On 9/17/19 at approximately 3:30 PM the ADON was asked if the patients were allowed to be alone while a nebulizer treatment is on she stated no that it was his expectation the nurses remain with the Residents during treatment. On 9/17/19 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 695		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility failed to provide annual nursing staff training based on their annual reviews for 5 out of 5 sampled Certified Nursing Assistants (CNA). The Findings included: The facility staff failed to provide annual training	F 730	F-730 1.) Certified Nursing Assistants□ O, P, A, S, T counseled on completing required training courses timely and training was completed. 2.) Current residents have the potential to be affected. Nursing staff completion of education reviewed to identify those staff who are not in compliance.	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 730	Continued From page 114 based on their annual performance reviews. On 9/17/19, a review was conducted of employee records. The facility Staff Coordinator (Employee J) was interviewed in her office. The employee records were computer-based. The Staff Coordinator utilized her computer to facilitate the review. The records did not contain documentation identifying the required training for the identified employees based on their annual review. In addition, according to the Relias System Course Completion History, the facility failed to implement required annual training for the following employees: Employee and Training Due Date (CNA O) 9/7/19 (CNA P) 9/14/19 (CNA A) 7/14/19 (CNA S) 7/20/19 (CNA T) 7/31/19 When asked about the importance of staff completing their training requirements, the Staff Coordinator stated, "Deficits in care can happen. Accidents can happen." She further stated that the facility did not have a policy that specified required annual training for CNA's. On 9/17/19 a review of facility documentation was completed, revealing a Compliance Training policy dated 1/6/18. An excerpt read: "training and education are critical to providing quality care and services..." No further information was received.	F 730	3.) DON re-educated all licensed Certified Nursing Assistants on timely completion of required training. 4.) Human Resources Director and/or designee to audit timely education/training for 5 Certified Nursing Assistants to ensure compliance weekly x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 740	Continued From page 115	F 740		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation the facility failed to ensure received behavioral health services for 1 Resident (#71) in a survey sample of 42 Residents. The findings included: For Resident # 71 the facility staff failed to ensure Resident received behavioral health services for increasing behavioral issues. Resident #71, a 66 year old woman admitted to the facility on 7/24/19 with diagnoses of but not limited to Cerebral Infarction (Stroke), Dysphagia, Cognitive Communication Deficit, Major Depressive Disorder, Anxiety Disorder, muscle weakness, Hemiplegia (one sided weakness) and Hemiparesis (one sided paralysis) following CVA, Congenital malformations unspecified. Resident is listed as her own Responsible Party (RP). Resident #71's most recent MDS (Minimum Data	F 740	F-740 1.) The facility obtained a psychiatric consult on Resident #71. 2.) Current residents with noted observed behaviors reviewed to identify those in need of a psychiatric consultation that have the potential to be affected. 3.) DON educated licensed nursing staff on timely referrals to psychiatric provider due to behaviors. 4.) Social Services Director and/or designee to audit 5 psychiatric referrals due to resident behaviors to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 740	Continued From page 116	F 740		

Set) with and ARD (Assessment Reference Date) of 8/21/19 coded Resident #71 as having a BIMS (Brief Interview of Mental Status) score of 12 indicating moderate cognitive impairment.

She is coded as requiring extensive assistance with 2 person physical assistance needed for transfers and dressing. She is set up help only for meals but bathing and hygiene requires 1 person physical assist. Her MDS for 8/21/19 also codes Resident #71 as having no behavioral disturbances.

On 9/15/19 at approximately 3:00 PM during an interview with Resident #71 she began saying she slept in her wheel chair most nights. She explained how she liked to go shopping to "Rose's" and she wasn't allowed to anymore. She told of falls she took trying to get to the bathroom. She was general in her statements and could not put dates or times with occurrences. She had a bruise on her right arm and stated it was from a fall. Her conversation went from topic to topic randomly.

On 9/16/19 during clinical record review it was discovered that the Resident had a BIMS of 12, was her own RP, and had several falls, and on two occasions had left to go shopping at Roses and on at least one occasion arranged her own transportation.

Excerpts from Nursing Progress Notes revealed the following behaviors:

"9/10/19 at 5:30 AM -Resident was asked by cna assigned and this nurse if she wanted to get up in her wheel chair. Resident started cursing at nurse and cna assigned. Resident was left alone and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 740	Continued From page 117	F 740		

re-approached. Resident agreed to be placed in her wheel chair by this nurse and assigned cna. When assigned cna witnessed resident just before fall resident was in her bathroom naked. When resident offered help she refused."

"9/12/19 at 6:19 PM - Resident noted going in and out of resident rooms without permission. Redirected multiple times so far this shift. Will continue to monitor."

"9/12/19 at 7:49 PM - Patient has been combative with staff and verbally abusive notable confusion."

"9/12/19 9:12 PM -Resident has refused meds this shift, no reason given writer got supervisor to try to get her to take her meds , supervisor said she put them in her mouth and spit them back out. "

"9/12/19 at 11:06 PM. - Resident has refused all care this shift she has been verbally abusive and physically abusive using her w/c she has rammed her w/c into the side of the writers nursing cart multiple times, along with writers leg, telling nurse to move her cart, but other resident were coming down the other side of the hall when nurse could not move, resident then tried running her w/c into the residents coming down the other side of hall. Writer was called by receptionist to come to the front of the building to retrieve resident d/t her being completely naked from the waist down."

"9/12/19 at 11:12 PM - Resident has also been going in and out of residents rooms with no clothes on waist down."

"9/13/19 at 7:04 AM - Resident was observed entering several other [resident] rooms at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 740	Continued From page 118	F 740		

beginning of the shift Resident was easily redirected."

"9/13/19 at 10:10 AM -Mental status WNL for resident. Resident with increased behaviors Resident more agitated. Resident has been verbally combative and physically combative by using her w/c cussing staff and other residents using her w/c to run into or over staffs carts or legs or other residents. Resident has also had lapses in memory not remembering what happened or what she said she has refused care help with transfers and meds. Refused to put on pants/ depends for whole shift propelling self through unit with just a towel over her from waist down."

On 9/16/19 at approximately 4:00 PM an interview was conducted with the DON, when asked if Resident has been seen by Psych she stated that she had. At that point the ADON said "No she hasn't been seen yet." The DON was asked if she was aware that the Resident had been walking in other Resident rooms uninvited and in some cases naked from the waist down, and at the front lobby area in the same manner, she replied "No I didn't realize it was that bad." She stated that she is on the list to be seen by psych. At that time requested proof of appointment with Psych. in form of consult request or fax or copy of appointment that has been scheduled. When asked about the Social Workers involvement in all of this she stated "Our social worker just started today, we have been without a social worker for a few weeks now."

09/17/19 01:32 PM - An interview with the Medical Director was conducted. He stated. "I don't remember her walking naked, I will have to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 740	Continued From page 119 involve [DON name redacted] in this." On 9/17/19 at 3:40 PM ADON brought fax copy of Referral for Resident to be evaluated by Psychiatric Services. The Referral was dated 9/17/19 at 3:33 PM and stated reason for Referral "Depression, Confusion, memory loss, sexually inappropriate behavior, verbal or physical aggression, and anxiety. The Consent was signed by Resident and dated 9/17/19. On 9/17/19 during the end of day meeting the Administrator was made aware of the issues and no further information was provided.	F 740		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 755	Continued From page 120 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure medications were available for administration for 1 resident (Resident #108) in a survey sample of 42 residents. The findings included; For Resident # 108, the facility staff failed to ensure medications were available for administration as ordered by the physician. Resident #108 was a 55 year old male admitted to the facility on 3/20/2018, with diagnoses of but not limited to: Gastrostomy, contracture, history of traumatic brain injury, tracheostomy, pressure ulcer of sacral region, flaccid hemiplegia, Diabetes, Pneumonia and Hypertension. The most recent Minimum Data Set (MDS) Assessment was a Quarterly assessment with an Assessment Reference Date (ARD) of 6/15/2018. Under Section B 0100, the MDS coded Resident # 108 with being Comatose with Persistent vegetative state. The assessment also coded Resident # 108 as requiring total assistance of	F 755	F-755 1.) Resident #108 is discharged from facility. 2.) Current resident□s medication regiment reviewed to identify those that have the potential to be affected. 3.) DON re-educated all licensed nurses on ensuring medications available for administration by review of first dose machine. 4.) Director of Nursing and/or designee to audit medications available for administration to 5 residents by review of first dose machine to ensure compliance weekly x 3 weeks then monthly x 3 months to with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 755	Continued From page 121	F 755		

two staff persons with activities of daily living; and frequently incontinent of bowel and always incontinent of bladder.

Review of the electronic clinical record and paper clinical record was conducted on 9/15/2019 and 9/16/2019.

Review of the nurses notes revealed documentation of medications not being administered because they were not available from the Pharmacy.

4/12/2018 22:07 (10:07 PM)-eMAR(electronic Medication Administration)-Medication Administration Note: Pneumococcal vaccine .5 milliliters in the evening for 1 day start date changed due to wait on med to be delivered from pharmacy

4/26/2018 14:04 (2:04 PM) eMar-Medication Administration Note: medication unavailable. NP (Nurse Practitioner)_____notified and ok for medication to be on hold until arrives from pharmacy. Pharmacy has been notified and spoke with ____r/t (related to) arrival of medications.

5/15/18 15:00 (3:00 PM) Nurses Note-"Resident IVABT (Intravenous Antibiotic Therapy) have not arrived from pharmacy. Spoke with NP (Nurse Practitioner) _____ and got new orders to hold medication until arrival from pharmacy. Resident is currently on a PO (by mouth) ABT (Antibiotic Therapy). Pharmacy stated med would arrive on late night transport.

5/15/18 10:35 AM- eMar Medication Administration Note: Zosyn Solution

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 755	Continued From page 122	F 755		

Reconstituted 3.375 (3-.075) GM (Gram) Use 3.375 gram intravenously four times a day for pneumonia for 7 days. Hang first dose on arrival of medication. Then start timing of medication.

5/14/18 14:24 (2:24 PM) Nurse Practitioner/PA (Physician Assistant) Progress Note: .....received call over weekend wbc (white blood count) 23,000 urine and leukocyte esterase. Patient given 1 dose of rocephin 1 gm im (intramuscularly), started on Levaquin 500 mg po qd (milligrams by mouth daily.)

Review of the May 2018 Medication Administration Record revealed documentation of Zosyn being administered for the first time on 5/16/18 at 8:44 AM.

Review of Physicians Orders revealed the order for Zosyn 3.375 milligrams IV every 6 hours for 7 days was written on 5/14/2018 and scheduled to start on 5/14/2018 then to end on 5/21/2018.

Another order for Zosyn 3.375 milligrams IV every 6 hours for 7 days was written on 5/16/2018 to start on 5/16/2018 and to end on 5/22/2018.

9/16/19 05:15 PM, an interview was conducted with the DON (Director of Nursing) who stated: "they should have went to see if we had the first dose in house, if it was in the box or call the pharmacy and have then call back up pharmacy which is here in Petersburg and have then bring it over. A copy of the "First Dose" stat box contents was requested and received.

Review of the First Dose contents revealed the facility should have had two vials of Zosyn 3.375 grams in stock according to the list submitted by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 755	Continued From page 123 the Director of Nursing. During the end of day debriefing on 9/17/2019, the Administrator, Director of Nursing were informed of medications not being available for administration as ordered by the physician. No further information was provided.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility documentation the facility failed to ensure Residents are free from	F 757	F-757 1.) Resident #71 had Cyclobenzaprine discontinued on 9/17/2019.	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 757	Continued From page 124 unnecessary medications for 1 Resident (#71) in a survey sample of 42 Residents. The findings included: Resident #71, a 66 year old woman was admitted to the facility on 7/24/19 with diagnoses of but not limited to Cerebral Infarction (Stroke), Dysphagia, Cognitive Communication Deficit, Major Depressive Disorder, Anxiety Disorder, muscle weakness, Hemiplegia (one sided weakness) and Hemiparesis (one sided paralysis) following CVA, Congenital malformations unspecified. Resident is listed as her own Responsible Party (RP). Resident #71's most recent MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 8/21/19 coded Resident #71 as having a BIMS (Brief Interview of Mental Status) score of 12 indicating moderate cognitive impairment. She is coded as requiring extensive assistance with 2 person physical assistance needed for transfers and dressing. She is set up help only for meals but bathing and hygiene requires 1 person physical assist. Her MDS for 8/21/19 also codes Resident #71 as having no behavioral disturbances. On 9/16/19 during clinical record review it was noted that among her medications Resident #71 was receiving the following: Baclofen 20 mg tablet (muscle relaxer) - give 1.5 tab (30 mg) by mouth every 8 hours for muscle spasms. Cyclobenzaprine HCL (Flexural) 20 mg - give 1 Tablet by mouth three times a day for muscle	F 757	2.) Current residents medication regimen reviewed to identify those that have poly pharmacy orders have the potential to be affected. 3.) Regional Director of Clinical Operations to educate Facility Medical Director and Consultant Pharmacist on ensuring residents are free of unnecessary medications. 4.) Director of Nursing and/or designee to audit pharmacy consultant reviews on all residents to ensure compliance monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 757	Continued From page 125	F 757		

spasms.

Pramipexole Dihydrochloride 0.75 - mg give 1 tablet at bedtime for muscle spasms.

Cymbalta (Duloxetine Hall) 60 mg give 1 capsule daily

On 9/17/19 at 1:32 PM an interview with the Medical Director was conducted and when asked if he was aware that the Resident was receiving 2 muscle relaxers known to cause dizziness and she has had some falls "You don't have 2 muscle relaxer's at the same time, they should not be given together."

The FDA (Food and Drug Administration) guidelines for use of Cyclobenzaprine with elderly patients read:

"Use in the Elderly
The plasma concentration of cyclobenzaprine is increased in the elderly (see CLINICAL PHARMACOLOGY, Pharmacokinetics, Elderly). The elderly may also be more at risk for CNS adverse events such as hallucinations and confusion, cardiac events resulting in falls or other sequelae, drug-drug and drug-disease interactions. For these reasons, in the elderly, cyclobenzaprine should be used only if clearly needed."

The Mayo Clinic guidelines for use of Baclofen in geriatric patients read:
Side effects such as hallucinations, confusion or mental depression, other mood or mental changes, and severe drowsiness may be especially likely to occur in elderly patients, who are usually more sensitive than younger adults to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 757	Continued From page 126 the effects of baclofen. The NIH (National Institutes of Health) defines CNS Depressants as "Central Nervous System (CNS) depressants are medicines that include sedatives, tranquilizers, and hypnotics. Sedatives are often prescribed to treat sleep disorders like insomnia and hypnotics can induce sleep, whereas tranquilizers are prescribed to treat anxiety or to relieve muscle spasms." "Side effects from use and misuse can include: Slurred speech Poor concentration Confusion Headache Light-headedness Dizziness Problems with movement and memory Lowered blood pressure Slowed breathing" On 9/17/19 at approximately 5:00 PM the ADON produced proof the MD had discontinued use of the Cyclobenzaprine and is only using the Baclofen. At the end of day meeting the Administrator was made aware and no further information was provided.	F 757		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff	F 760	F-760	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 760	Continued From page 127 interview, facility documentation review, and clinical record review, the facility staff failed to ensure resident's are free from significant medication error for 3 Residents (Resident #83, #109, and #72) in a survey sample of 42 Residents. The findings included: 1. The facility staff failed to ensure Resident #83 was free from significant medication error by ensuring the Resident did not receive expired insulin. Resident #83 was admitted to the facility on 2/18/12. Diagnoses for Resident #83 included but were not limited to: cerebral infarction, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and type 1 diabetes mellitus without complications. Resident #83's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 8/25/19 was coded as an annual assessment. Resident #83 was coded as having had moderately impaired daily decision making. Resident #83 was also coded as being totally dependent upon facility staff for her ADL's (activities of daily living) which included: bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. On 9/16/19 at 11:03 AM an observation of unit 2 top hall medication cart was performed with LPN D. The following expired medication, belonging to Resident #83, was observed: * Toujeo Solostar Pen 300u/ml, which contained no date as to when it was opened.	F 760	1.) All expired insulins related to Resident #83, 109 and 72 were properly discarded on 9/16/2019. 2.) Current residents who have an active order of insulin administration reviewed to identify those that have the potential to be affected. 3.) DON re-educated all licensed nurses on ensuring medications are not expired. 4.) Director of Nursing and/or designee to audit 5 medication carts to ensure compliance weekly x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 760	Continued From page 128	F 760		

Review of the physician's orders for Resident #83 revealed an order for Toujeo which read, "Toujeo SoloStar Solution Pen-Injector 300 unit/ml (Insulin Glargine) Inject 100 unit subcutaneously one time a daily related to type 1 diabetes mellitus without complications".

Review of Resident #83's Medication Administration Record (MAR) for September 2019 revealed she had received Toujeo daily, Sept. 1-Sept. 17. With no open date on the Toujeo pen, the nursing staff were unaware of if the insulin had expired, that was being administered.

LPN D was asked how long insulin is kept once opened, LPN D stated, "28 days after opened". LPN D was asked what the adverse effects of expired insulin is and why one would not want to use expired insulin, LPN D stated, "because the effects of the medication after open won't be good anymore because it is not refrigerated". LPN D was asked if Resident #83 had been administered the expired insulin, LPN D stated, "yes".

2. The facility staff failed to ensure Resident #109 was free from significant medication error as evidenced by ensuring the Resident did not receive expired insulin medication.

Resident #109 was admitted to the facility on 6/21/19 with a readmission date of 7/1/19. Resident #109's diagnoses included but were not limited to: Hypertension, diabetes mellitus with unspecified complications, end stage renal disease and altered mental status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 760	Continued From page 129	F 760		

Resident #109's most recent MDS assessment with an ARD (assessment reference date) of 6/25/19 was coded as an admission assessment. Resident #109 had not been assessed for cognitive skills and daily decision making on this assessment. The Resident was coded as being totally dependent upon staff for transfers, toilet use, personal hygiene and bathing.

On 9/16/19 at 11:03 AM an observation of unit 2 top hall medication cart was performed with LPN D. The following expired medications, belonging to Resident #109, was observed:
* Humalog Kwikpen which contained an open date of 8/7/19 and handwritten expiration date of 9/5/19.
* Basaglar Kwikpen [Lantus], with an open date of 8/10/19

Review of the physician's orders for Resident #109 revealed an order dated 7/22/19 for Humalog Kwikpen which read, "inject as per sliding scale subcutaneously before meals and at bedtime for diabetes". There was an order Lantus dated 7/1/19 that read, "inject 25 unit subcutaneously one time a day for diabetes".

Review of Resident #109's Medication Administration Record (MAR) for September 2019 revealed he had received Humalog, 23 occasions after the insulin should have been discarded, from Sept. 6-Sept. 17. Further review of the MAR revealed that Resident #109 received Lantus on 5 occasions following when the insulin should have been discarded (9/11/19, 9/12/19, 9/13/19, 9/16/19, 9/17/19).

LPN D was asked how long insulin is kept once

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 760	Continued From page 130	F 760		

opened, LPN D stated, "28 days after opened". LPN D was asked what the adverse effects of expired insulin is and why one would not want to use expired insulin, LPN D stated, "because the effects of the medication after open won't be good anymore because it is not refrigerated". LPN D was asked if Resident #109 had been administered the expired insulin, LPN D stated, "yes".

3. The facility staff failed to ensure Resident #72 was free of significant medication errors by ensuring the Resident did not receive expired insulin.

Resident #72 was a 102 year old, admitted to the facility on 12/28/18. Diagnoses for Resident #72 included but were not limited to: muscle weakness, repeated falls, cognitive communication deficit, and type 2 diabetes mellitus without complications.

Resident #72's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 8/21/19 was coded as a quarterly assessment. Resident #72 was coded as having had a BIMS (brief interview for mental status) score of 11, which indicated, impaired daily decision making. Resident #72 was also coded as extensive assistance of facility staff for ADL's (activities of daily living) which included: bed mobility, transfers, and toilet use. Resident #72 was coded as being totally dependent upon staff for assistance with dressing, personal hygiene and bathing.

On 9/16/19 at 11:03 AM an observation of unit 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 760	Continued From page 131	F 760		

top hall medication cart was performed with LPN D. The following expired medications, belonging to Resident #72, was observed:
* Novolog 100u/ml multi-dose vial, with an open date of 8/12/19 and an expiration date of 9/12.

Review of the physician's orders for Resident #72 revealed an order for Novolog which read, "Novolog Solution 100 Unit/ML, inject as per sliding scale".

Review of Resident #72's Medication Administration Record (MAR) for September 2019 revealed she had received Novolog, Sept. 13-Sept. 15, following the expiration of the medication. From Sept. 13-Sept. 15 Resident #72 received 6 doses.

LPN D was asked how long insulin is kept once opened, LPN D stated, "28 days after opened". LPN D was asked what the adverse effects of expired insulin is and why one would not want to use expired insulin, LPN D stated, "because the effects of the medication after open won't be good anymore because it is not refrigerated". LPN D was asked if Resident #72 had been administered the expired insulin, LPN D stated, "yes".

On 9/16/19 at 3:41 PM, the Director of Nursing (DON) was asked about insulin storage and she stated insulin is to be discarded "28 days after opening".

On 9/17/19 the DON provided the survey team with 4 inservices that had been conducted 9/15/19-9/16/19 that discussed "5 rights of medication administration, check insulin for expiration daily, and placing date once opened,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 760	Continued From page 132	F 760		

expiration dates [sic]".

Review of the facility policy titled, Storage of Medications read, "outdated medications are immediately removed from inventory, disposed of according to procedures for medication disposal and reordered from the pharmacy, if a current order exists". On the second page of the policy, it read, "5. when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. a. The nurse shall place a date opened sticker on the medication and enter the date opened. b. If a vial or container is found without a date opened, the date opened will automatically default to the date dispensed and the expiration date will be calculated accordingly. 6. The nurse will check the expiration date of each medication before administering it. 7. No expired medication will be administered to a resident."

Review of the facility policy titled, Medication Administration read on page 3 under the subheading "basic safety in administration, check expiration dates. Do not administer expired medications."

Manufacturer Instructions were requested and received for the insulin's found. Each of the insulin manufacturer's indicated insulin is to be stored 28 days after opened and discarded following that, with the exception of Toujeo, which is safe to be stored and in-use for 56 days following opening.

The American Diabetes Association (ADA) commented in a journal accessed at the following web page address: https://care.diabetesjournals.org/content/26/9/266

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 760	Continued From page 133 5 "The importance of not using bottles past their expiration date after opening is critical to good patient care". The article also stated, "ADA' s Clinical Practice Recommendations 2002, it is stated that "The patient should always have available a spare bottle of each type of insulin used. Although an expiration date is stamped on each vial of insulin, a loss of potency may occur after the bottle has been in use for >1 month, especially if it was stored at room temperature". The facility Administrator and DON were made aware of the findings during an end of day meeting on 9/17/19. No further information was provided.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for	F 761		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 761	Continued From page 134 storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility record review, and clinical record review the facility staff failed to label and store medications and medical supplies within accepted professional principles in one of two medications rooms and on one of four medications carts. The findings included: 1. The facility staff failed to remove expired medical supplies from the medication storage room, to prevent the use of expired items. On 9/16/19 at approximately 10:40 AM an observation of the medication storage room on station 1 was performed with LPN E. Observation revealed in a locked cabinet the following items: * a dressing kit. Medline dressing change tray with an origination date of 6/2/2017 on the prescription label. The label also stated "discard after 6/1/2018". LPN E stated, "I've never heard of these people," (referencing she didn't know the Residents whose name was on the prescription label). * MaxPlus- clear needless connector with an origination date of 7/2/2017 on the prescription label and a discard date of 7/1/2018.	F 761	F-761 1.) All expired medical supplies removed/discarded on 9/16/2019. 2.) Current residents that require medical supplies reviewed to identify those that have the potential to be affected. 3.) DON re-educated all licensed nurses on labeling/storage of medications and medical supplies within accepted professional principles. 4.) Director of Nursing and/or designee to audit 5 medication rooms/carts to ensure compliance weekly x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 761	Continued From page 135	F 761		

* Medline dressing change tray, with an origination date of 6/20/17 and discard after 6/19/2018. The manufacturer expiration date read, 7/31/2018.

LPN E stated, "they probably never even look down there, this stuff is from 2017. I have no explanation why they would keep things of this nature".

LPN F, the unit manager was shown the items and was asked what they are. LPN F, the unit manager, stated, "looks like IV supplies". She was asked to look at the tubing and that the date indicated it had expired, LPN F stated, "I don't know why they were down there, I will get rid of this stuff".

On 9/16/19 a request for the facility policy regarding medication storage was requested. An additional request was made on 9/17/19. At the time of exit the only related documents provided were the following policies:

* Ordering and receiving non-controlled medications
* Emergency pharmacy & emergency kits
* Medication Administration

No further information was provided.

2. The facility staff failed to label insulin when opened and remove from use after expiration date.

On 9/16/19 at 11:03 AM an observation of unit 2 top hall medication cart was performed with LPN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 761	Continued From page 136	F 761		

D. The following was observed:
* Humalog 100u/ml multi-dose vial, with an open date of 8/13/19
* Novolog 100u/ml multi-dose vial, with an open date of 8/12/19 and discard date written as 9/12/19.
* Humalog 100u/ml multi-dose vial, with an open date of 7/18/19 and an expiration date written as 8/18/19
* Lantus 100u/ml multi-dose vial, with an open date of 7/18/19 and an expiration date written that read, 8/18/19
* Humalog Kwikpen with an open date of 8/7/19 and an expiration date written that read 9/5/19
* Basaglar Kwikpen with an open date of 8/10/19
* Toujeo Solostar Pen 300u/ml without any date as to when opened.

LPN D was asked how long insulin is kept once opened, LPN D stated, "28 days after opened". LPN D was asked what the adverse effects of expired insulin is and why one would not want to use expired insulin, LPN D stated, "because the effects of the medication after open won't be good anymore because it is not refrigerated".

On 9/16/19 at 3:41 PM, the Director of Nursing (DON) was asked about insulin storage and she stated insulin is to be discarded "28 days after opening".

Review of the facility policy titled, Storage of Medications read, "outdated medications are immediately removed from inventory, disposed of according to procedures for medication disposal and reordered from the pharmacy, if a current order exists". On the second page of the policy, it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 761	Continued From page 137 read, "5. when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. a. The nurse shall place a date opened sticker on the medication and enter the date opened. b. If a vial or container is found without a date opened, the date opened will automatically default to the date dispensed and the expiration date will be calculated accordingly. 6. The nurse will check the expiration date of each medication before administering it. 7. No expired medication will be administered to a resident." Manufacturer Instructions were requested and received for the insulin's found. Each of the insulin manufacturer's indicated insulin is to be stored 28 days after opened and discarded following that, with the exception of Toujeo, which is safe to be stored and in-use for 56 days following opening. The facility Administrator and DON were made aware of the findings during an end of day meeting on 9/17/19. No further information was provided.	F 761		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a	F 806		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 806	Continued From page 138 different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review, and facility documentation review, the facility staff failed to ensure meals were tailored to the preferences of 2 residents, (Residents #37, and #54) in a survey sample of 42 residents. The findings included; 1. For Resident #37, the facility staff failed to ensure the resident received his preferred diet, which the Resident complained about repeatedly and did not want to eat. Resident #37 was admitted to the facility on 4-15-19. Diagnoses included: hypertension, anemia, arthritis, chronic kidney disease moderate, high cholesterol, heart disease, seizures, and a history of dysphagia. The most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an assessment reference date (ARD) of 9-9-19. Resident #37 was coded with a Brief Interview of Mental Status score of 11 indicating mild to no cognitive impairment and the Resident required extensive assistance, to complete dependence, on staff for all activities of daily living. This included extensive assistance of 1 staff member's physical assistance to eat. The Resident was coded with no aberrant behaviors, and no refusals of care or assistance from staff. On 4-15-19, Resident #37 was admitted on a "Regular diet with low potassium, regular texture, thin liquids." On 6-25-19 the Resident's diet was	F 806	F-806 1.) Resident #37 has discharged from facility. Resident #54 preferences updated to reflect lactose intolerance on 9/17/2019. 2.) Current residents with known allergies/preferences reviewed to identify those that have the potential to be affected. 3.) DON and/or designee re-educated licensed nurses and dietary staff re-educated on resident dietary preferences and allergies. ED educated Food Services Manager on resident allergies and food preferences, and ensuring proper items are in stock and available in center. 4.) The Registered Dietitian and/or designee to audit dietary preferences of 5 residents to ensure compliance weekly x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 806	Continued From page 139	F 806		

changed to "Dysphagia ground texture, thin consistency low potassium diet". On 9-11-19 the Resident's diet was again changed to "Regular diet puree texture, nectar consistency, for dysphagia." The Resident's diet card was requested from the kitchen and stated the pureed diet with nectar thickened liquids was being served.

On 9-15-19 at 12:00 noon, observations and interviews were conducted with Resident #37. Resident #37 was asked if we could help him with anything while we were there, and he complained of hunger, and stated he wanted something to eat. He stated his family brought him things and he enjoyed that food.

The lunch meal tray did not arrive at the bedside until 12:45 p.m., and at 2:30 p.m., no staff had entered the room to assist the Resident to eat. Surveyor A, and this surveyor looked at the tray which was uncovered, and untouched. We went to the nursing station to enquire as to how long it would be for the Resident to be fed. They stated that Resident #37 "was a self feeder, and independent."

Resident #37 was observed again at 3:30pm. The tray had been left there and the thick pudding consistency portions of food had approximately 2 spoonfuls missing from 2 of the 3 scoops of pureed food. Each of the scoops measured approximately 3 inches by 3 inches circular, and 1/2 inch depth, and had spread out into each other on the plate. The Resident stated "I can't eat that stuff, it's awful like cold wet bread." He went on to say "I told them when I got here that I can't eat that stuff, and I don't have any trouble eating if I like the food, but they don't listen."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 806	Continued From page 140	F 806		

On 9-16-19 at 10:00 a.m., another observation was conducted for this Resident by Surveyor C. Surveyor C reported that for the breakfast meal the tray was followed and went into the Resident's room, left uncovered, and removed from the room untouched and returned to the kitchen. On 9-16-19 at 3:00 p.m., the Resident's lunch meal tray was again left untouched, and the Resident was not fed.

Resident #37's breakfast tray was followed by Surveyor C from delivery by CNA N, to discard, and it was not disturbed, nor did the Resident attempt to consume it. No staff member attempted to assist with the meal, and the tray was simply removed from the room, untouched, and discarded.

On 9-16-19 at 3:00 p.m., an interview was conducted with the Director of Nursing (DON), and "Unit manager" RN (registered nurse) D, by surveyors in the conference room. They stated that they were talking to the family. They were asked why it had taken 5 months to get a plan going, and they stated "At first his family was bringing in food that he was eating, he doesn't like the pureed texture or the nectar thick liquids."

They were asked why the physician had not talked with the Resident himself and decide a course of action? They stated "We discussed the doctor talking to him (the Resident), and we didn't have a social worker as Employee O has been gone about a month and a half ago, and he has lost weight since that." The DON stated "I see we need to make a decision and talk to him to see if he wants a peg tube because he doesn't like the pureed texture to maintain his BMI (Body Mass

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 806	Continued From page 141	F 806		

Index)."

The DON and unit manager continued with, "Speech therapy did a swallowing eval, and he didn't do well." They were asked when that occurred as no therapy notes were found in the clinical record. She stated, I don't know, I will get those for you." "The family brings in McDonalds, and that he eats." She was asked if he had ever aspirated or been hospitalized, or treated for aspiration pneumonia, or had any respiratory problems, and they stated "no." They were asked why the Resident was not being fed by staff who thought he was independent, when his MDS showed he needed extensive assistance from staff to eat since the 7-12-19 MDS which included a seven day look back to 7-5-19. They responded "He should be fed."

On 9-16-19 at 3:15 p.m., Employee E, the speech language pathologist (ST/SLP) entered the interview in progress in the conference room with surveyors, and with the unit manager and DON. She stated "he was on ground meat with pureed solids and the Resident didn't like it so the family requested an upgrade so he would eat, and then the FEES study was ordered on 9-10-19." She was asked if there was no problem, or outcome with the regular diet that the family brought in that the Resident did eat, why the change. She stated "he needs positioning and encouragement to not aspirate, he is at risk for silent aspiration". She continued "he wasn't really eating the ground texture, or anything off of the pureed tray but pudding, oatmeal, and cream of wheat, and that's why the FEES study was done." "A bedside swallowing evaluation was done by another speech therapist who was full time here. I am not typically treating most of the time. Her last day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 806	Continued From page 142	F 806		

was weeks ago, I don't remember how many, we have a new one starting today. Between the last one and this one we have had PRN (as needed) staff and I have been helping treat as well." She was asked if she had assessed or treated Resident #37, and she stated "no." The ST notes were again requested.

The "FEES" ("Dysphagia systems test") study was requested at 3:15 p.m., during the interview with Employee E, and received at 4:00 p.m. The study documented no diagnoses linked to dysphagia, and documented that the Resident took his medications whole. The document describes the "Potential risks" to the Resident, and documents that the Resident is at "Potential risk" for aspiration. Any and all ST notes from Resident #37's time of admission to today were requested again.

On 9-16-19 at 4:00 p.m., the Registered Dietician (RD), and Assistant Director of Nursing (ADON) were interviewed by surveyors in the conference room. The current RD stated there had been "a lot of turnover in the department and there had been one RD from April to May 2019, and then travel and consultant RD's had come in as needed until mid August 2019 during his significant weight loss", and she herself (employee G) "started work in the facility in mid august, and had been there just under a month."

6-25-19 physician progress note documented: The diet change to dysphagia ground diet with thin liquids, which the Resident did not like.

8-27-19 - RD progress note revealed "Weight not stable, Spoke with Resident who says that he doesn't like the ordered texture of his food. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 806	Continued From page 143	F 806		

reports that he feels like he's lost weight and does feel hungry throughout the day and at bedtime. He is agreeable to drinking 2 cal and trying snacks between meals and at bedtime...." Orders are then initiated and follow below.

On 9-17-19 at 12:32 p.m., the physician was called on the telephone and asked for an interview. He stated he would come to the facility and look at the chart and let surveyors know about Resident #37. The physician arrived and stated he had looked at the chart, and said "the Resident is severely malnourished and doesn't like the texture of the diet."

He stated, "We had speech look at the patient, and they said he isn't able to eat regular food. The family said no to a PEG (Per Endoscopic Gastrostomy) tube, there is nothing else to do." The doctor was asked why was speech therapy was consulted, if the Resident had no signs of aspiration, was not hospitalized or ever suffered from any respiratory illness associated with aspiration, and had been here in the facility for 5 months. He stated, "the family was concerned."

The comprehensive care plan was reviewed in it's entirety and revealed the following interventions .
GOAL: Resident will remain adequate nutritional status as evidenced by maintaining weight with no significant weight changes through review date.
INTERVENTIONS: (all created and initiated on 4-19-19 immediately after admission) Administer medications as ordered. Monitor/document for side effects and effectiveness. Provide/serve diet as ordered, honoring resident preferences. Monitor intake and record every meal. RD to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 806	Continued From page 144	F 806		

monitor and follow up per protocol. Weigh per facility protocol. (initiated 6-25-19) No hot liquids for safety.

On 9-17-19 at 5:00 p.m., the DON was again asked for ST notes, and none were supplied. At that time, the facility Administrator and Director of nursing were made aware of findings at the end of day meeting. The facility stated they had no further information to provide.

2. For Resident #54, the facility staff failed to provide lactose free milk

Resident #54 was admitted to the facility on 1/10/19. Diagnoses for Resident #54 included, but were not limited to: complete traumatic amputation at level between knee and ankle, right lower leg, peripheral vascular disease, and type 2 diabetes.

Resident #54's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 7/16/19 was coded as a quarterly assessment. Resident #54 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact.

On 9/15/19 during an interview with Resident #54, the Resident verbalized that he loves milk but is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 806	Continued From page 145	F 806		

lactose intolerant and the facility doesn't provide lactose free milk.

Review of Resident #54's clinical record revealed "diet history/food preferences" dated 1/12/19, 1/17/19, 4/10/19 and 7/10/19.

On 09/16/19 at 01:22 PM, an interview was conducted with Employee G, the Registered Dietitian (RD). She was asked if the facility provides lactose free milk. The RD stated, "I will have to check". The RD returned to the conference room and reported "we do provide lactose free milk" and provided a list of Residents who receive lactose free milk and Resident #54 was not on the list.

On 9/16/19 in the afternoon, this surveyor spoke with Employee D, the dietary manager was interviewed. The dietary manager reported she was unaware of Resident #54's request for lactose free milk. During an interview, the dietary manager stated she meets with residents quarterly to obtain likes/dislikes, etc. However, there was no evidence that she had met with Resident #54 since April 3, 2019.

On 9/17/19 at approximately 8:55 AM the dietary manager was interviewed. The dietary manager reported they were currently out of lactose free milk until the milk delivery, later in the week. The dietary manager was asked to provide a copy of Resident #54's meal ticket, she stated she had not put the request for lactose free milk on there, but would do it now.

On 9/17/19, in the afternoon, the dietary manager was in the conference room being interviewed by Surveyor C and when asked about obtaining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 806	Continued From page 146 items Resident's request, the dietary manager stated, "we can go to the store or go to our sister facility to get items they want, if we don't have it". However, this option was never discussed in regards to the lactose free milk. No further information was provided.	F 806		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed for 1 resident (Resident #28) in the survey sample of 42 residents, to provide meals at scheduled mealtimes.	F 809	F-809 1.) Resident #28 (referred to as #60) currently receiving tray in a timely manner. 2.) Current resident□s diets reviewed to identify those that have the potential to be affected.	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 809	Continued From page 147 The Findings included: For Resident #28, the facility failed to provide meals at scheduled mealtimes. Resident #28 was a 67 year old who was admitted to the facility on 4/12/19. Resident #28's diagnoses included Diabetes Mellitus Type 2, Muscle Weakness, and Hypertension. The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 4/22/19 was reviewed. Resident #28 was coded with a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. He was also coded as requiring set up assistance with meals, and being able to ambulate independently with his wheelchair. On 9/15/19 at 1:40 P.M. an interview was conducted with Resident #28 in his room. His lunch had not been served. He stated that he had been waiting almost two hours for his lunch to arrive. He complained that his food was late on a daily basis. On 9/16/19 at approximately 5:00 P.M., an interview was conducted with the Director of Nursing (DON Employee B). When asked why Resident #28 had to wait almost 2 hours for his lunch to be served, the DON did not answer. She stated that a "Huddle meeting had been conducted with the CNA's about that." She submitted the Meeting Notes. An excerpt read, "9/15/19 at 3 P.M. & 9/16/19 at 3:30 P.M. Passing trays at meal times, Assisting Feeders, Documenting on Amounts Eaten." The document was signed by only 6 CNA's.	F 809	3.) Regional Dietary Manager educated CDM and dietary staff on providing meals at scheduled times. 4.) Regional Dietary Manager and/or designee will audit timely meal delivery all 3 meals to ensure compliance weekly x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to provide special eating utensils for one Resident (Resident #104) in a survey sample of 42 Residents. The findings included: Resident #104 was admitted to the facility on 8/25/14, with a most recent readmission on 10/21/18. Resident #104's diagnoses included but were not limited to: unspecified convulsions, muscle weakness, chronic pain, and type 2 diabetes. Resident #104's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 9/5/19 was coded as an annual assessment. Resident #104 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. The Resident was also coded as requiring extensive assistance of staff with dressing, eating, personal hygiene, bed mobility and toileting. For bathing, Resident #104 was totally dependent upon staff. On 9/16/19 at approximately 9:30 AM, Resident #104 was observed in bed with his breakfast tray	F 810	F-810 1.) Facility Food Service Director obtained weighted fork/adaptive equipment from rehab on 9/16/2019 related to Resident # 104. 2.) Current residents with orders for adaptive eating equipment reviewed to identify those that have the potential to be affected. 3.) All dietary and nursing staff to be re-educated on providing special eating equipment for residents per order. 4.) The Rehab Director and/or designee to audit adaptive equipment provided per order to 5 residents to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 810	Continued From page 149	F 810		

in front of him. It was observed that his meal ticket, which was laying on the tray, read "weighted fork". A standard fork was observed on the tray.

On 9/16/19 at approximately 9:37 AM, RN D, Unit Manager accompanied Surveyor F to the room of Resident #104. The Unit Manager was asked to observe Resident #104's meal tray. She was shown the tray ticket which stated "weighted fork". She was asked if the fork on his tray was weighted, the Unit Manager stated, "I really don't know, it doesn't look weighted to me". The surveyor then walked to the nursing station and observed Employee K, who was a Physical Therapy Assistant (PTA) walking by. Employee K, (PTA) accompanied surveyor F to the room of Resident #104, however, the meal tray had been removed from the room. The PTA and surveyor went to the tray cart in the hall, observed Resident #104's tray and the PTA was asked if the fork was weighted, the PTA stated, "it is not, he has been working with OT [occupational therapy] with feeding with a weighted fork".

On 9/16/19 at 10:13 AM employees L, who was a certified occupational therapy assistant (COTA), and Employee M, who was an occupational therapist registered, (OTR) came to the conference room. Employees L and Employee M were asked about the eating utensils of Resident #104. Employee L, the COTA stated, "we have been working with various things, built up and weighted utensils, they have been providing both so we can see what works best to eliminate his tremors and which he can bring to his mouth the best". Employee M, the OTR stated, "he should have his adaptive equipment at all times".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 810	Continued From page 150	F 810		

Review of the Occupational Therapy Plan of Care for Resident #104 dated 9/12/19 revealed, "reason for referral: nursing has noticed a decrease in self care resulting in decreased safety and an increased need for assistance for feeding self due to significant tremors in UE's [upper extremities]. Therapy necessity: OT therapy is necessary to address decline from supervision after setup of meals. OT is necessary to facilitate return of function to remain PLOF [prior level of functioning] with feeding self. Goals: self feeding: hand to mouth: the patient will effectively utilize AE [adaptive equipment] PRN [as needed] to get food to mouth increasing to stand by assist".

Review of Resident #104's careplan revealed a focus with a revision date of 1/22/19 that read "[Resident #104's name redacted] has the potential for nutrition/hydration imbalance r/t DM2 [related to type 2 diabetes]. Built up fork with breakfast, lunch, and dinner" was listed as interventions with an initiation date of 3/6/18. An intervention of "weighted fork at all meals" was initiated on 4/5/16 and resolved on 4/13/16. An additional intervention of "weighted for with meals" was initiated on 12/26/17 and canceled on 3/20/18.

Review of the facility policy titled "Assistive Eating Devices" with a review date of 5/29/19 read, "it is the policy of this facility to provide assistive eating devices to residents with limited arm mobility, grasp, range of motion or coordination as recommended by nursing or therapy to promote independence in drinking and eating to their maximum ability".

No further information was provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 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, the facility staff failed to effectively wear a hair restraint during meal preparation, and failed to ensure that an unidentified green vegetable was labeled and dated in the refrigerator in one of one kitchens. The Findings included: The facility cook (Employee I) failed to effectively restrain his moustache. And; The facility staff failed to ensure that an unidentified green vegetable was labeled and dated in the refrigerator.	F 812	F-812 1.) Facility Food Service Director removed greens and staff member placed appropriate beard restraint upon notification from surveyor. 2.) Current residents diets reviewed to identify those that have the potential to be affected. 3.) Dietary District manager re-educated facility CDM on food procurement, Store/Prepare/Serve-Sanitary. CDM re-educated dietary staff related to food procurement, Store/Prepare/Serve-Sanitary 4.) The ED and/or designee to audit food procurement, store/prepare/serve-sanitary	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 812	Continued From page 152 On 9/15/19 at 1:00 P.M. a tour was conducted of the facility kitchen. The cook (Employee I) was not wearing his beard restraint over his moustache, which was approximately one-quarter inch long. When asked about the effectiveness of his hair restraint, the cook stated, "I usually wear it this way", indicating that he usually did not restrain the hair on his upper lip. The kitchen Manager (Employee O) was present. He stated, "I have told him many times to cover his moustache." The kitchen refrigerator contained a plastic bowl covered with cellophane. There was no label identifying the item, and no date on the container. The Kitchen Manager described the item as "greens". He stated that the item should have been dated. On 9/15/19 a review was conducted of facility documentation, revealing a Staff Attire policy dated May 2014. An excerpt from it read, "The Food Services Director insures that all staff members have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained." According to the "2017 Food Code" published by the U.S. Public Health Service, FDA U.S. Food & Drug Administration chapter 3, section 3-302.12, pages 73-74 stated: "Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food service establishment, shall be identified with the common name of the food." On 9/17/19 at approximately 11:00 A.M. the	F 812	to ensure compliance on 3 food service observations a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 812	Continued From page 153 Administrator was notified of the findings and he submitted the Staff Attire policy.	F 812		
F 839 SS=E	Staff Qualifications CFR(s): 483.70(f)(1)(2) §483.70(f) Staff qualifications. §483.70(f)(1) The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. §483.70(f)(2) Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility staff failed to obtain verification of licensure for 6 of 6 Registered Dieticians. The Findings included: On 9/16/19 a review was conducted of facility staff, including Registered Dieticians. The facility Staff Coordinator stated that she did not have any employee files on any of the Registered Dieticians who had worked in the facility during the past year. On 9/16/19 at approximately 10:50 A.M., an interview was conducted with the facility Administrator (Employee A). He stated that he did not know how many Registered Dieticians had been employed at the facility during the past year. employee information records on any of the Registered Dieticians who had worked at the facility during the past year. He stated that the	F 839	F-839 1.) All files for Registered Dietitian contractors provided to surveyors upon request. 2.) Current residents having a need for RD assessment/consult reviewed to identify those that have the potential to be affected. 3.) Executive Director to re-educate Regional Registered Dietitian on obtaining licensure/credentials for Registered Dietitians prior to working in facility. 4.) Executive Director or designee to audit records of Registered Dietitians to ensure compliance monthly x 3 months and upon new hire with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 839	Continued From page 154 facility utilized the services of an outside agency to provide Registered Dieticians. On 9/16/19 at 5:50 P.M., the Administrator stated that the employee files "were just received via fax from the agency." He confirmed that the information on the Registered Dieticians had not been documented and on file in the facility prior to hire. The following 6 employee files were submitted for review: Employee P Employee Q Employee R Employee S Employee T Employee G (Current Registered Dietician) According to the facility Administrator, all 6 Registered Dieticians worked at the facility between 4/1/18 - present. He was unable to show documentation of their specific dates of employment, except for Employee U who started on August 12, 2019. On 9/17/19 a second interview was conducted with the facility Administrator. He stated, "We contract with vendors or agencies who verify credentials for their licensed staff. Those records are available upon request, and we get them from the vendors." No further information was received.	F 839		
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 842		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 842	Continued From page 155	F 842		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 842	Continued From page 156 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 clinical record review, and facility record review, the facility staff failed to ensure an accurate clinical record for one Resident (Resident #108) in a survey sample of 42 residents. The findings included; For Resident # 108, the facility staff did not ensure an accurate clinical record. Resident #108 was a 55 year old male admitted to the facility on 3/20/2018, with diagnoses of but not limited to: Gastrostomy, contracture, history of	F 842	F-842 1. Resident #108 was discharged from facility. 2. To identify residents with potential to be affected, Resident Assessment Coordinator and/or designee to audit discharged residents within the last thirty days. 3. Regional Resident Care Coordinator to educate Medical Records regarding timely closure of medical record per policy. 4. Resident Assessment Coordinator to audit records on 5 residents to ensure the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 842	Continued From page 157 traumatic brain injury, tracheostomy, pressure ulcer of sacral region, flaccid hemiplegia, Diabetes, Pneumonia and Hypertension. The most recent Minimum Data Set (MDS) Assessment was a Quarterly assessment with an Assessment Reference Date (ARD) of 6/15/2018. Under Section B 0100, the MDS coded Resident # 108 with being Comatose with Persistent vegetative state. The assessment also coded Resident # 108 as requiring total assistance of two staff persons with activities of daily living; and frequently incontinent of bowel and always incontinent of bladder. Review of the electronic clinical record and paper clinical record was conducted on 9/15/2019 and 9/16/2019. Review of the clinical record revealed the care plan documented the revision date on 1/13/2019. Further review of the care plan revealed statement that the care plan "closed date 1/13/2018" and "Reason for Close: Discharge" However, review of the Nurses Notes revealed that Resident # 108 was discharged from the facility on 6/30/2018 not 1/13/2019. No further information was provided.	F 842	care plan was closed with clinical record 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5. The facility□s alleged date of compliance is 10/21/2019.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the	F 880		10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 880	Continued From page 158 development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 880	Continued From page 159 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility record review, and clinical record review the facility staff failed to handle linen and facility equipment in a manner to prevent the spread of infection for 2 Residents (Resident #104, Resident #31) in a survey sample of 42 Residents. The findings included: 1 For Resident #104 facility staff failed to handle soiled/blood tinged linen in a manner to prevent the spread of infection. Resident #104 was admitted to the facility on 8/25/14, with a most recent readmission on 10/21/18. Resident #104's diagnoses included	F 880	F-880 1.) Resident #104 and 31 have received care with proper infection control protocols. 2.) Current residents requiring use of a mechanical and/or current residents needing assistance with linen changed reviewed to identify those that have the potential to be affected. 3.) DON and/or designee re-educated all nursing staff to be on proper handling of linen and sanitizing mechanical lift/pad after each use. 4.) Director of Nursing and/or designee to audit proper handling of linen and sanitizing mechanical lift/pad and utilizing individual mechanical lift pads to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 880	Continued From page 160 but were not limited to: unspecified convulsions, muscle weakness, chronic pain, and type 2 diabetes. Resident #104's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 9/5/19 was coded as an annual assessment. Resident #104 was coded as having had a BIMS (brief interview for mental status) score of 15, which indicated cognitively intact. The Resident was also coded as requiring extensive assistance of staff with dressing, eating, personal hygiene, bed mobility and toileting. For bathing, Resident #104 was totally dependent upon staff. 09/16/19 08:44 AM CNA A was observed in the room of Resident #104 changing the bed linen. CNA A stated, "I spilled water when taking in his breakfast tray, so I've got to change the linen". CNA A was observed to place the soiled linen, which had blood on it, on the floor. When asked if usually put linen on the floor, CNA A said "no, I didn't have another bag and was trying to empty one". "I know its wrong and I'm sorry". CNA A was asked why would you not want to put linen on the floor "the floor is very dirty and the linen has blood on it so it is going to contaminate the floor," which then could be tracked into other Resident rooms. Review of the facility policy titled "Infection Control Practices for Laundry/Linens" with a review date of 10/25/2018 read, "The safety of residents, staff and visitors will be primary consideration. b. Consider all soiled linen contaminated and treat and handle as such". The DON indicated that the facility uses	F 880	compliance for 3 licensed nursing staff weekly x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 880	Continued From page 161 Lippincott as their nursing standard of practice. Lippincott Manual of Nursing Practice, eighth edition, read on page 1032, "standard of care for standard precautions, all items soiled with blood or bloody body fluids are placed in bags that prevent leakage". No further information was provided. 2. For Resident #31, the facility staff failed to clean the mechanical lift and pad between use according to manufacturer's instructions on 09/16/2019. Resident #31, a 72-year old male, was admitted to the facility on 02/09/2019. Diagnoses included but not limited to dementia, dysphagia, and diabetes. Resident #31's most recent Minimum Data Set with an Assessment Reference Date of 07/15/2019 was coded as a quarterly assessment. Functional status for eating was coded as requiring a one-person physical assist and supervision (oversight, encouragement, or cueing) during meals. Functional status for bed mobility was coded as requiring extensive assistance from staff. Transferring between surfaces was coded as requiring limited assistance from staff. Walking in room was coded as requiring supervision (oversight, encouragement, or cueing) from staff. Mobility devices selected were walker and wheelchair. On 09/16/2019 at 4:52 PM, Certified Nursing	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 880	Continued From page 162	F 880		

Assistant H (CNA H), CNA I, and this surveyor entered the room of Resident #92 with the mechanical lift. CNA H and CNA I placed the pad (sling) under Resident #92 and attached the sling to the lift. CNA H weighed the resident. CNA H lowered Resident #92 back to the bed and they removed the pad (sling) from under Resident #92 and draped it over the handle bar of the mechanical lift.

After completing care for Resident #92, CNA H, CNA I, and this surveyor entered the room of Resident #31 with the mechanical lift. CNA H and CNA I removed the sling (pad) from the handle bar of the mechanical lift and placed it under Resident #31. CNA H began to raise Resident #31 in the lift.

After completing care for Resident #31 and exiting the room, CNA H and CNA I were asked if the same sling was normally used between residents. CNA H stated residents don't have their own pad. CNA I stated she didn't think the pad didn't fit correctly for [Resident #31] but it was the only one she could find. When asked if it should be cleaned between residents, CNA H stated that they didn't clean it and "We don't normally do weights, restorative does it."

On 09/17/2019 at 10:44 AM, the DON was notified. The DON stated they should not have used the same pad between residents because "It's an infection control issue."

The facility staff provided their policy entitled, "Mechanical Lifts and Transfer." The last sentence under the header entitled, "Policy" documented, "Follow manufacturer's recommendations for specific mechanical lift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 880	Continued From page 163 equipment." The facility staff provided the manufacturer's instructions for the mechanical lift. Under the header entitled, "Lift Cleaning and Care", it was documented, "Note: The lift and sling should be cleaned between use of different patients and/or when suspected to be contaminated." On 09/17/2019 at approximately 7:00 PM, the administrator and DON had no further information or documentation to offer.	F 880		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, facility documentation review, and clinical record review the facility staff failed to provide a functioning call bell system for 2 Resident's (Resident #30 and Resident #87) in a survey sample of 42 Residents. The findings included: 1. For Resident #30, the facility staff failed to ensure an operating call bell. Resident #30's most recent re-admission to the	F 919	F-919 1.) Resident #30 and 87 call bells are currently operational. 2.) Current residents have the potential to be affected. 3.) Divisional Facilities Manager re-trained Maintenance Director to ensure call bells/resident beds are operational and in working order. DON and/or designee trained all facility staff on timely work orders/requests. 4.) Maintenance Director and/or designee to audit call bell system/devices in 5	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 919	Continued From page 164 facility was on 2/12/19. The Resident's diagnoses included but were not limited to: end stage renal disease and hyperlipidemia. Resident #30's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 7/17/19 was coded as a quarterly assessment. Resident #30 was not assessed for cognitive functioning on this assessment. Resident #30 was coded as being independent with dressing, eating and bathing. He was also coded as having had required supervision of one staff person for transfers, toileting and personal hygiene. On 9/15/19 at 12:50 PM, during an interview with Resident #30, the Resident stated this his call bell did not work. He pushed the button and this writer confirmed that it did not work. On 9/16/19 at 5:03 PM, Employee F, the maintenance director accompanied this writer to the room of Resident #30. Employee F was asked to use the call bell and he stated "oh that's a dual call bell, I'm not sure why they put that on there. It's over here on the floor" [indicating on the opposite side of the bed] and picked up another call bell cord out of the floor and engaged it. That call bell did work. When Employee F was asked how Resident #30 would have known to not use one and to use the other, he stated "I will take it out". On 9/16/19 a request for all maintenance work orders involving Resident #30's room was requested. This revealed that on 7/1/19 a maintenance work order had been entered into the TELS system and was completed 7/1/19 with the following comments: "replaced station and B	F 919	resident rooms to ensure compliance 3x a week x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 919	Continued From page 165	F 919		

bed cord". This indicated that since 7/1/19 Resident #30 had been attempting to use a call bell that was not functioning and was unaware of a second call bell that had to used to call for staff assistance.

During an interview with the maintenance director on 9/16/19, the maintenance director stated he checks the call bells in 5 rooms each month. Logs of the audits were obtained, from January-August 2019, and revealed that the room of Resident #30 had not been checked in that time frame.

Review of the facility policy titled "maintenance work request system" it read, "corrective maintenance can be defined as those actions required to restore equipment, buildings and grounds to normal condition and operation. The department director will assign work requests to personnel and daily review completed work orders for completeness and correctness of repairs and/or the need for purchases or outside assistance".

The Administrator and Director of Nursing were made aware of the facility staff's failure to ensure an operating call bell during an end of day meeting on 9/17/19 at 5:31 PM.

No further information was provided.

2. For Resident #87, the facility staff failed to ensure an operating call bell.

Resident #87 was admitted to the facility on 1/14/16. Diagnoses for Resident #87 included but were not limited to: hyperlipidemia, anxiety,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 919	Continued From page 166 depression and huntingtons. Resident #87's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 8/29/19 was coded as a significant change assessment. Resident #87 was coded as having a BIMS (brief interview for mental status) score of 7, which indicated severe cognitive impairment. Resident #87 was also coded as having required the extensive assistance of 2 staff members for transfers and dressing. Resident #87 required the extensive assistance of 1 staff member for eating, toileting and personal hygiene. On 9/17/19 at approximately 3:50 PM, during environmental rounds, it was revealed that the call bell for Resident #87 was not working. On 9/17/19 at 4:39 PM, the maintenance director accompanied this writer to the room of Resident #87. He was asked to engage the call bell. The maintenance director was asked, if the call light came on and he stated, "no, it didn't come on the cord needs to be replaced, when I unplugged it, it came on". During an interview with the maintenance director on 9/16/19, the maintenance director stated he checks the call bells in 5 rooms each month. Logs of the audits were obtained, from January-August 2019, and revealed that call bell for Resident #87 was checked on 3/30/19. Additional documentation was received which indicated the call bell for Resident #87 was replaced 8/14/19. Review of the facility policy titled "maintenance work request system" it read, "corrective	F 919		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 919	Continued From page 167 maintenance can be defined as those actions required to restore equipment, buildings and grounds to normal condition and operation. The department director will assign work requests to personnel and daily review completed work orders for completeness and correctness of repairs and/or the need for purchases or outside assistance". The Administrator and Director of Nursing were made aware of the facility staff's failure to ensure an operating call bell during an end of day meeting on 9/17/19 at 5:31 PM. No further information was provided.	F 919		
F 920 SS=E	Requirements for Dining and Activity Rooms CFR(s): 483.90(h)(1)-(4) §483.90(h) Dining and Resident Activities The facility must provide one or more rooms designated for resident dining and activities. These rooms must-- §483.90(h)(1) Be well lighted; §483.90(h)(2) Be well ventilated; §483.90(h)(3) Be adequately furnished; and §483.90(h)(4) Have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed, for 1 resident (Resident #28), in the survey sample of 42 residents, to provide access to a dining room	F 920	F-920 1.) Resident #28 (reported as #60) educated that main dining room currently open during all meals including weekends.	10/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 920	Continued From page 168 for his meals. The Findings included: For Resident #28, the facility staff failed to provide access to a dining room for his meals, confining him to his room. Resident #28 was a 67 year old who was admitted to the facility on 4/12/19. Resident #28's diagnoses included Diabetes Mellitus Type 2, Muscle Weakness, and Hypertension. The Minimum Data Set, which was an Admission Assessment with an Assessment Reference Date of 4/22/19 was reviewed. Resident #28 was coded with a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. He was also coded as requiring set up assistance with meals, and being able to ambulate independently with his wheelchair. On 9/15/19 at 12:45 P.M. a tour was conducted of the facility. There were no residents in the dining room, or the activity room. A Certified Nursing Assistant (CNA M) was asked why the residents weren't eating in the dining room, or the activity room. She stated, "The dining and activity rooms are closed. They are closed for breakfast, lunch and dinner on the weekends due to a staff shortage." When asked how long had the rooms been closed, CNA M stated that the rooms were closed on weekends for several months. She stated that during the week, residents who did not require feeding assistance ate in the dining room, and those who required feeding assistance ate in the activity room. On 9/15/19 at 1:40 P.M. an interview was	F 920	2.) Current residents who wish to attend meals in main dining room reviewed to identify those that have the potential to be affected. 3.) DON re-educated all staff on providing access for residents to common dining area for all meals. 4.) DON and/or designee to audit dining area access for all residents for 5 meals to ensure compliance weekly x 3 weeks then monthly x 3 months with results presented to QAPI Committee for review and recommendations. 5.) The facility□s alleged date of compliance is 10/21/2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495252	A. BUILDING _____ B. WING _____	C 09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BATTLEFIELD PARK HEALTHCARE CENTER	250 FLANK ROAD PETERSBURG, VA 23805

(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 920	Continued From page 169 conducted with Resident #28 in his room. He stated that he wanted to be allowed to eat with his neighbors in the dining room. He stated that he did not want to eat in his bedroom. He further stated that the dining room was closed all day on weekends. On 9/16/19 at approximately 5:00 P.M., an interview was conducted with the Director of Nursing (DON Employee B). When asked why Resident #28 was unable to eat in the dining room, the DON did not answer. She stated that a "Huddle meeting had been conducted with the CNA's about that." She submitted the Meeting Notes. An excerpt read, "9/15/19 at 3 P.M. & 9/16/19 at 3:30 P.M. Passing trays at meal times, Assisting Feeders, Documenting on Amounts Eaten." The document was signed by only 6 CNA's, and did not address ensuring the dining room and activity room would be used as appropriate.	F 920		