PRINTED: 09/04/2018 **FORM APPROVED** OMB NO 0938-0391

CHITTEIN	S FUR WIEDICARE &	MEDICAID SERVICES			T TO THE TOTAL BOOK
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495131	B. WING		C 08/24/2018
	ROVIDER OR SUPPLIER		2/	TREET ADDRESS, CITY, STATE, ZIP CODE 45 NORTH STREET RISTOL, VA 24201	V012-412010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
E 000	survey was conducte 08/24/18. The facility compliance with 42 C Requirement for Lon-	was in substantial CFR Part 483.73, g-Term Care Facilities.		This Plan of Correction is submitted a required under State and Federal Law submission of this plan does not consadmission on the part of NHC Health Bristol as to the accuracy of the Survifindings nor the conclusions drawn the facility's submission of the Plan of Correction does not constitute a deficit that the scope and severity regarding the deficiencies cited are correctly approximately.	w. The stitute an Care, eyors' herefrom. of ciency, or
F 580 SS=E	and Complaint surve through 08/24/18. Or investigated during the required for compliant Federal Long Term Covirginia Rules and Rof Nursing Facilities, survey/report will follow the census in this 107 at the time of the sample consisted of and 4 closed record Notify of Changes (In CFR(s): 483.10(g)(1) §483.10(g)(14) Notifi (i) A facility must immore consistent with his consult with the resiconsistent with his consult with the resiconsistent with his consult with the resiconsistent with his consults in injury and physician interventic (B) A significant charmental, or psychosodeterioration in heal	ne survey. Corrections are now with 42 CFR Part 483 care requirements and egulations for the Licensure. The Life Safety Code ow.  20 certified bed facility was a survey. The final survey. 19 current resident reviews reviews. Injury/Decline/Room, etc.) (i)-(iv)(15)  lication of Changes. Indicately inform the resident; dent's physician; and notify, or her authority, the resident there issisting the resident which has the potential for requiring	F 580	F-580 (E) – Notify of Changes  1. Corrective Actions Accomplished For Th Residents Found To Have Been Affected E Allegedly Deficient Practice.  Resident #43 had no negative outcome as of this deficiency. The identified nurses refor not notifying the physician of blood suggreater than 400 were in-serviced on the policy and procedure for insulin administra facility's sliding scale protocol. Completed 9/13/18  2. How We Have Identified Other Resident The Potential To Be Affected By The Same And What Corrective Action Has Been Tak All diabetic residents with orders for the sliscale protocol have the potential to be affethe same deficient practice. All current res 9/12/18 with the sliding scale protocol were reviewed by the DON, ADON, and Resider Coordinators to identify incidents that the scale protocol was not followed according facility policy. One other resident was ider with no adverse affects. Physician was no 9/1/18. Licensed Nurses involved will be re-educated on proper policy and proceduinsulin administration and facility's sliding sprotocol. Completed: 9/13/18.	a result sponsible ars roper tion and d by:  Is Having e Practice cen.  Iding cited by sidents on e ent Care sliding to the ntified stiffied re for

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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SEP 14 2018
VDH/OLC

TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495131	B, WING			- 60	24/2018
	ROVIDER OR SUPPLIER		·I	24	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	86	(XS) COMPLETION DATE
F 580	(C) A need to alter the a need to discontinual treatment due to advice commence a new for (D) A decision to train resident from the fact §483.15(c)(1)(ii).  (ii) When making not (14)(i) of this section all pertinent informat is available and proving physician.  (iii) The facility must resident and the resimble when there is (A) A change in room as specified in §483.  (B) A change in regulatification (e)(10) of this section (iv) The facility must update the address phone number of the representative(s).  §483.10(g)(15)  Admission to a community that is a composite §483.5) must disclose its physical configurations that composite §483.5 must disclose its physical configurations that composite §483.15(c)(9).	eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or insert or discharge the ellity as specified in iffication under paragraph (g), the facility must ensure that ion specified in §483.15(c)(2) ided upon request to the elitor also promptly notify the dent representative, if any, an or roommate assignment 10(e)(6); or dent rights under Federal or one as specified in paragraph in.  The record and periodically (mailing and email) and eresident elitor part (as defined in se in its admission agreement ation, including the various rise the composite distinct ify the policies that apply to een its different locations		580	3. The Measures we Have Put In Fand Systematic Changes We Have To Ensure That The Practice Does Recur.  All Licensed Nurses will be re-educed on the facility policy for safe medical administration, including the proper procedure for the facility's sliding superfocol and physician notification. Partner unavailable or on leave will in-serviced prior to their next shift to be completed by: 10/11/18  4. The Corrective Actions Will Be Monitored To Ensure the Practice Recur.  Beginning 9/17/18, the DON or dewill perform a monthly QA study x months of all patient blood sugars 400 to ensure the proper policy an procedure for insulin administration facility's sliding scale protocol have followed. Results will be reported to QA committee. The Center's Quanch Assurance Committee consists of Administrator, Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director Health Information Director and monthly. Additional in-services and monitoring will be determined as necessary by the Quality Assurance Committee. To be completed by: 10/11/18	e Made s Not  cated cation or cale Any Il be worked.  Will Not  signee 3 over d n and e been to the lity the  and eets d/or	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495131	B. WING			08/	24/2018
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  245 NORTH STREET  BRISTOL, VA 24201				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	admitted to the facili included, but were n Diabetes Mellitus, A of shoulder joint pro Status, History of Fa Hypotension, and M (Generalized). Section C (cognitive quarterly MDS (mini with an ARD (asses 07/12/18 included a mental status) summossible 15 points.  The Residents CCP included the problem the diagnosis DM (concluded the diagnosis	Review Resident #43 was ty on 01/23/18. Diagnosis ot limited to: Chronic, Pain, ftercare following explanation sthesis, Altered Mental alling, Orthostatic luscle Weakness  patterns) of the Residents mum data set) assessment sment reference date) of BIMS (brief interview for mary score of 15 out of a  comprehensive care plan) marea; Diabetes related to diabetes mellitus). ed, but were not limited to: sordered, Rotate sites, lered, Observe for increased/decreased BS  ent POS (physician order orders for sliding scale insulin t bedtime if greater than 400 and call MD. Humalog Kwik sof 0-150 0 units, 151-200 2 dits, 251-300 6 units, 301-350 8 ent #43 EMARs (electronic stration records) for 08/2018 dit2 at 8:00p.m. the Residents	i.	580	This page intentionally left blan	ık.	

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100		CONSTRUCTION	(X3) DATE S COMPL	ETED
		495131	B. WING			1	4/2018
	ROVIDER OR SUPPLIER			24	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	08/14 at 4:30 p.m. th 415, and 08/15 the R 496. There was no of that the MD had been 08/23/18 09:22 a.m. no Nursing notes or to indicate the Physic No further information	nts BS reading was 433, e Residents BS reading was desidents BS reading was documentation to indicate in notified.  the record review revealed Physician notes were found cian was notified per order.  In regarding this issue was ey team prior to the exit		580	F-641 (D) – Accuracy of Assessments 1. Corrective Actions Accomplished For The Residents Found To Have Been Affected in Allegedly Deficient Practice.  Resident #73 had no negative out come as of this deficiency. The identified inaccurate Minimum Date Set (MDS) assessment of 6 for Resident #73 was updated and correct Completed on: 8/24/18	By The s a result e 8/5/18	
SS=D	S483.20(g) Accuracy The assessment mu resident's status. This REQUIREMEN by: Based on staff inter review it was determ failed to ensure a co Minimum Data Set ( Residents in the sar The Findings Includ For Resident #73 th code/capture the us Medicare Minimum with an Assessmen 8/5/18. Resident #73 was a admitted on 7/21/18	y of Assessments. st accurately reflect the T is not met as evidenced view and clinical record hined that the facility staff omplete and accurate MDS) assessment for 1 of 24 hiple survey, Resident #73.			2. How We Have Identified Other Residen Having The Potential To Be Affected By The Practice And What Corrective Action Has Taken.  All residents have the potential to be affect the same deficient practice. All residents physician orders for oxygen had Section CMDS assessment reviewed for accuracy 69/13/18. Two other residents were identifitheir MDS assessments were corrected. Completed on: 9/13/18.  3. The Measures we Have Put In Place are Systematic Changes We Have Made To EThat The Practice Does Not Recur.  MDS Department will be re-educated to renurses' notes prior to completing assessmensure assessments are accurate and references.	ted by that have of the on ied and ied	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495131	B. WING			1	24/2018
	ROVIDER OR SUPPLIER	J		24	REET ADDRESS, CITY, STATE, ZIP CODE IS NORTH STREET RISTOL, VA 24201	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X6) COMPLETION DATE
F 641	history of falling, chrodisease, Alzheimer's with behaviors.  The most current Mir assessment located 14-Day MDS assess Reference Date (ARI coded that Resident memory impalrment (3) with daily decisio of Daily Living (ADL' coded that Resident assistance (3/3) with Special Treatments a staff did not code the oxygen.  On August 24, 2018 reviewed Resident # of the clinical record Notes" dated 8/3/18 that Resident #73 w.  On August 24, 2018 notified two Register the MDS Nurse's, the ARD of 8/5/18 with two R surveyor pointed ou Treatments did not oxygen use. The surveyor and two Skilled Nurse's Notes with the Skilled	nic obstructive pulmonary, hypertension and dementia himum Data Set (MDS) in the clinical record was a ment with an Assessment D) of 8/5/18. The facility staff #73 had short and long-term and was severely impaired in making regarding Activities is). The facility staff also #73 required extensive ADL's. In Section O. and Programs, the facility at Resident #73 was receiving at 11:15 a.m., the surveyor it?3's clinical record. Review produced Skilled Nurse's and 8/5/18 that documented	F	641	F-641  4. The Corrective Actions Will Be Monitored To Ensure the Practice Not Recur.  Beginning 9/17/18, the Regional Consultant or designee will performently QA study x 2 months of a patients receiving respiratory servensure Section O of the MDS assessments are accurate for the services provided. Results will be reported to the QA committee. To Center's Quality Assurance Commictonsists of the Administrator, Director, Housekeeping & Laundt Director, Housekeeping & Laundt Director and Health Information Director and Health Information In and meets monthly. Additional in-services and/or monitoring will determined as necessary by the CAssurance Committee.  To be completed by: 10/11/18	e Will  m a all vices to  he mittee ector of vice ry Director be	

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STATEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND FEMILOP	ANTINEO HOIS		A. BUILDII				
		495131	B. WING			08/2	24/2018
	ROVIDER OR SUPPLIER LTHCARE, BRISTOL			24	REET ADDRESS, CITY, STATE, ZIP CODE  5 NORTH STREET  RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X6) COMPLETION DATE
F 641	notified the Administr Nursing (DON) and A (ADON) that Resider 8/5/18 was incorrect Administrative Team not coded/captured in in Section O.  No additional inform exiting the facility as to ensure and complassessment for Resifalled to code/capture	at 11:45 a.m., the surveyor rator (ADM), Director of Assistant Director of Nursing at #73's MDS with the ARD of The surveyor notified the (AT) that the facility staff had Resident #73's use of oxygen atlon was provided prior to to why the facility staff failed lete and accurate MDS ident #73. The facility staff er the use of oxygen on a	F	641	F-676 (D) – Activities of Daily Living 1. Corrective Actions Accomplished For Th Residents Found To Have Been Affected B Allegedly Deficient Practice.  Resident #34 had no negative outcome as of this deficiency. Resident #34 received o as requested on 8/22/18. Nurse Aide was re-educated on proper oral care by the Sup Completed on: 8/22/18 The ADL documentation for Resident #34 t in error on 8/22/18 was corrected by a late	a result ral care pervisor.	
F 676 SS=D	Activities Daily Livin	sment with the ARD of 8/5/18, g (ADLs)/Mntn Abilities )(b)(1)-(5)(i)-(iii)	F	676	nurses note. Completed 9/13/18.  2. How We Have Identified Other Resident The Potential To Be Affected By The Same Practice And What Corrective Action Has E	•	
	assessment of a res resident's needs and provide the necessal ensure that a reside daily living do not di of the individual's cl	n the comprehensive sident and consistent with the d choices, the facility must ary care and services to ent's abilities in activities of minish unless circumstances inical condition demonstrate in was unavoidable. This ensuring that:			Taken.  All residents have the potential to be affect the same deficient practice. Beginning 9/17 DON and Nurse Supervisors will interview do mouth care observations of patients to mouth care is being completed appropriate  3. The Measures we Have Put In Place as Systematic Changes We Have Made To E That The Practice Does Not Recur.	7/18, and/or ensure ely.	
	treatment and servi	ident is given the appropriate ces to maintain or improve his y out the activities of daily se specified in paragraph (b)			All Nurse Aides will be re-educated by DOI designee on the facility policy and expecta providing the necessary care and services residents regarding oral care. Any Partner unavailable or on leave will be in-serviced their next shift worked. To be completed by 10/11/18	tion of for prior to	AND
	§483.24(b) Activitie The facility must pr accordance with pa activities of dally liv	ovide care and services in tragraph (a) for the following	40000000				THE STATE OF THE S

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495131	B, WING_			08/2	24/2018
	ROVIDER OR SUPPLIER			24	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676	Continued From page	ge 6	F	376	Continued from previous pa	ige.	
	§483.24(b)(1) Hygie grooming, and oral	ene -bathing, dressing, care,			F 676		
	§483.24(b)(2) Mobil including walking, §483.24(b)(3) Elimi	ity-transfer and ambulation, nation-toileting,			4. The Corrective Actions Washington Be Monitored To Ensure the Practice Will Not Recur.	- 1	
	§483.24(b)(4) Dinin snacks,	g-eating, including meals and munication, including	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Beginning 9/17/18, the DON designee will perform a mor QA study x 3 months consist of patient interviews regarding staff assistance with providi	nthly sting ing	170
	(iii) Other functiona This REQUIREMEN by: Based on observatinterview, and clinic staff failed to provic residents (Residen The findings includ The facility staff fail Resident #34 on 8/ The clinical record 8/21/18 through 8/ admitted to the fact that included but no dependence on su hypertensive chror long term use of as disorder, gastro-es	ed: led to provide oral care to		A description of the second of	necessary oral care. Resulvill be reported monthly to the QA committee. The Center Quality Assurance Committee Consists of the Administrate Director of Nursing, Medica Director, QA Physicians, Dietician, Social Service Director, Housekeeping & Laundry Director and Health Information Director and monthly. Additional in-service and/or monitoring will be determined as necessary be Quality Assurance Committed To be completed by: 10/11	the tr's tee tor, th teets ces y the tee.	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB	<u>10. 0938-0391</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			TE SURVEY MPLETED
			H, 004.01110			С
		495131	B, WING		0	8/24/2018
NAME OF P	ROVIDER OR SUPPLIER	-	STF	REET ADDRESS, CITY, STATE, ZIP COL	DE	
NUC UEA	LTHCARE,BRISTOL			NORTH STREET		
NIC NEA	LI HOARE, BRIGIOL		BR	RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X6) COMPLETION DATE
	Continued From pag Resident #34's quark (MDS) with an asses of 7/5/18 coded the interview for mental out of a possible 15. coded the resident in of 2 plus persons for hair, brushing teeth, washing/drying face required extensive at Resident #34's curre updated 7/16/18 inc (activities of dalty liv vision, generalized interventions: Assis need and preference The surveyor intervi 8/22/18 at 2:21 p.m. surveyor asked the received a shower. showers two times asked how often sh Resident #34 state bath days-two times seated beside the in #34 was lying in be enough to the resid was not pleasant.	terly minimum data set sement reference date (ARD) resident with a BIMS (brief status) Summary Score of 14 Section G Functional Status seeded extensive assistance repersonal hygiene (combing shaving, applying make-up, and hands). Bathing sesistance of one person.  Sent comprehensive care plan luded the care area for ADL ing) related to impaired muscle weakness.			)	

and the unit manager that she only gets her teeth brushed on bath days. The unit manager

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STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A, BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495131	B. WING			_	4/2018
170	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 245 NORTH STREET BRISTOL, VA 24201		NORTH STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 676 F 684 SS=D	registered nurse #1 sissue with the staff.  The surveyor and the nurse #1 reviewed the #34. The question "The box was marked a.m.  The surveyor information of the above a.m. and requested (activities of daily living sheet for 8/22/18 at nursing assistant har provided which it has stated the unit mana CNAs and the ADON nursing assistants to The surveyor information of nursing, and the register above concern during above concern during the wit conference on 8/23/18 at 4:01 pink of the without the provided which it has stated the unit mana CNAs and the ADON nursing assistants to The surveyor information 8/23/18 at 4:01 pink of the without the provided which it has stated the unit mana CNAs and the ADON nursing assistants to The surveyor information 8/23/18 at 4:01 pink of the without the provided which it has stated the unit mana CNAs and the ADON nursing assistants to The surveyor information 8/23/18 at 4:01 pink of the surveyor information 8/23/18 at 4:01	e unit manager registered be "Results List" for Resident Was oral care completed? I yes for 8/22/18 at 11:07  ed the assistant director of concern on 8/23/18 at 9:18 the August 2018 ADL ng) sheets. On the ADL 11:07 a.m., the certified d charted oral care was d not been. The ADON nger was in-servicing the N expected the certified o provide oral care.  ed the administrator, the he assistant director of ional nurse consultant of the ng the end of the day meeting .m.  on was provided prior to the 1/24/18.		676	This section intentionally left blank.  F-684 (D) – Quality of Care 1. Corrective Actions Accomplished Residents Found To Have Been Affe The Allegedly Deficient Practice.  When identified, staff replaced the o tank for Resident #73 on 8/21/18. T identified nurses responsible for not following physician orders when the	ected By xygen he	
	Quality of care is a tapplies to all treatm facility residents. Be assessment of a retthat residents received.	fundamental principle that ent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of			was asleep will be re-educated by R Care Coordinators on the proper pol procedure for medication and treatm administration on or before 9/25/18.	esident icy and ient	And the state of t

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495131	B. WING			1	4/2018
	ROVIDER OR SUPPLIER			24	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA. 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFIGIENCY)		(X6) COMPLETION DATE
F 684	practice, the comprei care plan, and the recare plan, and the receive it was determined to follow physic Residents in the same and Resident #393.  The Findings Included 1. For Resident #73 administer oxygen at to administer oxygen at to administer oxygen at to administer oxygen at admitted on 7/21/18, included, but were not history of falling, chridisease, Alzhelmer's with behaviors.  The most current Minessessment located 14-Day MDS assess Reference Date (AR coded that Resident (3) with daily decision of Daily Living (ADL coded that Resident assistance (3/3) with On August 21, 2018 observed Resident Geri-chair in the din Geri-chair in the din	nensive person-centered sidents' choices.  F is not met as evidenced riew and clinical record fined that the facility staff sian orders for 2 of 24 pple survey, Resident #73  Ind:  Ithe facility staff falled to the facility staff diagnoses of the facility diagnoses of the facility diagnoses of the facility the facility staff the clinical record was a sement with an Assessment to the clinical record was a sement with an Assessment the facility staff the facility staff also the	F	684	Continued from previous page.  F-684  2. How We Have Identified Other Residents The Potential To Be Affected By The Same I And What Corrective Action Has Been Take All residents have the potential to be affected deficient practice. All residents oxygen tank checked on 8/21/18. No other residents was affected. All in-house residents on 9/11/18 or reviewed for any pain medications not given the patient was asleep. No other residents widentified.  3. The Measures we Have Put In Place and Systematic Changes We Have Made To Entitle The Practice Does Not Recur.  All nursing staff will be re-educated by the D designee on the importance of checking oxy tank levels routinely and to replace as needed be completed by 10/11/18.  All licensed nursing staff will be re-educated DON or designee on the facility expectation proper procedure for the following physician Any Partner unavailable or on leave will be in-serviced prior to their next shift worked. To completed by: 10/11/18  4. The Corrective Actions Will Be Monitored Ensure the Practice Will Not Recur.  Beginning 9/17/18, the DON or designee will perform a monthly QA study x 2 months to exygen tanks are not empty and that resider respiratory related orders are being followed ordered by the Physician. Results will be remonthly to the QA committee. The Center' Assurance Committee consists of the Admir Director of Nursing, Medical Director, QA Physicians, Dietician, Social Service Director Housekeeping & Laundry Director and Heat Information Director and meets monthly. Ad in-services and/or monitoring will be determ necessary by the Quality Assurance Commit To be completed by: 10/11/18	Practice n.  d by the s were were when were when were  ON or gen ed. To by the and orders.  To be  To  Il ensure nts with d as ported s Quality nistrator, or, th dittional ined as	

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Event ID: VAIK11

Facility ID: VA0171

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PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
AND FLAN OF	CONTECTION	PACIFIC INCIDENTALISM AND ADDRESS OF THE PACIFIC	A. BUILDING			С
		495131	B. WING			/24/2018
	ROVIDER OR SUPPLIER		245	REET ADDRESS, CITY, STATE, ZIP CODE I NORTH STREET IISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	on the back of her will oxygen in the tank with oxygen tank was surveyor asked Resicannula for the surveyor asked in asal cannula from the light her hand in from the light her hand in from the surveyor alerted was a Registered Nuwas not getting any to get a tank of oxyg Assistant (C.N.A.) ca #73's oxygen satural O2 Sat was 83%.  On August 21, 2018 observed Resident #was setting up Resident #vas setting up Resident #rasis of the clinical record orders dated 7/21/11 included, but where "lpratropium-albuter base)/3 MI Neb (net BROMIDE/ALBUTE (ampule) nebulizatic supply no refill. Diva capsule (DIVALPRO	neelchair. The dial for as in the red, reflecting that low on oxygen. The dent #73 remove her nasal eyor to determine if oxygen Resident #73 removed the ner nose and the surveyor at of the nasal cannula and nen coming from the tank. If the Unit Manager (UM), who arse (RN), that Resident #73 oxygen. The UM (RN) went en and a Certified Nursing ame and obtained Resident #73's at 6:25 p.m., the surveyor fr3 in the day room. A C.N.A. dent #73's supper tray. The C.N.A. if Resident #73's O2 ed. The C.N.A. replied that eat had been repeated and at 1:05 p.m., the surveyor fr3's clinical record. Review produced signed physician 8. Signed physician orders	F 684	This page intentionally left blank	k.	

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					VO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	TOTAL TOTAL TOTAL OF THE PARTY			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495131	B. WING				C 08/24/2018
	PROVIDER OR SUPPLIER			245	BET ADDRESS, CITY, STATE, ZIP CODE NORTH STREET ISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
F 684	BREATH **4 L (liter needed as tolerated Continued review of Resident #73's Aug Administration Reconsideration Reconsideration Reconsideration Reconsideration Reconsideration Resident #73's Divalproex 12 at 2 a.m., The facility Resident #73 was a Further review of the documented that the not administered or The facility staff documented that the not administered or The facility staff documented that the surveyor observation of the property of the surveyor of the technologies and that the resident #73's Dejat 2 a.m., and that not given on 8/05/1 notified the LPN the documented that the Resident #73 was reviewed Resident #73 was reviewed Resident LPN. The surveyor orders did not give the medications. The August 2018 MAR informed the LPN	s) NC (nasal cannula) *** as I." (slc) If the clinical record revealed ust 2018 Medication ords (MAR's). The Is documented that Resident Is mg was not given on 8/2/18 by staff documented that	F 68	84	This page intentionally left blank.		

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stated, "I see that now."

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		(X3) DATE SURVEY COMPLETED		
		495131	495131 B. WING			08/	24/2018
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, BRISTOL				24	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	notified the Adminis Nursing (DON), Ass (ADON) and Assists that the facility staff orders for Resident the Administrative I had not administer ordered by the phys notified the AT that administered the pl and Ipratropium-All the AT that the facil Resident #73 was the AT that the facil hold/not administer  No additional Inform exiting the facility at to follow physician oxygen and medica 2. For Resident #3 administer the Res Lisinopril as ordere was for one time p administer medica  The record review had been admitted Diagnosis included Aftercare following Presence of Right (current) anticoagu (generalized), Ess and Type 2 dlabet complications.	at 3:53 p.m., the surveyor strator (ADM), Director of sistant Director of Nursing ant Regional Manager (ARM) had not followed physician #73. The surveyor notified feam (AT) that the facility staff ad Resident #73's oxygen as sician. The surveyor also the facility staff had held/not hysician ordered Divalproex buterol. The surveyor notified lity staff documented that asleep. The surveyor notified lity staff did not have orders to the medications.  The medications.  The surveyor notified lity staff failed orders for the administration of atlons for Resident #73.  33 the facility staff failed to sidents hypertensive medication ad by the Physician. The order er day and the facility failed to tion on 08/12/18 at 8:00 A.M.  The revealed that Resident #393 to the facility 08/06/18. In but were not limited to, a joint replacement surgery, artificial knee joint, Long term ulants, Muscle weakness ential (primary) hypertension, es mellitus without	F	684	This page intentionally left blank.		
	Resident's admiss	sion MDS (minimum data set) allable due to the Resident			I		

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CENTERS FOR WEDICARE &	WEDICAID SEITHISES		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
			C

B. WING

08/24/2018

NAME OF PROVIDER OR SUPPLIER

495131

STREET ADDRESS, CITY, STATE, ZIP CODE

NHC HEALTHCARE,BRISTOL			245 NORTH STREET BRISTOL, VA 24201				
(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 684	Continued From page 13	F 684	This section intentionally left blank.				
	being a new admission.						
	Resident #393 current POS (physician order						
	summary) included orders for Lisinopril 10mg tablet (LISINOPRIL) 1 tablet by mouth 1 time per						
	day DX (diagnosis): HYPERTENSION with an			i			
	order date 08/06/18.						
	A review of Resident #393 EMARs (electronic						
	medication administration records) for 08/2018						
	revealed that Lisinopril was not administered on						
	08/12/18 at 8:00 A.M. The EMAR was coded with						
	an "X" on 08/12/18 at 8:00 A.M. The "X" indicating medication not given due to "Special	1					
	Requirement Parameters".						
	Requirement diameters.	1					
	Per Clinical Record Review no Nursing notes or		The state of the s				
	Physician's orders were noted to hold medication.						
	Per random review of the Residents blood			K			
	pressures, last completed blood pressure was						
	performed prior to scheduled Lisinopril						
	administration on 08/11/2018 at 9:37pm results of						
	blood pressure were documented as 100/56 sitting. There were no HOLD orders for Lisinopril						
	that require Lisinopril to be held for certain						
	parameters. No Vital signs were obtained on the			1			
	morning of August 12th and the medication was			1			
	scheduled to be given at 8:00am.						
	08/23/18 12:50 PM Surveyor spoke to ADON						
	(assistant director of nursing) to obtain records	1	E 605 Continued on payt page				
	and report concerns.		F - 695 Continued on next page				
	No further information regarding this issue was						
	provided to the survey team prior to the exit						
	DIDAIGO (A HIG GOLLA) (ACCHE bean in me and	1		1			
	conference.		8 0 0 2				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
						С	
		495131	B. WING			08/2	24/2018
	ROVIDER OR SUPPLIER			24	(REET ADDRESS, CITY, STATE, ZIP CODE 15 NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	The facility must ensineeds respiratory cacare and tracheal sucare, consistent with practice, the compressore plan, the reside and 483.65 of this sign this REQUIREMEN by:  Based on observation record review and fadetermined that the respiratory equipment manner for 6 of 24 is survey, Resident #7 #29, Resident #32, #68.  The Findings Included 1. For Resident #73 was a admitted on 7/21/16 included, but were history of falling, child disease, Alzheimer with behaviors.  The most current for assessment located 14-Day MDS assessment located 14-Day MDS assessment pate 15 medians and 14-Day MDS assessment pate 15 medians and 14-Day MDS assessment pate 16 media	ory care, including and tracheal suctioning. Sure that a resident who are, including tracheostomy actioning, is provided such a professional standards of shensive person-centered ants' goals and preferences, abpart.  To is not met as evidenced on, staff interview, clinical acility document review it was facility staff failed to store and sanitary Residents in the sample 13, Resident #19, Resident Resident #34 and Resident ed:	F	695	F-695 - Continued from previous page.  F-696 (E) - Respiratory/Tracheostomy Care and Suc 1. Corrective Actions Accomplished For The Resider To Have Been Affected By The Allegedly Deficient P Resident #73: O2 tubing was replaced and nebulizer cleaned and bagged on 8/21/18. Resident #19: Nebulizer mask was cleaned and bag 8/21/18. Resident #29, #32, #34, and #68 had their concentrate replaced on 8/21/18  2. How We Have Identified Other Residents Having Potential To Be Affected By The Same Practice And Corrective Action Has Been Taken.  All residents receiving respiratory services have the be affected by the same deficient practice. All patier concentrator filters were cleaned and/or replaced on All residents using O2 tanks were checked and replanesessary on 8/21/18. All residents with nebulizer in reviewed to ensure they were properly stored on 8/2 3. The Measures we Have Put In Place and Systems Changes We Have Made To Ensure That The Pract Not Recur.  All nursing staff will be re-educated by the DON or of the facility expectation and proper procedure for stormaintaining respiratory equipment. Any Partiner und on leave will be in-serviced prior to their next shift be completed by: 10/11/18. Nursing staff will receive one re-education for any further incidents identified. 9/17/18, Central Supply staff or designee will clean replace oxygen concentrator filters weekly.  4. The Corrective Actions Will Be Monitored To Ensignating 9/17/18, the DON or designee will perfor QA study x 3 months consisting of weekly audits of equipment being stored properly and equipment filtic identify further incidents. Results will be reported mithe QA committee. The Center's Quality Assurance Committee consists of the Administrator, Director of Medical Director, QA Physicians, Deltician, Social S Director, Housekeeping & Laundry Director and Het Information Director and meets monthly. Additional and/or monitoring will be determined as necessary I Quality Assurance Committee. To be completed by	nts Found rectice.  I mask ged on ators filters  The What potential to nt O2 8/21/18. aced if nasks were 1/18. atic ice Does lesignee on ring and vallable or orked. To we one on Beginning and/or ure the mamonthly respiratory ars clean to onthly to e I Nursing, iervice alth in-services by the	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	IO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495131	B. WING			0	8/24/2018
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, BRISTOL			2	TREET ADDRESS, CITY, STATE, ZIP CODE 45 NORTH STREET IRISTOL, VA 24201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
F 695	memory impairment (3) with dally decision of Daily Living (ADL's coded that Resident assistance (3/3) with Special Treatments a staff did not code that oxygen.  On August 21, 2018 an initial tour of the u on. The surveyor of and observed Resid down. The surveyor cannula lying on top contact with the she observed a nebulizer The nebulizer was n contact with the top  On August 21, 2018 observed Resident observed that the na the bed linens and t lying on the bedside with the table.  On August 22, 2018 reviewed Resident of the clinical record orders dated 7/21/1 included, but where (Treatment Adminis every shift As Need BREATH **4 L (litet	and was severely impaired in making regarding Activities in so, The facility staff also #73 required extensive in ADL's. In Section O. and Programs, the facility at Resident #73 was receiving at 1:47 p.m. the survey made unit that Resident #73 resided beerved Resident #73's room ent #73 bed lines were pulled in observed an oxygen nasal of the sheet and in direct et. The surveyor also in top of the bedside table, not covered and was indirect of the bedside table.  If at 3:30 p.m., the surveyor #73's room. The surveyor #73's room. The surveyor asal cannula was still lying on that the nebulizer was still in the the head of the surveyor #73's clinical record. Review if produced signed physician in the surveyor #73's clinical record. Review if produced signed physician orders in the limited to: "Oxygen [TAR] in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record. Review if produced signed physician orders in the surveyor #73's clinical record.	F	695	This page intentionally left blank.		

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On August 21, 2018 at 6:14 p.m., the surveyor

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII		COMPLETED			
		495131 8. WING				08/24/2018	
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, BRISTOL				245	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA. 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE :	(X5) COMPLETION DATE
F 695	notified the Unit Mar Registered Nurse (Roxygen cannula and a clean and sanitary notified the RN (UM) cannula was lying on the nebulizer was lyi surveyor asked the land nebulizer were abags when not in us "Yes.). The surveyor and procedure for si when not in use.  August 23, 2018 at notified the Assistant Resident #73's nebulizer were not be sanitary manner who requested the facility storage of oxygen and the Administration of the Admin	e 16 lager (UM), who was a law, that Resident #73's nebulizer were not stored in manner. The surveyor that Resident #73's nasal at top of the bed linens and ang on the bedside table. The RN (UM) if the nasal cannula supposed to be kept in plastic e and the RN (UM) stated, or requested the facility policy torage of oxygen equipment.  11:40 a.m., the surveyor at Director of Nursing (ADON) oxygen nasal cannula and being stored in a clean and en not in use. The surveyor y policy and procedure for equipment when not in use.  13:43:53 p.m., the surveyor trator (ADM), Director of ON and Assistant Regional at Resident #73's oxygen was an and sanitary manner. The endaministrative Team (AT) nasal cannula and nebulizer grout and on top of bed linens.  13:43:50 a.m., the ADON hand by policy and procedure titled, proposed to the policy and procedure titled, proposed to the plastic bag when	F	695	This page intentionally left blank.		

	ENT OF DEFICIENCIES AN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
	495131 B. WING					08/2	4/2018
	NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, BRISTOL				REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD I		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	exiting the facility as to stored oxygen equalitary manner for 2. The facility staff filter on Resident #3 was clean.  The clinical record of 8/21/18 through 8/24 admitted to the facility included but not limit atherosclerotic hear	ation was provided prior to to why the facility staff failed uipment in a clean and	F	695	This page intentionally left blank.		
	disease (COPD), fai	ll history, weakness, ma, and dementia without					
	assessment with an (ARD) of 7/2/18 ass BIMS (brief interview Score of 15 cut of a	ual minimum data set (MDS) assessment reference date lessed the resident with a w for mental status) Summary a possible 15. Section O lures and Programs was herapy.	A STATE OF THE STA				
	identified the care a respiratory function Interventions: Oxyg nasal cannula as to Resident #32's phy 8/1/-8/22/18 read *0 (liters per minute) v (tolerated) Dx: (diag	gen 3 l/m (liters per minute) via plerated per order. sician order summary dated Oxygen every shift**3 LPM via NC (nasal cannula) as tol gnosis) COPD."					MALLEN STORY OF THE STORY OF TH
	The surveyor obser	rved Resident #32 during the					to the second

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A, BUILDING			SURVEY LETED	
		495131	B. WING_			08/2	24/2018
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, BRISTOL				245	REET ADDRESS, CITY, STATE, ZIP CODE S NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	)D PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X6) COMPLETION DATE
F 695	initial tour on 8/21/18 #32 was in bed. New concentrator with the tubing was dated 8/1 filter had a white debifilter. The surveyor of registered nurse #1 filter needed to be clawith soap and water.  The surveyor request cleaning the air filter concentrators. The the assistant director 8/21/18 at 4:05 p.m. of oxygen concentrators. The unit manager refliters need to be classified in part "Infection clean concentrator flaters and mild soap. The surveyor inform director of nursing, nursing and the region concern during the 8/23/18 at 4:01 p.m. No further information exit conference on 8.3. The facility staff	around 1:54 p.m. Resident at to the bed, was an oxygen a setting on 3 Liters. The O2 9/18; however, the oxygen aris on the charcoal colored showed the unit manager the filter. She stated the air eaned, took it out, washed it and replaced it.  Sted the facility policy on so the oxygen unit manager R.N. #1 called or of nursing (ADON) on for the facility policy on care stors.  Agistered nurse #1 stated the saned when the tubing is are different on 8/22/18. The policy on Control: 2. Check and ailter weekly. Clean with warm on pat dry with paper towel."  The dethe administrator, the the assistant director of ional nurse of the above and of the day meeting on was provided prior to the	F F	395	This page intentionally left blank.		

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED C		
	495131 B. WING		0	8/24/2018		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 245 NORTH STREET BRISTOL, VA 24201	Æ	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X6) COMPLETION DATE
F 695	The clinical record 8/21/18 through 8/21/18 through 8/21/18 through 8/21/18 through 8/21/18 through 8/21/18 through 18/21/18 chronical and sorder, gastro-est constipation, pulm dysphagia.  Resident #34's que (MDS) with an assof 7/5/18 coded the interview for ment out of a possible 1/21/18 through 18/21/18 through 18/21/18/18/18/18/18/18/18/18/18/18/18/18/18	of Resident #34 was reviewed 24/18. Resident #34 was stillty 11/20/15 with diagnoses to limited to respiratory failure, applemental oxygen, nic kidney disease, stage 3, spirin, major depressive sophageal reflux disease, conary hypertension, and arterly minimum data set sessment reference date (ARD) are resident with a BIMS (brief al status) Summary Score of 14 lb.  Figure 15.  Figure 15.  Figure 16.  Figure 17.  Figure 17.  Figure 18.  Figure 18.  Figure 18.  Figure 19.  Figure 19.	F 63	This page intentionally left blank	ζ.	

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Event ID: VAIK11

Facility ID: VA0171

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495131	B, WING		08/24/2018
	COVIDER OR SUPPLIER		2	TREET ADDRESS, CITY, STATE, ZIP CODE 45 NORTH STREET BRISTOL, VA 24201	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECT)		ULD BE COMPLETION
F 695	with soap and water The surveyor required cleaning the air filt concentrators. The the assistant direct 8/21/18 at 4:05 p.r of oxygen concent. The unit manager filters need to be of changed.  The surveyor revies "Supplemental Oxigen concentrator water and mild so the surveyor information of the surveyor review in the surveyor	ested the facility policy on ers on the oxygen e unit manager R.N. #1 called tor of nursing (ADON) on n. for the facility policy on care rators.  registered nurse #1 stated the cleaned when the tubing is eved the facility policy titled to one of the administrator, the new the administrator, the new the administrator, the new the day meeting on m.  ation was provided prior to the new to end of the day meeting on m.  ation was provided prior to the new to end of the day meeting on m.  ation was provided prior to the new to end of the day meeting on m.  ation was provided prior to the new to end of the day meeting on m.  ation was provided prior to the new to end of the day meeting on m.  ation was provided prior to the new to end of the day meeting on m.  ation was provided prior to the new to end of the day meeting on m.  ation was provided prior to the new to end of the day meeting on m.  ation was provided prior to the new to end of the day meeting on the tothe facility 10/27/2011 with	F 695		
	diagnoses that ind intervertebral disc type 2 diabetes m pulmonary diseas	cluded but not limited to c degeneration, lumbar region, nellitus, chronic obstructive se (COPD), hypokalemia, /itamin B deficiency, major			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
			Į.			c	
		495131	B. WING			08/2	24/2018
	ROVIDER OR SUPPLIER			245	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 695	Continued From pag depressive disorder,		F6	95	This page intentionally left blank.		
	(MDS) with an asses of 7/2/18 assessed t	terly minimum data set asment reference date (ARD) he resident with a BIMS (brief status) as 15 out of a	a supplied to Angular				
ic re h ir	Resident #29's current comprehensive care plan identified the care area/problem of impaired respiratory function related to dx (diagnosis) of heart failure, COPD, and sleep apnea. Interventions: Oxygen: 2 LPM (liters per minute) as patient tolerates (updated 1/9/18).		Services of the control of the contr				
	through 8/22/18 read	ent physician orders for 8/1/18 d in part "Oxygen as needed ed shortness of breath 2 L					
	(liters) nasal cannula maintain O2 sat (sat	a as patient tolerates, to turation) above 90%."					
	p.m., Resident #29 wheelchair. Her oxy use currently. Resident #29's permission, the was checked. The white debris on the surveyor informed the nurse #1 on 8/21/18 registered nurse #1 "I'll take care of that						
	cleaning the air filte	sted the facility policy on rs on the oxygen unit manager R.N. #1 called	A-Park				

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the assistant director of nursing (ADON) on 8/21/18 at 4:05 p.m. for the facility policy on care

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C		
		495131	B. WING		08/24/2018		
	ROVIDER OR SUPPLIER		245 N	ET ADDRESS, CITY, STATE, ZIP CODE NORTH STREET STOL, VA 24201			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 695	Continued From page of oxygen concentrations and the surveyor review "Supplemental Oxyread in part "Infectic clean concentrator water and mild soal The surveyor inform director of nursing, nursing and the region concern during the 8/23/18 at 4:01 p.m. No further informatic exit conference on 5. The facility staff Resident #68's oxy The clinical record	ge 22 ators.  egistered nurse #1 stated the eaned when the tubing is  wed the facility policy titled gen" on 8/22/18. The policy on Control: 2. Check and filter weekly. Clean with warm p, pat dry with paper towel."  med the administrator, the the assistant director of glonal nurse of the above end of the day meeting on it.					
	included but not lin disease with heart weakness, chronic (COPD), type 2 diaterm use of aspirin Resident #68's qua (MDS) with an ass of 8/1/18 assessed interview for menta out of 15. Oxygen	ility 5/1/18 with diagnoses that nited to hypertensive heart failure, atrial fibrillation, muscle obstructive pulmonary disease abetic neuropathy, and long .  arterly minimum data set essment reference date (ARD) If the resident with a BIMS (brief al status) Summary Score of 15 therapy was coded in Section ants, Procedures and					

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CENTERS FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0938-039
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING	(X3) DATE SURVEY COMPLETED

		495131	B. WING 08/			08/24/201	3/24/2018	
	ROVIDER OR SUPPLIER			245	REET ADDRESS, CITY, STATE, ZIP CODE NORTH STREET ISTOL, VA 24201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPL COMPL DA	ETION	
	Continued From page Programs.  Resident #68's currer was updated 5/21/18 impaired respiratory (liters) NC (nasal can The physician order s 8/22/18 included and L per NC as patient to During the initial tour p.m., Resident #68 w reading on the oxyge positioned on 4 liters permission, the oxyge checked. The filter hebris on the charco surveyor informed the nurse #1 on 8/21/18 manager registered and stated the filter s tubing is changed events.	of the care area of unction. Interventions: 4 L nula).  Summary for 8/1/18 through order for oxygen every shift 4 oberates.  on 8/21/18 beginning at 1:54 has observed in bed. The in concentrator was.  With Resident #68's en concentrator's filter was ad an accumulation of white al colored filter. The e unit manager registered at 4:10 p.m. The unit hurse #1 observed the filter should be cleaned when the ery Sunday.		395				
	cleaning the air filter concentrators. The the assistant directo 8/21/18 for the facilit concentrators. The unit manager re	sed the facility policy on son the oxygen unit manager R.N. #1 called or of nursing (ADON) on y policy on care of oxygen gistered nurse #1 stated the aned when the tubing is						
	"Supplemental Oxyg	red the facility policy titled gen* on 8/22/18. The policy n Control: 2. Check and liter weekly. Clean with warm				HERE THE PERSON AND THE PERSON		

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES DENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 08/24/2018 495131 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 245 NORTH STREET NHC HEALTHCARE, BRISTOL BRISTOL, VA 24201 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) This page intentionally left blank. F 695 F 695 Continued From page 24 water and mild soap, pat dry with paper towel." The surveyor informed the administrator, the director of nursing, the assistant director of nursing and the regional nurse of the above concern during the end of the day meeting on 8/23/18 at 4:01 p.m. No further information was provided prior to the exit conference on 8/24/18. 6. The facility staff failed to ensure the nebulizer facemask of Resident #19 was stored in a plastic bag. The clinical record of Resident #19 was reviewed 8/21/18 through 8/24/18. Resident #19 was admitted to the facility 7/21/17 with diagnoses that included but not limited to peripheral vascular disease, atherosclerosis of left leg with ulceration, chronic embolism and thrombosis of left popliteal vein, long-term use of anticoagulants, muscle weakness, pain in left foot, and chronic kidney disease stage 4. Resident #19's 14 (fourteen) day MDS (minimum data set ) with ARD (assessment reference date) of 8/6/18 assessed the resident with a BIMS (brief interview for mental status) of 15 out of 15 in Section C Cognitive Patterns. Resident #19's current comprehensive care plan was updated 7/5/18 for the care area of impaired respiratory function. Interventions: Administer

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Lasix.

medications per order: ipratropium albuterol,

Resident #19's physician order summary was

reviewed and included an order for

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CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495131	B, WING		C 08/24/2018	
	ROVIDER OR SUPPLIER	440101	8T 24	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201	0012412010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETION	
F 695	Ipratropium-albutero (2.5 mg base)/3 ml (	le 25 I 0.5 mg (milligrams)-3 mg milliliter) Neb (nebulizer) pulization every 6 hours-start	F 695	This page intentionally left blank.		
	initial tour on 8/21/18 was sitting in a whee nebulizer machine w nightstand behind he	ved Resident #19 during the B at 1:54 p.m. Resident #19 elchair and reading a book. A was observed on the er. The nebulizer facemask achine but was not in a plastic				
	8/21/18 at 3:30 p.m. stored in a plastic bahad no bags in any	ewed Resident #19 on and asked if the mask was ag. Resident #19 stated she of the drawers and had not ask in a plastic bag.				
	nurse #1 the nebuliz 3:47 p.m. and asked be in a plastic bag, be in a bag when no requested the facilit	ed the unit manager registered zer facemask on 8/21/18 at d if the facemask needed to She stated facemask are to ot in use. The surveyor by policy on the storage of at when not in use by the				
	"infection Control M policy read in part " nasal cannula, aero	wed the facility policy titled lanual Respiratory". The 3. Respiratory equipment (i.e., osols, etc.) at bedside will be tic bag when not in use."			And the second s	
	director of nursing, nursing and the reg	ned the administrator, the the assistant director of gional registered nurse of the the end of the day meeting on				

8/23/18 at 4:01 p.m.

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CENTER	S FOR MEDICARE	MEDICAID SERVICES			OMB NO	0938-039	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495131	B. WING		08/2	24/2016	
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 45 NORTH STREET BRISTOL, VA 24201			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	No further information was provided prior to the		further information was provided prior to the Tractice.		he Allegedly	4)	
exit conference on 8/24/18 F 697 Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Managen The facility must ensure the	anagement. nsure that pain management is	F 697	asleep will be re-educated by 9/25/1 policy and procedure for medication administration. There was no adver Resident #43.	sident # 43 was 18 on the proper n and treatment rse affect to			
	consistent with pro- the comprehensive and the residents' ( This REQUIREME by:	ats who require such services, fessional standards of practice, person-centered care plan, goals and preferences. NT is not met as evidenced		How We Have Identified Other Road The Potential To Be Affected By The And What Corrective Action Has Be All residents receiving medications to be affected. All in-house resident reviewed for any pain medications repatient was asleep. No other resides.	e Same Practice een Taken. have the potential is on 9/11/18 were not given when the		
	review, the facility	erview and clinical record staff failed to follow physician o pain management for one of ident #43.		The Measures we Have Put In Pl     Systematic Changes We Have Mad     The Practice Does Not Recur.	de To Ensure That		
	The findings includ Per Clinical Record admitted to the fac			All ticensed nursing staff will be re-common procedure for medication administration administration. Any Partner unavailable in-serviced prior to their next shi completed by: 10/11/18.	pectation and proper ation and physician le or on leave will fit worked. To be		
	Diabetes Mellitus, of shoulder joint progression, and (Generalized). Section C (cognitive quarterly MDS (mith an ARD (asset 07/12/18 included)	not limited to, Chronic, Pain, Aftercare following explanation rosthesis, Altered Mental Falling, Orthostatic Muscle Weakness we patterns) of the Residents inimum data set) assessment assment reference date) of a BIMS (brief interview for inmary score of 15 out of a		4. The Corrective Actions Will Be M the Practice Will Not Recur.  Beginning 9/17/18, the DON or des monthly QA study x 3 months consireviews of all medications not giver deficient practices. Results will be to the QA committee. The Center's Committee consists of the Administ Nursing, Medical Director, QA Phys Social Service Director, Housekeep Director and Health Information Dimonthly. Additional in-services and be determined as necessary by the Committee. To be completed by:	signee will perform a isting of weekly in to identify any reported monthly is Quality Assurance trator, Director of sicians, Dietician, ping & Laundry rector and meets for monitoring will a Quality Assurance		
	The Residents CC	P (comprehensive care plan)		l !		***************************************	

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included the problem area; Comfort/Pain related

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STATEMENT OF	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, -,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495131	B. WING				4/2018
	OVIDER OR SUPPLIER THCARE, BRISTOL		STREET ADDRESS, CITY, STATE, ZIP CODE  245 NORTH STREET  BRISTOL, VA 24201				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	8E	(X3) COMPLETION DATE
F 697	Syndrome. Interventilimited to, Administed assess for effectiven Tylenol, butalbital/ac Neurontin per order, Resident #43 curren summary) included of Hydrocodone-Acetal tablet (HYDROCOD ACETAMINOPHEN)	cture, Chronic Pain algia and Restless Legs ions included, but were not r medications as ordered and less, Administer Norco, letaminophen-caffeine, and land Assess for pain.  It POS (physician order lorder for minophen 10mg-325mg ONE BIT/ In 1 tablet by mouth every 6 gnosis): CHRONIC PAIN with	F	697	This section intentionally leblank.	eft	
F 757 SS=D	medication administ revealed that Hydror on 8/10, 8/11, 8/15, EMAR was coded wand 8/16 at 2:00am. Resident was asleed Per Clinical Record Physician's orders was assistant director of and report concerns. No further informati provided to the sunconference.  Drug Regimen is Fig. CFR(s): 483.45(d)(	Review no Nursing notes or were noted to hold medication.  Surveyor spoke to ADON of nursing) to obtain records a.  on regarding this issue was vey team prior to the exit		= 757	F-757 (D) – Drug Regime Free from Unnecessary D Continued on next page.		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		495131	B. WING			08/3	24/2018
	PROVIDER OR SUPPLIER			24	REET ADDRESS, CITY, STATE, ZIP CODE IS NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 757	Each resident's dru unnecessary drugs drug when used- §483.45(d)(1) In extra duplicate drug their garden drugster ga	arg regimen must be free from a. An unnecessary drug is any excessive dose (including rapy); or excessive duration; or nout adequate monitoring; or nout adequate indications for its me presence of adverse ich indicate the dose should be tinued; or combinations of the reasons shs (d)(1) through (5) of this ENT is not met as evidenced estaff failed to ensure 1 of 23 ont #35) was free of an lication.  ded:  alled to follow the diabetic gement of Resident #35's	F	757	F-757 (D) — Drug Regimen is Free from Unnece  1. Corrective Actions Accomplished For The Re To Have Been Affected By The Allegedly Deficit Resident #35 did not have any negative outcom deficient practice Identified. The Nurse respons notifying the physician of blood sugars greater to in-serviced on 8/24/2018 on the proper policy af for insulin administration and facility's sliding sci  2. How We Have Identified Other Residents Hav Potential To Be Affected By The Same Practice Corrective Action Taken.  All diabetic residents with orders for the sliding shave the potential to be affected by the same of practice. All current residents on 9/12/18 with the scale protocol were reviewed by the DON, ADO Resident Care Coordinators to Identify incidents sliding scale protocol was not followed accordin policy. One other resident was identified with naffects. Physician was notified 9/1/18. License Involved will be re-educated on proper policy an for insulin administration and facility's sliding sca Completed: 9/13/18.  3. The Measures we Have Put In Place and Sys Changes We Have Made To Ensure That The F Not Recur.  All Licensed Nurses will be re-educated on the for safe medication administration, including the procedure for the facility's sliding scale protocol notification. Any Pariner unavailable or on leav in-serviced prior to their next shift worked. Nurse receive one on one re-education for any further identified. To be completed by: 10/11/18.  4. The Corrective Actions Will Be Monitored To Practice Will Not Recur.  Beginning 9/17/18, DON or designee will perfor QA study x 3 months of all patient blood sugars ensure the proper policy and procedure for insu- administration, facility's sliding scale protocol an notification have been followed. Results will be monthly to the QA committee. The Center's Q Assurance Committee consists of the Administ of Nursing, Medical Director and meets monthly in-services and/or monitoring will be determined by the Quality Assurance Committee. To be completed by: 10/11/18	sidents Found ent Practice.  e from the ible for not han 400 were not procedure alle protocol.  ving The And What scale protocol efficient re sliding the siding the state of the siding the state of the siding state will be sing state will be siden siding the siding	

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behavioral disturbances, weakness,

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Fadlity ID: VA0171

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C		
		495131	B. WING		0	8/24/2018	
	ROVIDER OR SUPPLIER		24	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201	FE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 757	Continued From p	age 29	F 757	This page intentionally left blank.			
	hypertension, type use of insulin, don weakness.	e 2 diabetes mellitus, long-term salgia, dysphagia, and muscle					
	with an ARD (asse 6/11/18 assessed memory problems	day MDS (minimum data set) assment reference date) of the resident to have short-term by, long-term memory problems, aired cognitive skills for dally				- And Andrews	
	was updated 2/20 diabetes. Interve	rrent comprehensive care plan l/18 for the care area of ntions: Observe for of Increased/decreased blood					
	sheet was review included: Humaki (Insulin Lispro) Ut (subcutaneous) bif greater than 40 MD (medical doct Location 0-150=0 units 151-200=2 units 201-250=4 units 251-300=6 units 301-350=8 units 351-400=10 units	an 10 units * MD call Dx					
; ;	medication admit blood sugar resu recorded as 410.	elewed the June 2018 electronic nistration record (eMAR). The lit on 6/5/18 at 11:00 a.m. was Based on the sliding scale nt #35 should have had his blood					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED C
		495131	B, WING		08/24/2018
	ROVIDER OR SUPPLIER		245	REET ADDRESS, CITY, STATE, ZIP CODE S NORTH STREET RISTOL, VA 24201	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 757	sugar rechecked in 2 10 units of sliding so: The surveyor informer registered nurse #1 of surveyor's inability to blood sugar that sho around 1:00 p.m. on registered nurse #1 of progress notes but we results.  The surveyor interview practitioner on 8/23/practitioner stated slid of Resident #35's	hours after he received the ale Humalog.	F 757	This section intentionally le	ft blank.
F 842 SS=0	Resident #35's blood nurse did not document that she is As part of my defend dropped from 410 at 4:30 p.m.  The surveyor inform director of nursing, nursing and the regabove concern in the 8/23/18 at 4:01 p.m.  No further informations of the surveyor information of the regabove concern in the surveyor information of the surveyor informa	on was provided prior to the 8/24/18. Identifiable Information	F 842	F-842 (D) – Resident Reco Identifiable Information. Continued on next page.	ords-

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED C	
		495131	B. WING_			1	24/2018
	ROVIDER OR SUPPLIER	1		24	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842	§483.20(f)(5) Reside (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use or except to the extent to do so.  §483.70(i) Medical a §483.70(i)(1) In accordessional standarmust maintain medithat are- (i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically of the forecords, except who (i) To the individual representative when (ii) Required by Law (iii) For treatment, poperations, as permyth 45 CFR 164.5 (iv) For public health neglect, or domestiactivities, judicial a law enforcement proposes, research medical examiners a serious threat to	ent-identifiable information. release Information that is to the public. release information that is to an agent only in contract under which the agent r disclose the information the facility itself is permitted  records. ordance with accepted rds and practices, the facility cal records on each resident  mented; ble; and organized  acility must keep confidential ained in the resident's records, arm or storage method of the en release is- or their resident re permitted by applicable law; w; coayment, or health care nitted by and in compliance	F	342	F-842 (D) — Resident Records- Identifiable Inform  1. Corrective Actions Accomplished For The Resi Found To Have Been Affected By The Allegedly is Practice.  Resident #43 medication review was completed to 2/7/18 but not scanned into the electronic medica was scanned into the record on 8/24/18. Resident received oral care as requested on 8/22/18. Nursing re-educated on proper oral care by the Supervisor Completed on: 8/22/18  The ADL documentation for Resident #34 that was a 8/22/18 was corrected by a late entry nurses in Completed 9/13/18.  2. How We Have Identified Other Residents Having Properties Action Has Been Taken.  All residents have the potential to be affected by deficient practice. All current residents on 9/13/1 reviewed to ensure that medication reviews were and in the medical record. No other residents we identified. Beginning 9/17/18, DON and Nurse Swill interview and/or do mouth care observations to ensure mouth care is being completed appropriate to ensure all medication reviews are on the medical record.  Beginning 9/17/18, the Pharmacy Consultant will scanning medication reviews into the medical record ensure all medication reviews are on the medicitimely.  All Nurse Aides will be re-educated by DON or dithe facility policy and expectation of providing the care and services for residents regarding oral care and services for residents regarding or	dents Deficient Imely on I record. It It #34 Is Alde was I. Is in error In the same Is were In the same In the same Is were In	

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Facility ID: VA0171

IDENTIFICATION AND MARKED		A, BUILDIN		CONSTRUCTION	C C		
		495131	B. WING_			10	4/2018
NAME OF PROVIDER OR SUPPLIER  NHC HEALTHCARE, BRISTOL				24	REET ADDRESS, CITY, STATE, ZIP CODE 5 NORTH STREET RISTOL, VA 24201		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	, ,	ម 32 allity must safeguard medical	F	342	This page intentionally left blank.		
	record information as unauthorized use.	gainst loss, destruction, or					
	for- (i) The period of time	I records must be retained required by State law; or					
	there is no requireme	ne date of discharge when ent in State law; or ears after a resident reaches					
2	legal age under State	e law.					
	(i) Sufficient information	edical record must contain- tion to identify the resident;					10000110000
	(iii) The comprehens provided;	sident's assessments; live plan of care and services					
	(iv) The results of an and resident review determinations cond						
:	(v) Physician's, nurs	e's, and other licensed ess notes; and					
	services reports as I	ology and other diagnostic required under §483.50. IT is not met as evidenced					
	review the facility fa	view and clinical record iled to keep an accurate to of 23 Residents, Resident 34.					der so von der
E	The findings Include						gapanangan errere
		the facility failed to sustain an cord regarding monthly on Reviews.					
	Per Clinical Record	Review Resident #43 was					Company of the Compan

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495131	B. WING			C 08/24/2018	
	ROVIDER OR SUPPLIER			24	REET ADDRESS, CITY, STATE, ZIP CODE 15 NORTH STREET RISTOL, VA 24201	1 00:2	W. 2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842	admitted to the faciliticulded, but were no Diabetes Mellitus, Af of shoulder joint pros Status, History of Fall Hypotension, and Mi (Generalized). Section C (cognitive quarterly MDS (minirwith an ARD (assess 07/12/18 included a mental status) summ possible 15 points.  The clinical record direction Regimen Review for 08/23/18 10:04 AM I notified of discrepan Reviews, record reviews in clinical resurveyor. Per docum (clinical record reviews was perform 08/23/18 04:03 PM notified of missing in a meeting with surveyor Regimen Review for the Clinical Record the month of Februar 08/24/18 12:00 PM	y on 01/23/18. Diagnosis of limited to, Chronic, Pain, tercare following explanation thesis. Altered Mental ling, Orthostatic uscle Weakness  patterns) of the Residents num data set) assessment iment reference date) of BIMS (brief interview for early score of 15 out of a lid not include a Medication February 2018. DON (director of nursing) by with Medication Regimentewed with DON at this time DON showed pharmacy cord and provided copies to ments provided and CRR who, no Medication Regimented in February Administrative staff were dedication Regimen Review in ey team.  DON provided documentation timen Review was completed February 7, 2018. Medication referred for review for explication of review for explication completion of review for	F	842	This page intentionally left blank.		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		495131	B. WING		08/24/2018			
	ROVIDER OR SUPPLIER		245	STREET ADDRESS, CITY, STATE, ZIP CODE  245 NORTH STREET  BRISTOL, VA 24201				
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENT(FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION			
F 842	Continued From pag	ge 34	F 842	This page intentionally left blank.				
		o the clinical record on this exit meeting with survey						
	provided to the survicenference.  2. The facility staff frecord of Resident # documented oral ca 11:07 a.m. Oral car Resident #34 on 8/2							
	8/21/18 through 8/2- admitted to the facili- that included but no dependence on sup hypertensive chroni- long term use of asi disorder, gastro-esc	of Resident #34 was reviewed 4/18. Resident #34 was ity 11/20/15 with diagnoses t limited to respiratory failure, plemental oxygen, c kidney disease, stage 3, birin, major depressive ophageal reflux disease, nary hypertension, and						
	(MDS) with an asset of 7/5/18 coded the interview for mental out of a possible 15 coded the resident of 2 plus persons for hair, brushing teeth washing/drying fact required extensive	rterly minimum data set essment reference date (ARD) resident with a BIMS (brief I status) Summary Score of 14 b. Section G Functional Status needed extensive assistance or personal hygiene (combing the shaving, applying make-up, and hands). Bathing assistance of one person.						
	updated 7/16/18 inc	cluded the care area for ADL ving) related to impaired						

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMBI	NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		495131	B. WING			8/24/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE		
NUC NEAL	LTHCARE, BRISTOL			245 NORTH STREET			
INTO TIEM	LINOAKE, BRIGIOL			BRISTOL, VA 24201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 842	Continued From page 35 Interventions: Assist with ADL/meals per patient need and preferences.		F 84	This page intentionally left	blank.		
	8/22/18 at 2:21 p.m. surveyor asked the received a shower. showers two times a asked how often she Resident #34 stated bath days-two times seated beside the re #34 was lying in bed enough to the reside was not pleasant. T	During the interview, the esident how often she The resident stated she got week. The surveyor then brushed her teeth and "My teeth are brushed on my a week." The surveyor was sident in a chair. Resident I. The surveyor was close ent to smell her breath, which he surveyor asked Resident teeth today and she					
	registered nurse #1 asked her to come with the resident. The resident. The resident and the unit manage brushed on bath day registered nurse #1 issue with the staff.  The surveyor and the nurse #1 reviewed the wide with the staff.	ed the unit manager on 8/22/18 at 2:31 p.m. and with the surveyor to observe esident told both the surveyor or that she only gets her teeth ys. The unit manager stated she would address the ne unit manager registered he "Results List" for Resident "Was oral care completed?	Annual or the control of the control				
	a.m. The surveyor inform	d yes for 8/22/18 at 11:07  ned the assistant director of a concern on 8/23/18 at 9:18					

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a.m. and requested the August 2018 ADL (activities of daily living) sheets. On the ADL sheet for 8/22/18 at 11:07 a.m., the certified nursing assistant had charted oral care was

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OCH TENOTON GEOGRAPHICA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DAT	(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A, BUILDING			COMPLETED	
		Partico com Particol	_			С	
		495131	B. WING		0	8/24/2018	
NAME OF P	ROVIDER OR SUPPLIER	1	ST	REET ADDRESS, CITY, STATE, ZIP COD	E		
MAC LIEA	TUALDE DDISTOL		24	S NORTH STREET			
NHC HEA	LTHCARE,BRISTOL		В	RISTOL, VA 24201			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 842	provided which it has stated the unit mana CNAs and the ADON nursing assistants to document correctly.  The surveyor inform director of nursing, the nursing, and the regabove concern during on 8/23/18 at 4:01 p  The surveyor review documentation on 8 "Professional Stand in part "Observation assessments/evalue and patient respons and authenticated with the ADON to	d not been. The ADON tiger was in-servicing the N expected the certified o provide oral care and  ed the administrator, the the assistant director of tional nurse consultant of the ting the end of the day meeting o.m.  eved the facility policy on tived the facility policy on t	F 842	This page intentionally left blank	k.		

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