STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0188	A. BUILDING: _____ B. WING _____	12/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PULASKI HLTH & REHAB CNTR	2401 LEE HIGHWAY PULASKI, VA 24301

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 12/28/21 through 12/29/21. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 120 bed facility was 93 at the time of the survey. The survey sample consisted of 8 current Resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. Nursing Services 12 VAC 5-371-220 (C)(1) Based on the Code of Virginia, staff interview, clinical record review, and facility document review, the facility staff failed to provide services to prevent the risk of clinically avoidable complications related to pressure ulcers for 1 of 8 residents in the survey sample, Resident #4. The findings included: Resident #4's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Nontraumatic Intracerebral Hemorrhage Affecting Right Dominant Side, Peripheral Vascular Disease, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease,	F 001	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated F 001 Resident # 4 Physician was notified and orders were updated for appropriate treatment orders for wounds. Current residents in the center with wounds have the potential to be affected.	1/12/22

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

Electronically Signed | 01/07/22

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F 001	Continued From page 1 Chronic Kidney Disease Stage 3, and Dysphagia. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/22/21 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory loss in section C, Cognitive Patterns. In section M, Skin Conditions, Resident #4 was coded for the presence of one Stage 1 pressure ulcer and two unstageable pressure ulcers due to coverage of the wound beds by slough and/or eschar that were present on admission. Resident #4's clinical record included a "Weekly Skin Evaluation" dated 12/27/21 which documented a pressure area to the right side of back measuring 1.0 cm x 1.0 cm with no stage documented. The previous "Weekly Skin Evaluation" assessments were reviewed and failed to include documentation of a pressure area to the right side of back. No physician's order for treatment to this area was located in the clinical record. On 12/29/21 at 12:36 pm, a meeting was held with the DON (director of nursing) and RN (registered nurse) #1 to discuss the area to Resident #4's back. RN #1 stated the area was there since Resident #4's return from the hospital on 11/13/21, that it started as a skin tear and was now a stage II. RN #1 stated "I could have sworn I put a treatment in." After reviewing Resident #4's clinical record, RN #1 stated there was no treatment order but the night shift was doing treatment and they have seen dressings on the area. There was no documentation of monitoring or treatment being provided to the pressure area to the right back located in the clinical record.	F 001	Licensed Nurses were educated by the DON/designee on the appropriate documentation on treatment administration record when treatments are completed. DON/ Designee will monitor the missed documentation report at least 5 times per week to assure no missed documentation. The results will be reported to the monthly Quality Assurance Committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exits then audits will be on a random basis. Resident #5 and Resident #4 care plans have been updated/revised to reflect the residents current physical and psychosocial status. Current residents in the center have the potential to be affected. The MDS Coordinator will be educated by the Regional DAVS/designee on updating/revising care plans to reflect resident□s current physical and psychosocial status. The DON/designee will audit 5 care plans weekly to ensure care plans are updated/revised to reflect the resident□s current physical social status. The results will be reported to the monthly Quality Assurance Committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exits then audits will be on a random basis. Date of completion 1-12-22	

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F 001	Continued From page 2	F 001		

The facility policy entitled, "Pressure Ulcer Monitoring & Documentation" documented in part:
Policy: All pressure ulcers will be monitored
Procedure:
3. The Skin Wound Evaluation will be completed weekly by a licensed nurse for any patient with pressure ulcers/injuries.
4. There will be a Wound Evaluation for each site.

Resident #4's "Weekly Skin Evaluation" dated 12/27/21 also included documentation of a stage I pressure area to the right outer ankle measuring 0.8 cm x 0.8 cm and a stage II pressure area to the coccyx measuring 4.0 x 3.0 x 1.2 with undermining. Both areas were documented on the 12/27/21 "Weekly Skin Evaluation" as being present on readmission. Resident #4 was readmitted to the facility on 11/13/21.

A review of Resident #4's December 2021 TAR (treatment administration record) revealed physician ordered treatments to right outer ankle were not documented as being provided on 12/04/21, 12/05/21, 12/06/21, 12/19/21, 12/20/21, 12/22/21, 12/25/21, and 12/27/21. The December 2021 TAR also revealed physician ordered treatments to the coccyx were not documented as being provided on 12/19/21, 12/22/21, and 12/27/21.

On 12/29/21 at 12:36 pm during a meeting was held with the DON and RN #1, to discuss the concern of the treatment omissions to Resident #4's pressure areas to the right outer ankle and coccyx.

No further information regarding this issue was presented to the survey team prior to the exit

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F 001	Continued From page 3 conference on 12/29/21. Resident Assessment and Care Planning 12VAC5-371-250 Based on observation, staff interview, clinical record review and facility document review the facility staff failed to review and revise the care plan for 2 of 8 residents, Resident #4 and Resident #5. The findings included: 1. Resident #5's face sheet listed diagnoses which included but not limited to Alzheimer's disease, anemia, diabetes mellitus, gastroesophageal reflux disease, depression, hypertension, adult failure to thrive and dementia. Resident #5's most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/26/21 coded the resident as having both long and short term memory problems with severely impaired cognitive skills for daily decision making. Resident #5's CCP (comprehensive care plan) was reviewed and contained a care plan which read in part, "The resident is at risk for falls r/t (related to) Weakness, fatigue, gait imbalance." Interventions for this care plan included, "Assistive Devices: assist bars, low bed, anti-tippers on w/c (wheelchair), seatbelt in w/c, low bed and fall mats." This care plan was created on 07/03/2019 and revised on 12/28/2021. The CCP also contained a care plan for "The resident uses physical restraint with lap buddy r/t	F 001		

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F 001	Continued From page 4	F 001		

multiple falls to prevent falls d/t (due to) advanced dementia." Interventions for this care plan included, "RESTRAINT USE: Apply lap buddy restraint and check q (every) 30 min and release (q 2H [hours]) and reposition and ambulate. Document restraint use and release." This was created on 10/10/2019 and revised on 06/03/2021.

Resident #5's physician's order summary for the month of December 2021 was reviewed and contained an order for "Seatbelt when resident is in wheelchair, release and check skin integrity frequently every shift." This order had a start date of 09/07/2021.

On 12/29/21 at 8:20 am Resident #5 was observed seated in a wheelchair with a seatbelt in place.

On 12/29/21 at 12:10 pm the MDS coordinator was interviewed regarding Resident #5's care plan. The MDS coordinator stated that the restraint care plan should have been resolved and removed from the CCP. The MDS coordinator also stated that resident had been ordered the seatbelt on 09/07/21, and since the resident can remove it themselves, it was not considered a restraint.

The facility policy entitled "Resident Assessment and Care Planning: Care Planning", documented in part "Policy: A licensed nurse, in coordination with the inter disciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental and psychosocial well-being of the patient.

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F 001	Continued From page 5	F 001		

Procedure: 6. Computerized care plan will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment."

The concern of not revising the resident's care plan was discussed with the director of nursing and human resources manager on 12/29/21 at 2:30 pm. No further information was provided prior to exit.

2. Resident #4's diagnosis list indicated diagnoses, which included, but not limited to Hemiplegia and Hemiparesis following Nontraumatic Intracerebral Hemorrhage Affecting Right Dominant Side, Peripheral Vascular Disease, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease Stage 3, and Dysphagia.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 11/22/21 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory loss in section C, Cognitive Patterns. In section M, Skin Conditions, Resident #4 was coded for the presence of one Stage 1 pressure ulcer and two unstageable pressure ulcers due to coverage of the wound beds by slough and/or eschar that were present on admission.

Resident #4's "Weekly Skin Evaluation" dated 12/27/21 documented a stage I pressure area to the right outer ankle present on admission, a stage II pressure area to the coccyx present on admission, and a pressure area to the right side of back without documentation of stage or onset.

Resident #4 was most recently readmitted to the

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F 001	Continued From page 6 facility on 11/13/21. A review of Resident #4's comprehensive plan of care failed to reveal documentation of the pressure areas to the resident's right outer ankle, coccyx, and the right side of back. On 12/29/21 at 12:11 pm, the MDS Coordinator was interviewed about Resident #4's comprehensive plan of care and lack of inclusion of the pressure areas to the right outer ankle, coccyx, and the right side of back. The MDS Coordinator reviewed Resident #4's comprehensive plan of care and stated "I don't see them either." the MDS Coordinator was asked if the pressure areas should be included and the MDS Coordinator stated "yeah, you would think they'd be on there." Surveyor requested and received the facility policy entitled, "Care Planning" which states in part "Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment". On 12/29/21 at approximately 2:15pm, surveyor notified the director of nursing of Resident #4's comprehensive plan of care not including the resident's pressure areas. No further information regarding this issue was presented to the survey team prior to the exit conference on 12/29/21.	F 001		