PRINTED: 04/28/2017
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2625	A. BUILDING ______ B. WING ______	04/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARTHA JEFFERSON HOUSE	**1600 GORDON AVENUE** **CHARLOTTESVILLE, VA 22903**

(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 04/25/17 through 04/26/17. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 28 bed facility was 23 at the time of the survey. The survey sample consisted of four (4) current Resident reviews (Residents #1 through #4).	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: Nursing Services 12 VAC 5-371-220(A) Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure safety during a transfer for one of 4 residents in the survey sample. Resident #4 was transferred from a chair to bed with the assistance of one person when her plan of care required the assistance of two people for transfers. The resident's unsupported left arm, paralyzed from a stroke, fell forward during the transfer resulting in a fracture of the resident's left upper arm. The certified nurse's aide transferring the resident failed to promptly report the incident to nursing. The findings include: Resident #4 was admitted to the facility on 7/30/14 with a re-admission on 3/13/17. Diagnoses for Resident #4 included stroke with left sided	F 001	Noncompliance 12 VAC-371-220 (A) 1. All licensed nursing staff will be educated on the Resident's plan of care, as well as all locations that contain information regarding resident transfers by 6/1/17. 2. All licensed nursing staff will be educated on the facility protocol regarding reporting abnormal findings during resident interactions to their direct supervisor by 6/1/17. 3. All new hires will continue to be educated on the facility policies and procedures. 4. DON, or designee to review Resident care plans quarterly to ensure appropriate transfer status, findings to be reported at quarterly QA meeting. 5. The facility will be in compliance by 6/1/17. RECEIVED MAY 09 2017 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], Administrator (TITLE) — (X6) DATE 5/5/17

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paralysis and impaired sensation, atrial fibrillation, depression and cerebrovascular disease. A re-admission nursing assessment dated 3/13/17 assessed Resident #4 as alert and oriented to person, place, time and situation.

A facility reported incident form dated 2/17/17 documented Resident #4 was transferred on 2/12/17 with assistance of one person when the resident required the assistance of two people for transfers. The report stated the resident complained of left shoulder pain on 2/12/17 and 2/13/17. The report stated the nurse practitioner assessed the resident on 2/14/17 for increased left shoulder pain and ordered an x-ray of the left shoulder. The report stated, "The x-ray completed on 2/14/17 showed an acute fracture of the left humeral neck [left upper arm]." The report documented the resident's shoulder was immobilized with a sling, was treated by an orthopedic physician regarding the fracture and received Tylenol as needed for pain. The facility incident form documented, "Upon investigating this nurse spoke with [Resident #4]...She stated that while being transferred her left arm swung and she felt it, however she did not have any pain at the time...This nurse began investigation among staff, the staff member involved was questioned...she [staff member] stated that she had transferred [Resident #4] without assistance and [Resident #4] slouched over causing her weak arm (left) to swing around. [Resident #4] reported to the staff member that she heard a crack, however she said she was ok. The staff member failed to notify [Resident #4's] nurse of the incident in question...the staff member failed to follow facility protocol resulting in an injury to a Resident..."

A documented witness statement from the certified nurses' aide (CNA #1) that transferred

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Resident #4 on 2/12/17 stated, "While transferring her [Resident #4] to stand and pivot, she slouched over me (like going down) but I still had a hold to her and her weak side arm swung back Extreme and she said that she felt a crack, but I continued to ask was she okay she said she was ok...And I was alone with her and pivoted and I reported and told nurse 2-13-17, but she wasn't complaining at the time about pain and didn't ask for any pain med [medicine]... And again told me she was fine the pain was not there or intense! And I was tranferring [transferring] her from the chair to bed!" (sic)

Resident #4's clinical record documented the following nursing notes regarding the resident's left shoulder pain.

2/12/17 at 10:11 p.m. - "Resident had a good shift did c/o [complain of] left shoulder pain, prn Tyl. [as needed Tylenol] given and ice pack with positive results noted..."

2/14/17 at 6:21 a.m. - "Received several new orders per [nurse practitioner] to obtain Xray to left shoulder for increased pain during movement..."

2/15/17 at 6:16 a.m. - "Resident with c/o [complaint of] left shoulder pain, NP [nurse practitioner] ordered left shoulder/clavicle x-ray and scheduled pain medications."

2/15/17 at 10:49 a.m. - "Notified [nurse practitioner] of Xray results to resident left Clavicle positive for acute humeral neck fracture. Receive new orders for resident to see orthopedic...immobilize left shoulder as much as possible, use hoyer lift for transfers..." (sic)

Resident #4's clinical record documented an x-ray report dated 2/14/17 stating, "There is an acute

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nondisplaced humeral neck fracture seen... Impression: Acute humeral neck fracture is noted." A physician's progress note dated 2/17/17 documented, "...Lt [left] arm in sling... Lt [left] humeral neck fracture s/p [status post] mild trauma during patient transfer..."

Resident #4's care plan (initiated 5/11/16) listed the resident required assistance with activities of daily living due to her left sided weakness from a stroke. Interventions to maintain safety included the requirement for the extensive assistance of two people for transfers between surfaces. Resident #4's CNA care card in use prior to the incident listed a requirement of two people for transfers. Resident #4's monthly nursing assessment for February 2017 documented the resident required total assistance for all activities of daily living (bathing, grooming, hygiene, dressing) with the exception of eating.

On 4/25/17 at 11:20 a.m. Resident #4 was observed in her wheelchair in her room. The resident's left arm was positioned in an arm tray mounted on the left armrest of her wheelchair. The resident's left leg was positioned on a leg/foot rest mounted to the wheelchair. Resident #4 was interviewed at this time about her fractured left upper arm in February 2017. Resident #4 stated her left arm "jerked" forward while being transferred. Resident #4 stated she did not feel pain at first but her shoulder pain increased in the days following the transfer. The resident stated she did not have good sensation on her left side and she was unable to use her left arm or leg due to paralysis from a stroke.

On 4/25/17 at 11:45 a.m. the director of nursing (DON) was interviewed about Resident #4's fractured upper arm. The DON stated CNA #1 no longer worked at the facility. The DON stated

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prior to the incident on 2/12/17 Resident #4 required the assistance of two people for transfers. The DON stated on 2/12/17 CNA #1 transferred the resident without assistance and the resident's weak left arm fell forward during the transfer. The DON stated CNA #1 did not immediately report the incident to nursing. The DON stated two days later Resident #4 complained of increased shoulder pain and x-ray revealed a fractured upper arm. The DON stated the aides go by "care cards" for guidance regarding the assistance required for transfers. The DON stated Resident #4 was supposed to have two people assisting her with the transfer and CNA #1 performed the transfer alone.

These findings were reviewed with the administrator and director of nursing on 4/25/17 at 4:05 p.m.

Policies and Procedures
12VAC5-371-140(E)(3)(a).

Employee files were reviewed on 04/26/2017 at 8:00 a.m. During this review two of 25 employee files did not have proof of licensure from DHP (Division of Health Professionals) prior to employment. The two files were identified as Employee #2 and Employee #23, both LPN's (licensed practical nurses).

At approximately 8:10 a.m. the Administrator was asked if there was a policy for pre-employment requirements. He stated, "Per the HR (human resource) representative here is a copy of the checklist she uses for all new hires." A copy of the checklist was given to this surveyor. Included on the checklist was "License Check."

Plan of correction:

Noncompliance 12VAC5-371-140(E)(3)(a):
1. The 2 missing license verifications were obtained and placed in the respective employee file on 4/26/17.
2. All active employee files will be audited to ensure proof of licensure from DHP by 6/1/17.
3. Human Resource's new hire checklist will be clarified to include "license verification through DHP" by 6/1/17.
4. Human Resources to audit 10% of personnel files quarterly to ensure compliance with state regulations of license verification, the audit results will be reported at the quarterly QA meeting.
5. The facility will be in compliance by 6/1/17.

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At 8:35 a.m. the Director of HR was interviewed regarding the two missing licensure verifications for Employee #2 and Employee #23. Director of HR stated, Employee #23 "was before my time so I can't speak to their process then. I have been through all the records and if it isn't in there, it wasn't done." Regarding Employee #2 she stated, "Yes that was me. I may have just gotten a copy of her license and not checked it. (Re: licensure verification on DHP) Let me check her medical file and be sure."

At approximately 8:45 a.m. the HR Director and DON (director of nursing) returned to the surveyor room and stated, "Neither of those employee's licenses were verified, but we have verified them today."

The Administrator was informed of the above information during the exit conference conducted on 04/26/17 at 9:30 a.m.

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