STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E256	A. BUILDING _____ B. WING _____	12/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR LADY OF PERPETUAL HELP	4560 PRINCESS ANNE ROAD VIRGINIA BEACH, VA 23462

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicaid standard survey was conducted 11/29/16 through 12/1/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 30 certified bed facility was 30 at the time of the survey. The survey sample consisted of 10 resident reviews: 9 current residents (Residents #1 through #9), and 1 closed record review (Resident #10).	F 000		
F 168 SS=C	RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES CFR(s): 483.10(g)(10)(ii)(k) (g)(10) The resident has the right to- (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. (k) Contact with External Entities. A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), regarding any matter, whether or not subject to	F 168		12/30/16

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

Electronically Signed | 12/16/2016

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F 168	Continued From page 1 arbitration or any other type of judicial or regulatory action. This REQUIREMENT is not met as evidenced by: Based on a group interview, general observations of the facility and staff interviews, the facility staff failed to ensure information regarding client advocate agencies were available in readable form with large enough print, as well as positioned on the wall at a height which allowed reading by residents in wheelchairs. The findings include: A group interview with the surveyor was conducted on 11/30/16 at 10:00 a.m. with 5 high functioning interviewable residents to include the Resident Council President. It was a consensus of all 5 residents that they were not sure where the posting of the resident rights or local and State agencies were located for review, but thought it was somewhere in the general main hallway of the nursing center. All of the residents in the group were in wheelchairs and stated it was their main mode of transportation. Resident #9 was admitted to the nursing facility 9/26/16 and scored a 13 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated she was intact for the skills needed for daily decision making. The resident was in her wheel chair when she approached the posting of the Resident Rights, as well as the local and State agencies and stated it was no reason to try to read it because it was too high and the print was too small. Resident #8 was admitted to the nursing facility on 3/10/15 and scored a 15 out of a possible	F 168	F000 The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed as evidence of Our Lady of Perpetual Help□s desire to comply with the requirements of participation and to continue to provide high-quality resident care. F168 Corrective Action: On 12-2-2016, the Resident□s Rights posting was lowered to ensure the print was legible at a wheelchair height. Identifying Other Potential Residents: All residents have a potential to be affected. Systemic Changes: The Social Worker and the Activity Director were in-serviced on the hanging of the current version of the Resident□s Rights poster, dated 11/21/2016 (font size 14) at a level which allows residents in wheelchairs to read the information. Information concerning where the poster is hanging and the type of information contained in the poster will be reviewed at the resident council meetings by the social worker or designee. Monitoring System:	

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F 168	Continued From page 2 score of 15 on the Brief Interview for Mental Status (BIMS) which indicated he was intact for the skills needed for daily decision making. In the presence of the facility's Administrator, Resident #8 was in his wheelchair and stated he needed his glasses to attempt to read the posting. Once he obtained his glasses, he tried several times to read some if the print and on his last attempt, he pushed up on the hallway railing to bring his line of sight on the level of the posting. He stated, "I am not able to stand and if I were you, I would increase the font size so we can better read it." The Maintenance Director measured from the floor to the last printed line in the framed posting to be 55 inches. The Administrator stated she was going to immediately rectify the problem. The facility's Resident Rights policy (Voice complaints, grievances and to examine Survey results) dated 12/24/14 indicated the resident's respective Federal or State agencies information would posted in a conspicuous place at a height which allowed reading by a resident in a wheelchair, usually not higher than 44 inches above floor level.	F 168	Resident council minutes will be reviewed by the Administrator or designee, monthly x 3 months. Minutes will be submitted for review by our Quality Assessment / Quality Improvement committee. Date: December 30, 2016	
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		12/30/16

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F 281	Continued From page 3 Based on observations during a medication pass, clinical record review, staff interviews and facility documentation review the facility staff failed to ensure professional standards of quality was met during the administration of medications for 1 of 22 residents (Resident #14) in the survey sample. Licensed Practical Nurse (LPN) #1 poured liquid Colace medication in and out of its multi-dose bottle, using a 30 milliliter (ml) medicine cup, until she acquired the prescribed dose. The findings included: Resident #4 was admitted to the nursing facility on 2/10/15 with diagnoses that included epilepsy. Resident #4 had physician's orders dated 5/11/16 for *Neurontin (Gabapentin) solution; 250 milligrams (mg)/ 5 ml three times a day (TID). *Neurontin (Gabapentin) capsules, tablets, and oral solution are used to help control certain types of seizures in people who have epilepsy (https://medlineplus.gov/druginfo/meds/a694007.html). During a medication pass observation on 11/29/16 at 11:30 a.m., LPN #1 poured liquid Neurontin medication in and out of its multi-dose bottle, using a 30 ml medicine cup, until she acquired 5 ml. An interview was conducted with the Assistant Director of Nursing (ADON) on 12/1/16 2:00 p.m. She stated the overage of a poured medication should be discarded and never poured back into a multi-dose bottle of any type of medication.	F 281	F000 The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed as evidence of Our Lady of Perpetual Help□s desire to comply with the requirements of participation and to continue to provide high-quality resident care. F281 Corrective Action: On 12-2-2016, LPN #1 was in-serviced on Medication Preparation, to include the fact that excess or over-poured liquid medication will be discarded. LPN #1 was evaluated for competency with medication preparation and administration, via the gastrostomy tube with resident #4. Identifying Other Potential Residents: All residents with liquid medications have the potential to be affected. Systemic Changes: 1) Each licensed nurse will be in-serviced on Medication Preparation, to include the fact that excess or over-poured liquid medication will be discarded. Each licensed nurse will be evaluated for competency with medication preparation and administration of liquid medications, as well as other forms of medications. 2) Medication administration observations will be performed, with randomly selected licensed nurses, monthly by the Director of Nursing or	

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F 281	Continued From page 4 The above aforementioned observation was shared with the Administrator, and DON on 12/1/16 at 4:30 p.m. The DON stated it was the facility's policy to discard any overage amounts and not re-pour medication back into its multidose container. She stated she was going to personally re-train LPN #1 on the standards to follow regarding the same. On 12/1/16 at approximately 5:15 p.m. The DON presented facility's Competency Evaluation Tool to include gastrostomy or jejunostomy tube medication administration that was adapted from http://www.mass.gov/eohhs/docs/dmr/reports/gj-tube-tool-med-admin.pdf. The tool indicated the following standard: "Prepares medications, shakes suspensions vigorously before pouring, and crushes pills finely before mixing with water or other liquid. Excess or over poured medication is discarded. DO NOT POUR BACK INTO CONTAINER".	F 281	designee. Evaluator will assess for proper preparation and administration of medications, in all forms. Monitoring System: Results of the Competency Evaluations and Medication Administration Observations will be submitted for review to the Quality Assessment / Quality Improvement committee. Date: December 30, 2016	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 441		12/30/16

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accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 441	Continued From page 6 (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility documentation review, the facility failed to ensure a safe, sanitary environment to prevent the development and transmission of disease and infection. 1. The facility staff failed to put soiled linens in linen roll cart located in hallway. 2. The nurse failed to sanitize equipment before and after use. 3. The facility staff failed to put a bag of soiled disposable briefs, pads and gloves in the trash. The findings include: 1. On 11/29/16 at 8:15 a.m., while on the initial tour, there was a soiled cloth under pad and linens observed on the sink in room 117. Located outside of the resident's room in the hallway was a rolling bin with a lid that had trash and soiled linens. During the pre-exit meeting with the Administrator and Director of Nursing (DON), this surveyor	F 441	F000 The filing of this plan of correction does not constitute an admission that the deficiencies alleged did in fact exist. This plan of correction is filed as evidence of Our Lady of Perpetual Help□s desire to comply with the requirements of participation and to continue to provide high-quality resident care. F441 Corrective Action: On 11-29-2016, the noted soiled linens were bagged and placed in the proper soiled linen receptacle. On 11-30-2016, the sectional tray was sanitized and placed in a baggy, for storage. On 12-1-2016, the noted bag of trash was removed and placed in the proper trash receptacle. Identifying Other Potential Residents: All residents have a potential to be affected. Systemic Changes: Facility staff was in-serviced on Infection	

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F 441	Continued From page 7 asked the DON, "What are your expectations of the staff regarding leaving soiled linens and pads on the residents sink". The DON replied, "Put them in a plastic bag in the roll cart in the hallway, that's what the roll cart is used for waste and soiled linens". The facility policy on infection control: Revised on 1/1/2009. "Infection prevention and control measures are: collection of soiled linen. Handle soiled linen as little as possible. Place soiled linen in leak-resistance bags and/or hampers or carts at or near the location where it was used." 2. During medication observation on 11/30/16 at 10:25 a.m. with LPN #1, LPN #1 went into the medication room, removed a gray sectional tray out of the lower cabinet and placed it on top of the medication cart. LPN #1 proceeded to pull the medications for Resident #4, putting each medication in a separate clear white 30cc (milliliter) medicine cup then placing each cup on the tray. LPN #1 took the tray into the resident's room and placed the tray on the resident's bedside table. LPN #1, administered all the medications via Peg-Tube to the resident, she then washed her hands, returned back to the bedside table, removed the tray, walked out of the room and placed the tray on top of the medication cart. LPN #1, then picked up the tray, went into the medication room, opened the lower cabinet door and placed the tray back inside the cabinet. During the pre-exit with the Administrator and Director of Nursing (DON), this surveyor asked the DON, "What are your expectations of the nurse not wiping down equipment after coming out of a resident's room and putting it away	F 441	Control Practices and Policies Environmental rounds will be made weekly to ensure infection control practices / policies are being followed. Monitoring System: Audits of environmental rounds will be performed weekly x 4, then monthly x 3. Results of those audits will be submitted for review by our Quality Assessment / Quality Improvement committee. Date: December 30, 2016	

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without sanitizing it first". The DON replied, "All equipment must be cleaned after being used and coming out of a resident's room.

3. During General Observation tour on 12/1/16 at 11:00 a.m., a bag of soiled disposable pads, briefs and gloves were observed on the floor in the Common bathing/shower room on the nursing unit. The Maintenance Director said, "That should not be there" and he placed the bag with the soiled items in the trash can located in bathing/shower room.

During the pre-exit meeting with the Administrator and Director of Nursing (DON), the surveyor asked the DON, "What are your expectations of the staff regarding leaving a bag of disposable pads, briefs and gloves on the floor in the shower room. The DON replied, "I expect for the staff to put the bag with soiled items in the trash can and bring it out of the room or put the bag in the roll cart in the hallway but not on the floor".

The facility policy on infection control: Revised on 1/1/2009. "Infection prevention and control measures are: collection of soiled linen Handle soiled linen as little as possible. Place soiled linen in leak-resistance bags and/or hampers or carts at or near the location where it was used."