

FOIA Data Base - The Law Office of Jeffrey Downey Serving clients in Washington D.C., Virginia and Maryland

If you have been injured in a nursing home or assisted living facility, call the Law Office of Jeffrey J. Downey for a free consultation.

Phone: 703-564-7318; email: jdowney@jeffdowney.com; www.jeffdowney.com

Potomac Falls Health and Rehabilitation Center
46531 Harry Byrd Highway
Sterling, VA 20164

Facility Characteristics: For-Profit Corporation with 150 certified beds
Legal Business Name – CCSP NOVA LLC

website: www.potomacfalls-rehab.com

Operator Managerial Control – John Mitchell

As of November 1st, 2020 – Potomac Falls Health and Rehabilitation Center is listed as a two-star facility by the Centers of Medicare and Medicaid Services, according to Medicare.gov

Researching Nursing Homes

A note by attorney Jeffrey J. Downey:

Thank you for visiting my website. Anyone who is considering the admission of a loved one into a nursing home should undertake a review of surveys or other data that will provide a snapshot of some of the issues or problems that the facility is experiencing. Keep in mind that this information can be limited and may not reflect the actual condition of the facility when your loved one is admitted. You should consider personal visits of any facility you are evaluating.

The Virginia Department of Health inspects nursing home facilities including Potomac Falls Health and Rehabilitation Center in Sterling, Virginia. Periodically they do inspections as complaint surveys which should be public record. State law requires that all nursing facilities obtain a license to operate in Virginia. In Virginia, nursing facilities are inspected every two years under the state licensure and on an average of 12 months under Medicare/Medicaid certification. When the Virginia Office of Licensure and Certification (OLC) conducts inspections and investigations in response to complaints received from the public, the identity of the complainant and the identity of any patient who is the subject of the complaint,

or identified therein, shall be treated as confidential and shall not be open to inspection by members of the public. Nothing contained herein shall prevent the OLC or its employees from making reports under §63.2- 1603 et. seq. of the Code of Virginia. (Ref. §32.1- 127.1:03 of the Code of Virginia) You can register a complaint by mailing to Virginia Department of Health, Office of Licensure and Certification, Virginia Department of Health, 9960 Maryland Drive, Suite 401, Henrico, VA 23233-1463 or via email at OLC- Complaints@vdh.virginia.gov or Fax to (804) 527-4503.

For Assisted Living Facilities in the Virginia, you may call directly or send in a complain online at https://www.dss.virginia.gov/about/email_licensing_complaint.cgi. There is a 24-hour number at (888) 832-3858 to report abuse of an elderly person.

I've provided links on my website for further information for other department in the DC/Maryland/Virginia region.

<https://www.jeffdowney.com/reporting-abuse/>

Having already researched Potomac Falls Health and Rehabilitation Center and obtained FOIA responses, I am posting these statements of deficiencies here, in a searchable format. Keep in mind that these surveys have been altered during the conversion process and you should update your search results.

I am interested in any additional information you may have on this facility. Please call me with any question about this or any other facility you may be interested in searching or prosecuting civilly for patient neglect or abuse.

Disclaimer: Information is built using data sources published by Centers for Medicare & Medicaid Services (CMS) under Freedom of Information Act (FOIA). The information disclosed on the NPI Registry are FOIA-disclosable and are required to be disclosed under the FOIA and the FOIA amendments to the FOIA. There is no way to 'opt out' or 'suppress' the NPPES record data for health care providers with active NPIs. Some documents may not be accurately copied or some results may have changed upon appeal, which may not be noted here.

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FACILITY STAFFING

	Tag Number	A			B			C			D		
		Services Provided			Full-Time Staff (hours)			Part-Time Staff (hours)			Contract (hours)		
		1	2	3									
Administration	F33				1	0			1	7			
Physician Services	F34	V	M	I									
Medical Director	F35												0
Other Physician	F36												1
Physician Extender	F37	V	N	M									
Nursing Services	F38	V		N									
RN Director of Nurses	F39						9	1					
Nurses with Admin. Duties	F40				2				1	0			
Registered Nurses	F41								1	15	2		
Licensed Practical/ Licensed Vocational Nurses	F42				1	8			3	0			
Certified Nurse Aides	F43												
Nurse Aides in Training	F44												
Medication Aides/Technicians	F45												
Pharmacists	F46	V	N	M									
Dietary Services	F47	V	N	N									
Dietitian	F48						1	0					3
Food Service Workers	F49				1	7	0		2				
Therapeutic Services	F50												
Occupational Therapists	F51	V	N	M									
Occupational Therapy Assistants	F52												
Occupational Therapy Aides	F53												
Physical Therapists	F54	V	N	M									
Physical Therapists Assistants	F55												
Physical Therapy Aides	F56												
Speech/Language Pathologist	F57	V	N	M									
Therapeutic Recreation Specialist	F58	V	N	M									
Qualified Activities Professional	F59	V	N	M									
Other Activities Staff	F60	V	N	M									
Qualified Social Workers	F61	V	N	M									
Other Social Services	F62	V	N	M									
Dentists	F63	V	N	M									
Podiatrists	F64	V	N	M									
Mental Health Services	F65	V	N	M									
Vocational Services	F66	V	N	M									
Clinical Laboratory Services	F67	V	N	M									
Diagnostic X-ray Services	F68	V	N	M									
Administration & Storage of Blood	F69	V	N	M									
Housekeeping Services	F70	V	N	M									
Other	F71	V	N	M									

Name of Person Completing Form	Zojie Niko	2/26 - 3/11/2017	Time 8:50 AM
Signature			Date 3/22/2017

Katarie Kelly 3/22/17

LONG-TERM CARE FACILITY APPLICATION FOR **MI\JJ.JW!t'SOOD** MEDICAID

Standard Survey: From: F1 (mm/dd/yyyy) <u>10/1/18</u> To: F2 (mm/dd/yyyy) <u>10/11/18</u>		Extended Survey: From: F3 (mm/dd/yyyy) _____ To: F4 (mm/dd/yyyy) _____	
Name of Facility Potomac Falls Health Rehab		Provider Number 5	Fiscal Year Ending: FS (mm/dd/yyyy) 10/31/18

Street Address
1000 Halfway Bend Hwy

City Lyons, VA	County LOUISIANA	State VA	Zip Code 20141
Telephone Number: F6 (703) 315-0000	State /County Code: F7 (45)	State /Region Code: F8 CJ319	

F9 **1031** 01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

Is this facility hospital based? F10..... Yes No
If yes, indicate Hospital Provider Number: F11

Ownership: F12 <input checked="" type="checkbox"/> For-Profit	<input type="checkbox"/> Non-Profit	<input type="checkbox"/> Government
01 Individual	04 Church Related	07 State
02 Partnership	05 Nonprofit Corporation	08 County
03 Corporation	06 Other Nonprofit	09 City
		10 City/County
		11 Hospital District
		12 Federal

Owned or leased by Multi-Facility Organization: F13..... Yes No

Name of Multi-Facility Organization: F14
Commission on wealth Care of Roanoke

Dedicated Special Care Units: (show number of beds for all that apply)

F15 AIDS 101	F16 Alzheimer's Disease 101	F17 Dementia 101
F18 Disabled Children/Young Adults 161	F19 Head Trauma 101	F20 Hospice 101
F21 Huntington's Disease 101	F22 Ventilator/Respiratory Care 101	F23 Other Specialized Rehabilitation 101

Does the facility currently have an organized residents' group? F24..... Yes No

Does the facility currently have an organized group of family members of residents?..... Yes No

Does the facility conduct experimental research? F26..... Yes No

Is the facility part of a continuing care retirement community (CCRC)? F27..... Yes No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement: Date: F28 (mm/dd/yyyy) _____ Hours waived per week: F29 _____	Waiver of 24 hr licensed nursing requirement: Date: F30 (mm/dd/yyyy) _____ Hours waived per week: F31 _____
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Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32..... Yes No

Name of Person Completing Form
UOL-irv M. McLee, LI

Signature 

Time
1:00 AM

Date
10-10-18

Stephan Russell

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/30/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/05/2019
NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARRY BYRD HIGHWAY STERLING, VA 20164		
(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 Medicare/Medicaid abbreviated standard survey was conducted 12/3/19 through 12/5/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. 3 complaints were investigated during the survey. The census in this 150 certified bed facility was 143 at the time of the survey. The survey sample consisted of 5 current Resident reviews (Resident #1 through Resident #5) and 1 closed record review (Residents #6).	F 000			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		1/6/20	

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

TITLE

(X6) DATE

Electronically Signed

12/20/2019

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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F 609	<p>Continued From page 1</p> <p>investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview, staff interviews, clinical record review, and in the course of a complaint investigation, the facility staff failed to report an allegation of abuse to the State Agency (Office of Licensure and Certification) for 1 (Resident #1) of 6 residents in the survey sample.</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on 05/23/2011. Diagnoses included but were not limited to, Unspecified Dementia Without Behavioral Disturbance and Major Depressive Disorder. Resident #1's Quarterly Minimum Data Set (MDS an assessment protocol) with an Assessment Reference Date of 11/26/2019 was coded with a BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #1 as requiring extensive assistance of 1 for bed mobility, transfer, dressing, toilet use and personal hygiene, and physical help of 1 limited to transfer only with bathing.</p> <p>On 12/03/2019 at approximately 4:45 p.m., an interview was conducted with the Administrator and when he was asked for information concerning an incident of a certified nursing assistant (CNA) #2 pouring hot water on Resident #1, the Administrator stated, "At the last care plan</p>	F 609	<ol style="list-style-type: none"> 1. The two Facility Reportable Incidents report forms were submitted on 12/4/2019 for Resident number #1 after the administrator was made aware of abuse allegations. 2. Any resident has the potential to be negatively affected if the center staff fails to implement the abuse policy for the reporting of allegations of abuse. A review of progress notes for 72 hours will be conducted to identify any allegation or statement that indicates need for further investigation or reporting. 3. Director of Nursing (DON) or designee will provide in-service education/training to all staff members regarding reporting incidents related to abuse reporting guidelines so that any alleged violation can be reviewed by the Administrator and or designee to ensure timely reporting. 4. Director or Nursing (DON) or designee will audit 24 hour report to identify any allegation or statement that indicates need for further investigations or reporting daily for 4 weeks, weekly x 2 weeks then monthly x 2 months. 		

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F 609	<p>Continued From page 2</p> <p>meeting the resident's daughter stated that about a year ago that an aide had left her mother (Resident #1) sitting on the toilet and she (the resident's daughter) had to wash her mother's bottom with toilet water. She was unsure of the aide's name, thought it was (Name)." The Administrator stated that he would look and see if there was any information.</p> <p>On 12/04/2019 at 12:30 p.m., an interview was conducted with the Administrator and when he was asked if he located any records concerning an incident between CNA #2 and Resident #1, the Administrator stated, "I don't have anything concerning the resident and the CNA." The Administrator stated, "There was an issue with the hot water not working in the shower but no complaint of a staff member pouring hot water on the resident."</p> <p>An interview was conducted with Resident #1 on 12/04/2019 at 1:00 p.m., when she was asked if anyone had poured hot or cold water on her, Resident #1 stated, "Yes, (CNA #2)." Resident #1 stated, "I had diarrhea, large diarrhea, and I was in my wheel chair. (CNA #2) filled up the bowl with hot water, I was sitting on the toilet and she poured the hot water on me to wash the diarrhea off. I told (CNA #2) that the water was hot. (CNA #2) then poured cold water on me." (Resident #1 motioned with her hands that the CNA poured the water down in the front of between her thighs.) Resident #1 then stated that she was sitting on the toilet by herself and raised up and lifted the toilet seat up and sat down in the toilet bowl and splashed water from the toilet bowl up to wash her vaginal area. The Surveyor tried to clarify with Resident #1 if she was in the bathroom alone or if the CNA was still present, but was unable to</p>	F 609			

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F 609	<p>Continued From page 3</p> <p>clarify. Resident #1 stated that she gathered up the dirty pads from her wheel chair and placed them in the garbage. When Resident #1 was asked if she had ever had an injury to her pinky finger on her right hand, Resident #2 stated, "No."</p> <p>On 12/04/2019 at 3:00 p.m., an interview was conducted over the telephone with the previous Unit Manager. An email that had been sent to her from Resident #1's daughter (Responsible Party) dated August 11, 2019 was read to her as follows: "(Previous Unit Manager Name), The last time we spoke on July 29th I explained to you about (CNA #2's) behavior towards my mother. I explained on July 28th my mother had diarrhea. I had to call the (Nurse Name) for help and (Nurse Name) told my mother she could not help her. Therefore, (Nurse Name) got (CNA #2) who did not have any patience to deal with my mother. When my mother asked (CNA #2) for help washing the diarrhea off my Mom (CNA #2) filled a bowl with hot water and poured it on my mother. When my mother screamed and complained the water was too hot then (CNA #2) filled the bucket with cold water and poured it on my mother. When my mother told (CNA #2) the water was too cold, (CNA #2) put the bucket back in my mother's dresser and left my mother to attend to herself. As my Mom tried to clean herself, she had diarrhea stuck in her vaginal area. When I asked my mother what did she do to clean herself off? She told me she had to take the water from the toilet to clean her vaginal area and struggle to get off the toilet seat by herself and transfer herself to her wheel chair. Fast forward today, as (CNA #2) was trying to help my mother get in bed, as (CNA #2) was helping my mother remove her skirt over her head, my mother complained that (CNA #2)</p>	F 609			

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F 609	<p>Continued From page 4</p> <p>was very rough as she was removing the skirt off, over my mother's head, the pinky finger on my mother's right hand got sprained and it felt like (CNA #2) was choking my (?) around the neck with her skirt. (Name of Previous Unit Manager), please be advised, (CNA #2) has been removed from my mothers care a year before but now (Administrator's Name) is adamant about putting (CNA #2) back on my mothers care team. But once again, I am asking for (CNA #2) to be removed. (CNA #2) lacks the skills, patience and ability to handle a sick, disabled patient who is in need of her assistance."</p> <p>When the previous Unit Manager was asked if she remembered the email, the previous Unit Manager stated, "Yes." The email was sent on a Sunday. When asked if she was working on that Sunday, the previous Unit Manager stated, "No, I opened the email up on Monday." When asked if she filled out a incident report, the previous Unit Manager stated, "No, typically we did not fill out a incident report on concerns that a family reported." The previous Unit Manager stated, "I forwarded the email to (Previous Director of Nursing Name)." When asked if she checked Resident #1's skin, the previous Unit Manager stated, "No, I did not." The previous Unit Manager stated, "(Previous Director of Nursing Name) and I spoke to (CNA #2). (CNA #2) helped clean (Resident Name) off. Hard to gauge the water temperature, water doesn't usually get that hot. (CNA #2) used a basin to clean the resident. We spoke to (CNA #2) about checking the water temperature to make sure they are adequate." When asked if she documented the conversation with (CNA #2), the previous Unit Manager stated, "No, just verbal education." When asked if there was any further investigation she stated, "No, can't remember."</p>	F 609		

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F 609	<p>Continued From page 5</p> <p>An interview was conducted with CNA #2 on 12/04/2019 at 3:10 p.m., and when she was asked if she assisted Resident #1 when she had a diarrhea stool and poured water on her to clean her up and the resident stated the water was too hot and then poured cold water on her, CNA #2 stated, "No." When asked if Resident #1 had complained to her of being rough while providing her care and injuring her pinky finger on her right hand, CNA #2 stated, "No." CNA #2 stated, "Two (2) staff go in together to care for (Resident Name). CNA #2 stated, "(Resident Name) told me that my mother is a b****." When asked if she said anything back to the resident, CNA #2 stated, "No. I reported the resident talking to me like that to Registered Nurse (RN #1), House Supervisor." When asked if she had training on working with residents with Dementia, CNA #2 stated, "Yes."</p> <p>On 12/04/2019 at 3:45 p.m., an interview was conducted via telephone with the previous Director of Nursing (DON), when she was asked if she remembered receiving an email from the previous Unit Manager dated August 11, 2019 concerning an alleged incident that occurred on July 28, 2019 involving (CNA #2 and Resident #1), the previous DON stated, "No, my last day at the facility was on Friday July 26, 2019." When asked what she would do if someone reported an allegation of abuse, the previous DON stated, "I would make sure the resident was safe, report it to the Administrator and have 2 hours to report it to the state."</p> <p>On 12/04/2019 at approximately 4:00 p.m., the email dated August 11, 2019 that Resident #1's daughter had sent to the previous Unit Manager</p>	F 609			

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F 609	<p>Continued From page 6</p> <p>was reviewed with the Administrator. The Administrator was made aware of the telephone interviews with the previous Unit Manager and DON. The Administrator stated, "No one knows about it. I will do a FRI (facility reported incident)."</p> <p>On 12/04/2019 at approximately 5:00 p.m., copies of the completed FRI's regarding CNA #2 and Resident #1 were provided to the Surveyor.</p> <p>On 12/04/2019 at approximately 5:30 p.m., a copy of Abuse and Neglect Certificate of Completion dated 05/06/2019 and a signed Acknowledgement of Mandated Reporter Status dated 07/06/2015 for the previous Unit Manager was received. A copy of Abuse and Neglect Certificate of Completion dated 05/23/2019 and a signed Acknowledgement of Mandated Reporter Status dated 02/07/2018 for CNA #2 was received.</p> <p>On 12/05/2019 at approximately 11:00 a.m., the above concern was reviewed with the Administrator, Director of Nursing and Corporate Clinical Services Specialist. The facility did not present any further information about the finding.</p> <p>The facility policy titled - Abuse Prevention</p> <p>Policy Statement: The facility is committed to maintaining a safe and abuse-free environment for all residents and committed to a comprehensive investigation of any allegation of activities or situations that may constitute abuse. Corrective and preventive action to minimize recurrence will be developed and implemented on an individual resident and on a facility basis. Outside agencies, including regulatory agencies,</p>	F 609			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/05/2019
NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARRY BYRD HIGHWAY STERLING, VA 20164		
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F 609	Continued From page 7 ombudsman, protective services, police, etc. will be notified and involved as appropriate to the situation. This is a complaint deficiency.	F 609		

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F 000	<p>INITIAL COMMENTS</p> <p>An unannounced Medicare/Medicaid standard survey was conducted 3/21/17 through 3/23/17. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Immediate Jeopardy was identified in the area of Quality of Care, which constituted Substandard Quality of Care.</p> <p>After accepting the Administrator's plan for removal of the Immediate Jeopardy and determining the Immediate Jeopardy was eradicated, the deficiency was assigned a Scope and Severity level 3 pattern.</p> <p>The Life Safety Code survey/report will follow.</p> <p>The census in this 150 bed facility was 144 at the time of the survey. The standard survey sample consisted of 24 resident reviews, 21 current records (Residents #1 through #21) and 3 closed records (Residents #22 through #24). The Expanded survey sample consisted of 23 current residents (Residents #25 through #47).</p>	F 000		
F 246 SS=D	<p>483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:</p> <p>(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the</p>	F 246		5/2/17

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

TITLE

(X6) DATE

Electronically Signed

04/13/2017

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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F 246	<p>Continued From page 1</p> <p>resident or other residents. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations, resident, staff and group interviews, the facility staff failed to provide laundry services with reasonable accommodations for one resident, Resident #17, in the survey sample of 47 residents.</p> <p>the findings included:</p> <p>Resident #17 was admitted to the facility 7/1/15 with diagnoses which included hypertension, neurogenic bladder, diabetes mellitus, hyperlipidemia, anxiety disorder and depression. The facility staff failed to return Resident #17's laundry after 23 days.</p> <p>A Quarterly Minimum Data Set (MDS) assessed this resident as having adequate hearing, clear speech, makes self understood, able to understand and having adequate visions. This resident was assessed as having a Brief Interview for Mental Status (BIMS) score of 12 indicating moderate cognitive impairment. This resident was assessed as having no behaviors. In the area of Activities of Daily Living (ADLs) this resident was assessed as requiring extensive assistance in the area of dressing. In the area of personal hygiene this resident was assessed as requiring limited assistance of one person.</p> <p>A revised care plan dated 1/28/17 indicated: "Resident at risk for impaired cognition. Intervention- Activity staff will encourage Resident to attend mental activities such as trivia, reminisce, music and games. Provide consistency in daily routine as much as possible. Resident has been diagnosed with depression.</p>	F 246	<ol style="list-style-type: none"> 1. Resident #17 had her clothing laundered and returned during the survey on 3/22/2017. 2. Any resident who has designated the Center to launder clothes is at risk to have delays in laundry service if soiled clothing is not handled promptly. 3. Environmental services staff will be re-educated on the process of collecting, laundering and returning clothes to residents timely. 4. The Administrator or designee will audit resident rooms and soiled utility rooms to ensure clothing is collected, laundered and returned to the residents timely, daily 5x/week x2 weeks, weekly x2 weeks and monthly x2months. Results will be reported to the QAPI Committee and any variances addressed. 	

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F 246	<p>Continued From page 2</p> <p>Interventions- Report changes in mood which may include new onset or prolonged sadness, crying, tearfulness, changes in sleep pattern, changes in appetite, and negative statements. Resident is able to choose leisure activity with reminders. Interventions- Activity staff will provide a monthly calendar activities. Resident needs assist with ADLs, Intervention- assist with mouth care, brush/comb hair QD (every day) wash face, hands QD."</p> <p>During the Group Interview on 3/22/17 at 10:00 A.M. attended by five (5) residents including the President and Vice President of Resident Council, the Group voiced a grievance to the facility staff (Administrator as well as the Director of Environmental Services) regarding Laundry Service.</p> <p>Residents shared their frustrations with the new laundry services initiated by the facility on March 1, 2017. A resident was very vocal concerning her roommate's laundry not being returned since picked up on February 28, 2017. A copy of an e-mail sent to the Environmental Service Director dated March 20, 2017 at 12:09 PM indicated: "We have reached a critical mass. It is Monday and many of the people in the Shenandoah Unit still do not have their laundry back. Some people still did not get their dirty laundry picked up from the last March 11 return date. My roommate (Resident #17) for example has not had any of her laundry done since February 28. Today is the 20th and according to the schedule tomorrow is laundry day again."</p> <p>An e-mail dated March 20, 2017 at 10:27 A.M. from the Vice President of Resident Council, directed to the Assistant Administrator who also</p>	F 246			

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F 246	<p>Continued From page 3</p> <p>oversees the Laundry Director indicated: "It is Monday morning and still no laundry. it was picked up on Friday, the date specified in your handout, with a return "(within twenty-four hours)". Residents are appearing in the dining room in hospital gowns, partially hidden by sheets, outer garments. The purpose of which seems to be to hide the fact that the residents are only wearing hospital gowns."</p> <p>An e-mail dated March 14, 2017 at 8:01 PM from the Vice President of Resident Council directed to the Environmental Service Director and copied to the Assistant Administrator indicated: "While we schedule our meeting, could someone please locate the laundry that was picked up on Saturday?</p> <p>A gentleman down the hall, has been wearing the same clothes for three days because everything was taken and it seems to have disappeared! More people are in the dinning room wearing gowns rather than clothes because it has been so long since their laundry was picked up and some people still, after all this time have not had any of their soiled laundry picked up."</p> <p>On 3/22/17 at 1:30 P.M. Resident #17's laundry was observed being delivered to her room. Resident #17 stated, "I am so relieved, I can put on my own clothes." Resident #17 stated, she had been wearing her roommate's clothes to get by.</p> <p>A Resident Laundry Process form, no date was given on the form, but the Environmental Service Director stated it was started on March 1, 2017, Indicated: " Laundry hours -Monday- Friday 3:30 P.M. to 10:00 P.M.</p>	F 246			

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F 246	<p>Continued From page 4</p> <p>Laundry Process- All clothing items must be marked with resident name with permanent marker or label to prevent loss. Individual laundry hampers are provided in each resident bath room. A sticker, placed on the lid of the hamper by Environmental Services, indicates if family or facility is responsible for resident laundry. Soiled laundry should be placed in the laundry hamper in the resident's bathroom. Laundry staff gather soiled clothing according to pick up schedule. Laundry is folded or hung on hangers depending on what is appropriate. Laundry staff will return the clean clothing to resident's room and place in drawers or closets as appropriate.</p> <p>Resident Laundry Pick up Schedule (PM = after 3:30 PM) Allegheny Unit - Monday Shenandoah Unit - Tuesday Piedmont/Tidewater Unit - Wednesday Allegheny Unit- Thursday Shenandoah Unit - Friday</p> <p>All personal laundry will be returned to the resident's room within 24 hours of pick-up.</p> <p>Resident #17 resided on the Shenandoah Unit. The laundry delivered to residents was observed to be in plastic bags. Residents were observed asking nursing nursing staff to assist them with hanging their clothing.</p> <p>During an interview on 3/23/17 at 9:43 A.M. with the Environmental Service Director he stated, we have been behind and just now are able to</p>	F 246			

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F 246	Continued From page 5 catch-up. When asked why Resident #17's laundry had not been returned after repeated pleas from her as well as her roommate and Resident Counsel members he stated, "I have no reason." During an interview on 3/23/17 at 10:40 A.M. with the Assistant Administrator he stated, we have been trying to get all residents' laundry completed. We are still training staff to the new process. The facility staff failed to accommodate Resident #17 with reasonable laundry services.	F 246			
F 252 SS=E	483.10(e)(2)(i)(1)(i)(ii) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 252		5/2/17	

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F 252	<p>Continued From page 6</p> <p>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interview, facility documentation review, the facility staff failed to maintain a clean comfortable homelike environment in 3 of 8 resident shower rooms.</p> <p>On 3/22/17 at approximately 10:00 to 11:00 a.m. during the General Observation tour of the facility the surveyor observed the following items:</p> <p>Soiled Shower rooms (3B, 2B, 2A)</p> <p>On 3/22/17 during the General Observation tour of the facility from 10:00 to 11:00 a.m. 3B Resident Shower Room was observed soiled. Used towels were observed lying in the shower room. The Shower room bench was observed with torn rough edges on the padded seat.</p> <p>On 3/22/17 during the General Observation tour of the facility from 10:00 to 11:00 a.m. 2B shower room was observed to be soiled. A used towel was observed lying in the shower room. The shower room bench was observed with torn rough edges.</p> <p>On 3/22/17 during the General Observation tour of the facility from 10:00 to 11:00 a.m. 2A shower room was observed to be soiled. A used brief was observed on the floor and a used glove was observed on the floor. Used towels were observed on the shower bench. A round brown</p>	F 252	<ol style="list-style-type: none"> 1. Resident shower rooms were cleaned in 3 of 8 shower rooms at the time of survey. The padded shower seats were replaced. 2. Residents who use the shower rooms are at risk to be affected if the resident shower rooms are not clean and in good repair. 3. Nursing and environmental services staff will be re-educated on the process to clean and maintain the resident shower rooms to ensure a clean and comfortable homelike environment, in good repair. 4. The Administrator or designee will audit the resident shower rooms daily 5x/week x 2 weeks, weekly x 2weeks, and monthly x 2months to ensure a clean and comfortable homelike environment in good repair. Results will be reported to the QAPI committee and any variances addressed. 		

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F 252	<p>Continued From page 7</p> <p>ball that looked like feces and a wet washcloth were observed on the shower floor. The Bathtub was observed soiled with apparent grime and what looked to be a dried up white sponge pad in the bottom of the tub. The sink was covered with items around the faucets (knife, toilet paper roller, and sharp edged broken plastic part from the toilet paper roller).</p> <p>During the observations of all three showers, the Maintenance Director picked up soiled items. Both the Maintenance Director and the Assistant Administrator agreed that the shower rooms were "dirty".</p> <p>Residents #44 and #43 were asked if they would have the expectation that their shower rooms be clean. Both residents #44 and #43 stated, "yes."</p> <p>The National Long Term Care Ombudsman Resource documented the following:</p> <p>The 1987 Nursing Home Reform Law requires each nursing home to care for its residents in a manner that promotes and enhances the quality of life of each resident, ensuring dignity, choice, and self-determination.</p> <p>All nursing homes are required "to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care that ... is initially prepared, with participation, to the extent practicable, of the resident, the resident's family, or legal representative." This means a resident should not decline in health or well-being as a result of the way a nursing facility provides care.</p> <p>The 1987 Nursing Home Reform Law protects</p>	F 252		

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F 252	<p>Continued From page 8</p> <p>the following rights of nursing home residents:</p> <p>The Right to Participate in One's Own Care documents that Residents should: Receive adequate and appropriate care</p> <p>The Policy and Procedure titled, "General Infection Control Policies" with a revision date of 02/13 was reviewed. The Policy documented the following:</p> <p>Specialty bathing tubs and chairs are cleaned between each resident with a germicidal cleaner. Shower chairs are cleaned by housekeeping with germicidal cleaner daily and by CNA's (Certified Nursing Assistants) as needed with soiled. No item (clean or soiled linen, clothing, personal items, etc.) are to touch the floor. No personal clothing, toilet articles, or clean or soiled linen are to be left in the bathing areas.</p> <p>The Policy and Procedure titled, "General Infection Control Nursing Policy" with a revision date of 4/05 documented the following:</p> <p>All resident care items will be cleaned and disinfected before being used for another resident.....other common used items will be cleansed according to the manufacturer's recommendations between resident uses. All resident common areas will be maintained in a clean and orderly manner and will be free of obvious hazards such as fall hazards, chemical hazards, etc.</p> <p>During the observations of the soiled areas the Maintenance Director picked up soiled items and discarded as the tour progressed. The</p>	F 252			

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F 252	Continued From page 9 Maintenance Director stated that he would be able to fix the remaining soiled areas. The facility administration was informed of the findings during a briefing on 3/23/17 at approximately 5:30 p.m. to 6:30 p.m. The facility did not present any further information about the findings	F 252			
F 309 SS=G	483.24, 483.25(k)(l) PROVIDECARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences .	F 309		5/2/17	

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F 309	<p>Continued From page 10</p> <p>(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and facility document review the facility staff failed to provide the necessary care and services for a 2nd degree abdominal burn in a timely manner to maintain the highest practicable physical wellbeing for 1 of 47 resident in the survey sample, Resident #18.</p> <p>The facility staff failed to properly assess, and follow Physician orders to obtain a Wound Consult following a 2nd degree abdominal burn from a hot coffee spill on 6/23/16 resulting in a 7 day delay in treatment for Resident #18, which constitutes harm.</p> <p>The findings include: Resident #18 was a 58 year old admitted to the facility initially on 6/10/05 and current admission date of 5/20/14 with diagnoses to include Seizures (1), Hemiplegia (2), Dysphagia (3), and Epilepsy (4).</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 6/3/16. The Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicated Resident #18 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living</p>	F 309	<p>1. Resident #18 had his wound assessed on the date of injury and treatment began. Subsequent assessment, treatment changes and care plan updates were completed on 6/29/2016. The area no longer required treatment on 08/05/2016.</p> <p>2. Any resident who develops a wound is at risk to have delays in assessment and treatment. Skin assessments will be completed for current residents to ensure wounds are identified, a treatment is in place, and wound consult is obtained if ordered.</p> <p>3. Licensed nurses will be re-educated on the process to identify, assess and treat wounds to ensure there is no delay in treatment. Licensed nurses will be educated on obtaining ordered wound consults. Licensed nursing assistants will be re-educated on the process of documenting and informing the licensed nurses of any wounds noted on the residents. Any newly noted wound will be evaluated by the DON/designee along with the wound nurse to ensure a treatment was immediately put into place and is appropriate daily 5x/week through the clinical meeting.</p> <p>4. Director of Nursing or designee will audit the EMR for any mention of wounds</p>		

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F 309	<p>Continued From page 11</p> <p>(ADL) Assistance, H. Eating = the resident was coded as requiring extensive 1 person physical assist. Under G0400 Functional Range of Motion the resident was coded as having upper extremity and lower extremity impairment on both sides.</p> <p>Resident #18's Care Area Assessment (CAA) of the above MDS signed and dated on 6/7/16 by the facility's Registered Dietitian is documented in part, as follows: Is this problem/need: Actual Nature of the problem/condition: Patient with a Body Mass Index (BMI) of 31.8, classified as obese. Patient is on a pureed diet with honey thickened liquids. Functional problems that affect ability to eat: Partial or total loss of arm movement. Functional limitation in range of motion. Hemiplegia/hemiparesis. Inability to perform Activities of Daily Living (ADLs) without significant physical assistance.</p> <p>Cognitive, mental status, and behavior problems that can interfere with eating: Poor memory. Communication problems: Difficulty making self understood. Difficulty understanding others. Care Planning Considerations: Maintain current level of functioning. Minimize risks.</p> <p>On 3/22/17 at approximately 4:00 p.m. the Administrator provided the surveyor with an incident report dated 6/23/16 for Resident #18 which documented in part, as follows: Incident Location: Resident's Room Incident Description: Private caregiver provided</p>	F 309	<p>requiring treatment, skin observations made by the CNA staff, and any reports of new wounds daily 5 times per week times 12 weeks. Results will be reported to the QAPI Committee and variances addressed.</p>		

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F 309	<p>Continued From page 12</p> <p>by family reported to the writer that patient spilled hot coffee on self and have burn at 17:30 (5:30 p.m.)</p> <p>Immediate Action Taken: The writer assessed the patient. Noted burn on bilateral lower quad. On the left quad is blister. On right quad is scar. Patient denies any pain. Cold compress applied. MD (Medical Doctor) notified with order for wound consult. R/P (Responsible Party) aware. Supervisor aware.</p> <p>Injuries Observed at Time of Incident: Injury Type: Burn Injury Location: Abdomen Mobility: Wheelchair bound</p> <p>The Administrator was asked for a copy of the Facility Reported Incident (FRI) that was sent to the Office of Licensure and Certification regarding Resident #18's burn from the hot coffee on 6/23/16. The Administrator stated, "I didn't do a FRI." The Administrator was then asked for the investigation documentation and plan put in place by the facility for Resident #18's burn from hot coffee on 6/23/16. The Administrator stated, "We didn't do an investigation and we didn't put a plan in place."</p> <p>Resident #18's current Comprehensive Care Plan with last review date of 3/13/17 is documented in part, as follows Focus: (Name of Resident #18) has actual impairment to skin integrity, open blisters on abdomen from hot coffee. Date Initiated: 6/29/16 Created on: 6/29/16 Created by: (Name of Unit Manager LPN(Licensed Practical Nurse) #1)</p>	F 309		

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F 309	Continued From page 13 Resolved Date: 9/20/16 Goal: (Name of Resident #18) will have no complications r/t (related to) blisters of the abdomen through the review date. Date Initiated: 6/29/16 Created on: 6/29/16 Created by: (Name of Unit Manager LPN (Licensed Practical Nurse) #1) Resolved Date: 9/20/16 Interventions/Tasks: *Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Date Initiated: 6/29/16 Created on: 6/29/16 Created by: (Name of Unit Manager LPN(Licensed Practical Nurse) #1) Resolved Date: 9/20/16 *Follow facility protocols for treatment of injury. Date Initiated: 6/29/16 Created on: 6/29/16 Created by: Name (Unit Manager LPN #1) Resolved Date: 9/20/16 Focus: Brain injury, disturbed sensory perception. Resident often has varying levels of attention span or ability to focus on a task, safety awareness, sociable communications within recreational activities. Date Initiated: 8/20/14 Created on: 6/29/16 Focus: (Name of Resident #18) has Hemiplegia r/t Brain Injury Date Initiated: 3/29/12 Created on: 3/29/12 Revision on: 9/25/12 Goal: (Name of Resident #18) will remain free of	F 309			

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F 309	<p>Continued From page 14</p> <p>complications or discomfort related to Hemiplegia through review date. Target Date: 6/4/17</p> <p>Focus: (Name of Resident #18) has Epilepsy r/t Brain Injury. Date Initiated: 3/29/12 Created on: 3/29/12 Revision on: 9/16/16 Goal: (Name of Resident #18) will be free of injury from seizure activity through the review date. Date Initiated: 3/29/12 Created on: 3/29/12 Revision on: 6/23/16 Target Date: 6/4/17</p> <p>Focus: (Name of Resident #18), his caregivers and his family will be advised that he remains at risk for burns related to decreased sensation, seizure disorder, thickened liquids when drinking hot liquids (enjoys coffee). Date Initiated: 3/22/17 Created on: 3/22/17 Created by: Director of Nursing Goal: (Name of Resident #18) will remain free from burns related to hot liquids over next review. Date Initiated: 3/22/17 Created on: 3/22/17 Created by: Director of Nursing Target Date: 6/4/17</p> <p>Interventions: *Education will be provided to family and caregivers about risk of injury from hot liquids. *Encourage use of adaptive cup with lid will be advised to decrease risk of injury. Date Initiated: 3/22/17</p>	F 309		

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F 309	<p>Continued From page 15 Created on: 3/22/17 Created by: Director of Nursing</p> <p>Resident #18's Physician Progress Note dated 6/17/16 was reviewed and is documented in part, as follows: Physical Exam: Abdomen: Soft, Normal bowel sounds. Musculoskeletal: Contractures Assessment and Plan:</p> <p>1. S/P (status post) Traumatic Brain Injury (TBI): LTC (long term care) supportive care. 2. Seizure 5. Dysphagia secondary to TBI: c/w (continue with) pureed diet and honey thick liquid.</p> <p>Resident #18's Braden Scale dated 6/2/16 was reviewed and documented in part, as follows:</p> <p>SENSORY PERCEPTION:</p> <p>3. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.</p> <p>Resident #18's Abnormal Involuntary Movement Scale (AIMS) dated 5/23/16 was reviewed and is documented in part, as follows:</p> <p>Examination Procedure:</p> <p>3. Have resident sit in chair with hands on knees, legs slightly apart, and feet flat on floor. Look at entire body for movements while in this position. *Resident unable to perform.</p> <p>7. Ask resident to tap thumb, with each finger, as</p>	F 309		

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F 309	<p>Continued From page 16</p> <p>rapidly as possible for 10-15 seconds: separately with right hand, then with left hand. *Resident unable to perform.</p> <p>8. Flex and extend resident's left and right arms, one at a time. Note any rigidity and rate it. *Right side rigid 3/10</p> <p>Extremity Movements:</p> <p>5. Upper (arms, wrists, hands, fingers). Include movements that are choreic (rapid, objectively purposeless, irregular, spontaneous) or athetoid (slow, irregular, complex, serpentine). Do not include tremor (repetitive, regular, rhythmic movements). *1. Minimal (may be extreme normal)</p> <p>Resident #18's Body Audits were reviewed and is documented in part, as follows:</p> <p>Date: 6/17/16 Skin integrity intact: 1) yes</p> <p>Date: 6/24/16 Skin integrity intact: 2) No Site: 14) Abdomen Description: Open area on bilateral lower quad (Burn) Signed By: LPN #3</p> <p>Date: 7/1/16 Skin integrity intact: 2) No Site: 19) Right iliac crest (front), Other: Description: opened area-tx in place Site: Other: Middle lower abd (abdomen), Description: opened area, tx (treatment) in place.</p>	F 309		

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F 309	<p>Continued From page 17</p> <p>Date: 7/8/16 Skin integrity intact: 2) No Site: Other Description: Open area on abdomen, treatment in place.</p> <p>Date: 7/15/16 Skin integrity intact: 2) No Site: 14 Abdomen Description: Opened area, treatment in place.</p> <p>Date: 7/23/16 Skin integrity intact: 2) No Site: Other Description: Opened area on abdomen, almost healed.</p> <p>Date: 7/30/16 Skin integrity intact: 2) No Site: 14 Abdomen Description: Open area (Tx in place)</p> <p>Date: 8/6/16 Skin integrity intact: 2) No Site: Other Description: 2 reddened areas on abdomen.</p> <p>Date: 8/20/16 Skin integrity intact: 2) No Site: 14 Abdomen Description: Old burn scars.</p> <p>Date: 8/17/16 Skin integrity intact: 1) yes</p> <p>Resident #18's Dietary Meal Preference slip was reviewed and is documented in part, as follows:</p>	F 309		

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F 309	<p>Continued From page 18</p> <p>Texture: Pureed Special Diets: Thick Fluids-Honey</p> <p>Breakfast: 6 fluid ounces Coffee-Honey Alerts: Blank Lunch: 6 fluid ounces Coffee-Honey Alerts: Blank Dinner: 6 fluid ounces Coffee-Honey Alerts: Blank</p> <p>Resident #18's Nursing Progress Notes were reviewed and are documented in part, as follows:</p> <p>6/22/16 11:30 a.m.: Resident had a seizure that lasted less than 10 seconds. MD and RP (responsible party) notified. Will continue to monitor.</p> <p>6/24/16 00:00 a.m.: Private caregiver provided by family reported to the writer that patient spilled hot coffee on self and have burn at 17:30 (5:30 p.m.) The writer assessed the patient. Noted burn on bilateral lower quad. On the left quad is blister. On right quad is scar. Patient denies any pain. Cold compress applied. MD (Medical Doctor) notified with order for wound consult. R/P (responsible party) aware. Supervisor aware. Signed (LPN #3)</p> <p>6/24/16 11:44 a.m.: Assessed skin on left upper thigh. Small area of discoloration of skin noted, no open areas or blister noted today. Resident denied any discomfort. Signed: (LPN #1 Unit Manager)</p> <p>6/28/16 23:32 (11:32 p.m.): abrasions noted on his stomach, was seen by evening cna (Certified Nursing Assistant), endorsed to night on duty</p>	F 309		

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F 309	<p>Continued From page 19 nurse.</p> <p>6/29/16 12:27 p.m.: Wound nurse asked to assess open areas on abdomen. Two open areas noted on abdomen that appear to be open areas from a previous blister, areas cleaned and foam dressing applied. Call place to resident's mother, undated on open areas and treatment. Mother voiced understanding. Talked with mother about the possibility of the seat belt of wheelchair causing the blister. Signed: (LPN #2 Wound Nurse at time)</p> <p>6/29/16 12:44 p.m.: (Name of Nurse Practitioner) made aware of open areas on abdomen and new treatment. Signed: (LPN #2 Wound Nurse at time)</p> <p>3/22/17 18:52 (6:52 p.m.): This writer and social worker spoke with patient and his full time caretaker, patients mother and father on the precautions needed when consuming hot liquids. Lids will be used so it cannot be as easily spilled and other precautions will be put in place. All were in agreement and understood. Signed By: (LPN #1 Unit Manager)</p> <p>3/23/17 14:12 (2:12 p.m.): This nurse measured scarring to the patient lower abdominal area.</p> <p>Site #1-is to the RLQ (right lower quadrant) of abdomen measures: 6.0 x 7.5 x 0 centimeters the skin is intact, no observable tenderness to the area, no redness or thickening observed.</p> <p>Site #2- is beneath the umbilicus to the LLQ (left lower quadrant) measures: 3.3 x 3.0 x 0 centimeters</p>	F 309		

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F 309	<p>Continued From page 20</p> <p>the skin is intact, no observable tenderness to the area, no redness or thickening observed. Signed By: (LPN #4 Current Wound Nurse)</p> <p>Resident #18's Telephone Physician Order dated 6/23/16 at 7:00 p.m. and signed by the Physician on 6/24/16 was reviewed and is documented in part, as follows:</p> <p>6/23/16: Wound Consult: DX (diagnosis) Burn (bilateral lower quad)</p> <p>On 3/22/17 at approximately 4:15 p.m. an interview was conducted with Resident #18's Attending Physician that ordered the above Wound Consult on 6/23/16. The Attending Physician was asked, "When you give an order for a Wound Consult what is your expectation of the facility?" The Attending Physician stated, "For the Wound Doctor to be called to come in and assess the resident's wound. This facility has a Wound Doctor that comes in to the facility weekly." The Surveyor asked, "So it's not your intention for the facility wound nurse to assess the wound based on that order?" The Attending Physician stated, "No, the Wound Doctor should access the wound." The Attending Physician was made aware that the Wound Doctor was never made aware of the order and never treated the resident. The Attending Physician stated, "No, I was not aware."</p> <p>Resident #18's Treatment Administration Record for June 2016 was reviewed and only indicated one treatment order for the entire month and is documented in part, as follows:</p>	F 309			

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F 309	<p>Continued From page 21</p> <p>Foam dressing to open blister areas on abdomen every 3 days to prevent infection. Start Date: 6/30/16 at 9:00 a.m. Discontinue Date: 8/5/16 at 7:49 p.m.</p> <p>On 3/23/17 at 9:20 a.m. a phone interview was conducted with Resident #18's mother. The surveyor asked about her knowledge of a coffee spill in June 2016. Resident #18's mother stated, "They told me he had a hot coffee spill on his stomach. When (Name of caregiver) brought him home to visit I saw his stomach and I was shocked because it was so bad of a burn. It took a long time to heal. His belly it was big, open, and bleeding. It was awful for a long time. They said it happened and it was no one's fault. He is an epileptic, he has seizures. They are not supposed to leave him with hot things because his seizures can happen any time, any place, and any day. Some days he has 2-3 seizures; he should be with somebody. I don't like it what happened, but I'm elderly, that's why we have a caregiver for him since day one."</p> <p>On 3/23/17 at 10:15 a.m. an interview was conducted with Unit Manager LPN #1. The Unit Manager was asked what happened on 6/23/16 when Resident #18 got burned. The Unit Manager stated, "(Name of Resident's private caregiver) went to get coffee and poured thickener in it took it to the room and handed it to the resident. The resident went to drink it and dropped it on his lower abdomen. Basically he is a brain injury resident and his last seizure was on 22 of June. I saw the area the next day and the area was red and the blister was still there. The Wound Nurse looked at it and put things in</p>	F 309		

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2017
NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARY BYRD HIGHWAY STERLING, VA 20164		
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F 309	<p>Continued From page 22</p> <p>place." The surveyor asked, "What was put into place?" The Unit Manager stated, "Leave it open to air." The surveyor asked, "What does the facility do when a Physician gives an order for a Wound Consult and if anyone had ever clarified it with a Physician?" The Unit Manager stated, "We get the wound nurse to look at it and no, I have never asked the doctor." The Surveyor asked, "What caused the resident's burn and what degree of a burn was it?" The Unit Manager stated, "He spilt the coffee and he got burned, it was a 3rd or 2nd degree burn."</p> <p>On 3/23/17 at 10:30 a.m. an interview was conducted with LPN #2 previous Wound Nurse and the Director of Nursing asked to be present as well. LPN #2 was asked to explain what was observed when she accessed Resident #18's burn. LPN #2 stated, "I read the nurse's note from the previous night and it said burn on quad. I thought it was on the leg so I went to look and I didn't see anything on the leg so I didn't proceed. Then someone said a few days later he had areas on his abdomen and I went up and looked. It was two blistered areas that had opened. I called his mom with an update and told her the blister areas had opened and it had been reported by the CNA the night before. I got a new order. It took a while to heal. What happened was I just looked at the wrong area at first, I looked at his leg because I was thinking quad was leg and I never looked at his abdomen where the burn had occurred. That's how I missed it." The surveyor asked, "Did you ever measure the two open blister burn areas so you could monitor for healing?" LPN #2 stated, "No, I never measured them." The surveyor asked, "Was the blister areas from a seatbelt?" LPN #2 stated, "No, they were from the coffee burn." The</p>	F 309			

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F 309	<p>Continued From page 23</p> <p>surveyor asked, "Did the Wound Doctor ever assess the resident's burn wounds as ordered by the Attending Physician?" LPN #2 stated, "No."</p> <p>The Director of Nursing stated, "He should have been assessed by the Wound Doctor as ordered." After LPN #2 left the room the Director of Nursing stated, "It's because of things like that she failed to do why she is no longer in the Wound Nurse position."</p> <p>The Director of Nursing provided the surveyor with the following statement documented in part, as follows:</p> <p>Expectations re: Nurse's taking Physician Orders</p> <p>Physician Orders</p> <ol style="list-style-type: none"> 1) Any order written by a physician will either be carried out by the nurse taking the order. 2) This nurse will pass the order on to the following shift. 3) If the order is not carried out, the nurse will get the order discontinued. <p>On 3/23/17 at 1:10 p.m. an interview was conducted with LPN #3. LPN #3 was asked to explain what happened to Resident #18 on 6/23/16. LPN #3 stated, "(Name of Private Caregiver) came to me around 5:30 p.m. because the resident has spilled his coffee. The caregiver had gotten the coffee from the kitchen and he had spilled it. So I pulled his shirt up to do an assessment. I looked at the left and right quads. The left quad had a blister and the right had a scar from the burn it was pink. After I did my assessment I called the doctor and his mom and dad. The doctor gave an order for a Wound</p>	F 309		

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F 309	<p>Continued From page 24</p> <p>Consult and I left a message for the wound nurse."</p> <p>On 3/23/17 at 1:30 p.m. an interview was conducted with Resident #18's Private Caregiver. The Caregiver was asked to explain what happened the night Resident #18 was burned from a coffee spill. The Caregiver stated, "(Name of Resident #18) has seizures. That day he said he liked to drink some coffee, so I went to the kitchen and got the coffee from the machine and I put thickener in it. After that I gave it to him and he had a seizure. His hand went down and the coffee went all over his abdomen. I toweled him off and told the nurse he had a seizure and spilt his coffee. Everytime he has a seizure I tell the nurse. She came in and checked him; he had blisters all over his belly. They never put anything on it. But the belly got worse bleeding and raw. It was 3-4 days later they came in and put a bandage on it, his skin had two open spots. It took more than a month to heal. It would bleed and when I took him to the shower he said I have pain and pointed to his belly. I have been with him for over 10 years he is like a brother tome. The surveyor asked if anyone had said anything to him about giving the resident coffee recently . The Caregiver stated, "Yes, yesterday (Name of Unit Manager) told me if I give him coffee just put a lid on it."</p> <p>On 3/23/17 at 2:00 p.m. an interview was conducted with Resident #18. The resident was asked to tell the surveyor about the day he spilled his coffee on his belly. Resident #18 stated, "(Name of caregiver) got me some coffee and when I started to drink it I had a seizure and dropped my coffee in my lap and it burned me. I'm scared to drink it by myself now." Resident</p>	F 309			

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F 309	<p>Continued From page 25</p> <p>asked if surveyor could look at his abdomen, he agreed and his caregiver lifted his shirt revealing the abdomen. The surveyor noted two well defined lower abdominal scars and asked the caregiver if they were the burn scars from the result of the hot coffee spill. The Caregiver stated, "Yes, those are the scars from the hot coffee."</p> <p>CDC (Centers for Disease Control) DEFINITION OF TYPES OF BURNS: (2)</p> <p>First-Degree Burns: First-degree burns involve the top layer of skin. Sunburn is a first degree burn.</p> <p>Signs:</p> <ul style="list-style-type: none"> * Red * Painful to touch * Skin will show mild swelling <p>Second-Degree Burns: Second-degree burns involve the first two layers of skin.</p> <p>Signs:</p> <ul style="list-style-type: none"> * Deep reddening of the skin * Pain * Blisters * Glossy appearance from leaking fluid * Possible loss of some skin <p>Third-Degree Burns: A third-degree burn penetrates the entire thickness of the skin and permanently destroys tissue.</p> <p>Signs:</p> <ul style="list-style-type: none"> * Loss of skin layers * Often painless * Skin is dry and leathery * Skin may appear charred or have patches that appear white, brown, or black 	F 309		

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F 309	<p>Continued From page 26</p> <p>According to an American Burn Association document entitled "Fire and Burn Safety for Older Adults Educator's Guide", under the heading General Background Information ...Risk Factors ...Physical Changes, the document read "Older adults experience a myriad of physical and cognitive changes associated with the aging process that makes them more vulnerable to fire and burn injuries... there are significant changes in sensory perception. The ability to see, hear and feel potential fire and burn dangers diminishes proportionally as one gets older...Since older adults also have thinner skin, they may experience a much deeper burn than a younger person, when exposed to the same amount of flame or other burn injury source.. Under the heading 'Working with the Older Adult Population', the document continues "With 12.5% of the population age 65 and older, there is a need to assess and address injury risks affecting them as they age".</p> <p>According to a document based on the above Burn Association Kit, found at http://www.ameriburn.org/Prevent/2000Prevention/Scald2000PreventionKit.pdf: "The severity of injury with scalds depends on two factors - the temperature to which the skin is exposed and the length of time that the hot liquid is in contact with the skin... When the temperature of a hot liquid is increased to 140o F / 60o C. it takes only five seconds or less for a serious burn to occur. Coffee, tea, hot chocolate and other hot beverages are usually served at 160 to 180o F./ 71-82o C. degrees, resulting in almost instantaneous burns that require surgery to heal". The two factors addressed above are underscored in a Burn Foundation document retrieved from the Internet:</p>	F 309			

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F 309	<p>Continued From page 27</p> <p>Which states "Hot Water Causes a Third Degree Burns ...</p> <p>...in 1 second at 156°</p> <p>...in 2 seconds at 149°</p> <p>...in 5 seconds at 140°</p> <p>...in 15 seconds at 133°.</p> <p>https://www.burnfoundation.org/programs/resource.cfm?c=1&a=3</p> <p>The facility policy titled "BURNS" last reviewed 10/26/16 is documented in part, as follows:</p> <p>Purpose: All burns and scalds are treated immediately to provide comfort and prevent infection.</p> <p>Policy:</p> <p>3. All burns and scalds should be seen by a physician.</p> <p>Procedure:</p> <p>6. Assess the burned area:</p> <p>a) First Degree: Redness; not serious unless a large area of the body is involved.</p> <p>b) Second Degree: Blisters form; superficial layers of skin are destroyed; hospitalization may be required if large area of the body are affected; classified as a major burn if over 30% of the body is burned.</p> <p>c) Third Degree: Destruction of full thickness of the skin, and often underlying fat, muscles and bone; hospitalization is required immediately; classified as a major burn if over 10% of the body is burned.</p> <p>8. Protect the burn area as quickly as possible with a sterile dressing.</p> <p>13. Document in detail in Nursing Notes and on 24-Hour Report.</p>	F 309		

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F 309	<p>Continued From page 28</p> <p>14. Update the Care Plan. 15. Complete incident report. 16. The DON or designee will report to the state health department if appropriate.</p> <p>The facility policy titled "Investigative Analysis of Incidents" last reviewed 10/26/16 is documented in part, as follows:</p> <p>Purpose: It is the intent of the center to maintain a safe and abuse-free environment for all residents. The facility is committed to a comprehensive investigation of all incidents or unusual occurrences. Corrective and preventive action to minimize recurrence will be developed and implemented on an individual resident and center basis. Outside entities, including regulatory agencies, ombudsman, protective services, and legal investigators will be notified an involved as appropriate to the situation.</p> <p>Procedure: 4. Upon completion of the investigation, the QA (Quality Assurance) Committee will review the incident and facility response to the incidents or unusual occurrences. The meeting may be at the discretion of the administrator and/or corporate representative, but consideration should be given for the potential of recurrent risk or risk to other residents.</p> <p>The facility policy titled "Unusual Occurrences" last reviewed 10/26/16 is documented in part, as follows:</p> <p>Policy: Unusual incidences or occurrences will be investigated and, if applicable, reported to the</p>	F 309		

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F 309	<p>Continued From page 29</p> <p>Office of Licensure and Certification, Adult Protective Services, local Ombudsman, and possibly law enforcement.</p> <p>Examples of Unusual Occurrences may include:</p> <p>6. Accidents or injuries of known origin that are unusual, such as a resident falling out of a window, a resident exiting the facility and sustaining an injury on facility property, or a resident being burned.</p> <p>Procedure:</p> <p>2. The Administrator or Director of Nursing is to be notified immediately.</p> <p>4. The Administrator, Director of Nursing, or their designee, must begin a documented investigation of the cause of the unusual occurrence using the Commonwealth Care Investigative Report form.</p> <p>5. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors, or volunteers which may have had contact with the resident and may help with the investigation.</p> <p>6. The Office of Licensure and Certification must be notified immediately (within 24 hours of knowledge of the event) by faxing the Facility Self Report form.</p> <p>8. A complete investigation must be initiated by the Administrator. Every effort is to be made to determine the cause of the unusual occurrence.</p> <p>9. A letter outlining the findings of the investigation, conclusions drawn, actions taken, and steps to prevent future reoccurrence will be submitted to the Office of Licensure and Certification within 5 working days.</p> <p>On 3/23/17 at 5:30 p.m. a Pre-exit debriefing was conducted with the Administrator, the Director of Nursing, the Clinical Services Specialist, and the</p>	F 309			

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F 309	Continued From page 30 Regional Director of Operations where the above findings were presented. The Clinical Services Specialist stated, "Life isn't without risk, everyone has the opportunity to drop coffee, I don't think it's considered an unusual occurrence." While this surveyor was reading the interviews verbatim to the attendees regarding the investigation of Resident #18's second degree abdominal burns from a hot coffee spill during a seizure the Regional Director of Operations stated, "We get it, we understand, this is getting emotional for us. We take it personal." Prior to exit no further information was shared. (1) Seizures: a hyperexcitation of neurons in the brain leading to abnormal electric activity that causes a sudden, violent involuntary series of contractions of a group of muscles. (2) Hemiplegia: paralysis of one side of the body. (3) Dysphagia: difficulty in swallowing, commonly associated with obstructive motor disorders of the esophagus. (4) Epilepsy: a group of neurologic disorders characterized by recurrent episodes of convulsive seizures, sensory disturbances, abnormal behaviors, loss of consciousness, or all of these. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 309			
F 323 SS=K	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		5/2/17	

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F 323	Continued From page 31 (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight . This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review, and facility document review the facility staff failed to provide an environment that was free of hazards to prevent accidents for 13 of 47 residents in the survey sample, Resident's #12, #18, #19, #20, #21, #25, #26, #27, #28, #29, #30, #31, and #32 resulting in the identification of Immediate Jeopardy. The facility staff failed to ensure safe coffee temperatures on 6/23/16 to prevent an avoidable	F 323	1. Resident #18 had his wound assessed on 6/23/2016, open blister wounds treated on 06/29/2016 and continued until discontinued on 08/05/2016. Resident #18's parents and private caregiver were educated on 06/29/2016 and again on 3/22/2017 regarding the risk of drinking hot beverages due to decreased sensation, seizure disorder and need for thickened liquid. Resident #18's care plan was updated to include recommendation		

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F 323	<p>Continued From page 32</p> <p>accident for Resident #18 resulting in second degree abdominal burns after spilling hot coffee on self, and on 3/22/17 during this survey coffee served to Resident's #12, #19, #20, #21, #25, #26, #27, #28, #29, #30, #31, and #32 during the lunchtime meal in all four dining rooms was identified at temperatures sufficient to cause tissue injury and third degree burns resulting in the identification of Immediate Jeopardy.</p> <p>The findings included:</p> <p>On 3/22/17 at approximately 12:15 p.m. after completing food temperatures in the main facility kitchen the facility prepared food carts left the kitchen for the 4 individual unit dining room steam tables. Surveyor #1 and the Director of Dietary Services followed the food cart enroute to the Tidewater Unit resident dining room. After the lunchtime food was retemped in the steam table, the staff began serving. One resident was observed being served a cup of hot tea. The surveyor asked the Director of Dietary Services to pour a second cup of hot tea and obtain a temperature. The cup of hot tea was 139 degrees Fahrenheit. Next the surveyor observed Resident #28 being served a cup of coffee without a lid and resident began drinking it. The Director of Dietary Services was then asked to pour another cup of coffee and obtain a temperature. The temperature of the coffee was 169.3 degrees Fahrenheit. The Director of Dietary Services stated, "That's much better than the hot tea temperature." When asked why by the surveyor, the Director of Dietary Services stated, "Because it's a lot hotter than the tea....well maybe it's too hot." The surveyor asked the Director of Dietary Services if she was aware of the federal guidelines for hot liquids and</p>	F 323	<p>of a cup with a lid due to this risk on 3/22/2017. It is duly noted residents #12, #20, #21, #25, #26, # 27, # 28, #29, #30, #31, and #32 were observed being served and drinking hot coffee in the public dining room. Resident # 19 was served hot coffee by the OT per resident request. No actual harm was experienced by these residents. The brew temperatures on the hot beverage machines were reduced to 150 degrees Fahrenheit on 3/22/2017. All dietary staff were educated to check temperature of coffee and water from automatic dispenser daily prior to meals on each unit and record on log. Any temperatures taken greater than 150 degrees Fahrenheit should be brought to the attention of the maintenance department and liquids withheld from resident use until temperature is 150 degrees Fahrenheit or lower. All nightshift supervisors were educated to check temperatures of coffee and water from automatic dispenser daily prior to meals on each unit and record on log. Any temperatures taken greater than 150 degrees Fahrenheit should be brought to the attention of the maintenance department and liquids withheld from resident use until temperature is 150 degrees Fahrenheit or lower. All staff were educated regarding changes to hot liquid service as they reported to duty. This education included the need to serve hot beverages in a cup with lid, temperature should not exceed 150 degrees Fahrenheit, if assistance is provided to place cream and/or sugar the lid should be replaced on the cup. A notice</p>		

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F 323	Continued From page 33 serious burns. The Director of Dietary Services stated, "No." The surveyor made the Director of Dietary Services aware that hot liquid at 155 degrees Fahrenheit with skin exposure of 1 second had the potential to cause a third degree burn jeopardizing residents. The Director of Dietary Services stated, "This coffee is too hot; it has to be cooled down before we can serve it." Immediately after the Director of Dietary Services made the last comment an Occupational Therapist (OT) grabbed a coffee cup and poured a cup of the coffee from the same container that was just temped at 169.3 degrees Fahrenheit for Resident #19. The Director of Dietary Services immediately told the OT, "The coffee is too hot to serve; it needs to be cooled down first." The OT stated, "It's fine I will get her some cream for it." The OT took the cup of hot coffee and immediately walked approximately 25 feet into Resident #19's room and placed it on her lunch tray. The OT never obtained or added any creamer to Resident #19's cup of coffee prior to placing on her lunch tray and did not verbalize to the resident that the coffee was hot. After placing the coffee on the resident's lunch tray the OT walked out of the room. This surveyor was standing in the hallway at Resident #19's door when the OT exited. The surveyor asked the OT why she had dismissed the warnings of the Director of Dietary Services that the coffee was too hot to be served and needed to be cooled down before it could be served. The OT stated, "I'm going to get her some cream to cool it off." The surveyor stated, "But you had knowledge the coffee was too hot and you placed it on the residents tray and walked out?" At this point the Director of Dietary Services was standing with us and the OT stated, "What, are we just not supposed to give her the coffee then." The	F 323	was given to all residents on 3/23/2017 advising of the changes in the hot beverage service. A notice was mailed to all responsible parties and contacts advising of the changes in the hot beverage service on 3/23/2017. Notices were distributed to all visitors, volunteers and private caregivers as they entered the Center advising of the changes in the hot beverage service 3/23/2017. A notice was posted at the front desk on 3/23/2017 advising of the changes in the hot beverage service on 3/23/2017. 2. Residents who request and are given hot liquids to drink may be at increased risk for injury if hot liquids are served. An audit was completed on 3/23/2017 to ascertain residents who request hot liquids to drink. Residents' Council was educated regarding new process involving hot liquids on 3/29/2017. An assessment was completed on 3/23/2017 with residents with impaired upper extremity mobility to determine the need for therapy referral for adaptive equipment; additional assessments will occur with significant change of condition. Any resident with a seizure diagnosis will be assessed and care planned for appropriate hot liquid container. The general resident population will receive hot beverages in cups with lids for hot beverage consumption. The corrective actions put in place on 3/22/2017 have been and will be maintained until reviewed by the QAPI committee for ongoing procedures. 3. All staff were educated on the hot beverage service policy and procedures to include burn risk factors for residents and		

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F 323	<p>Continued From page 34</p> <p>Director of Dietary Services stated to the OT, "I told you the coffee was too hot and needed to be cooled down before it could be served." The industrial coffee maker in the Tidewater dining room was broken so the coffee for lunch was obtained from the Piedmont dining room industrial coffee maker and brought over in a tall pump thermos container. Coffee was not removed from the residents after staff had knowledge of extreme hot temperatures.</p> <p>Resident #28 was a 58 year old admitted to the facility on 2/23/17 with diagnoses to include Cerebral Infarction (1), Hemiplegia (2) and Dysphagia (3).</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with an Assessment Reference Date (ARD) of 3/2/17. The Brief Interview for Mental Status (BIMS) was conducted by a staff assessment which indicated Resident #28 was modified independent regarding tasks of daily living. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as requiring supervision with 1 person physical assist. Under G0400 Functional Range of Motion the resident was coded as having upper extremity and lower extremity impairment on 1 side (right).</p> <p>Resident #19 was a 71 year old admitted to the facility on 2/13/17 with diagnoses to include Muscle Weakness (4), Diabetes Mellitus (5), and Osteoarthritis (6).</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with an Assessment Reference Date (ARD) of 2/20/17.</p>	F 323	<p>will be added to New Hire Orientation to assure ongoing awareness and compliance with policy.</p> <p>4.The Administrator or designee will audit temperature logs to ensure completion and that temperature does not exceed 150 degrees Fahrenheit without corrective action for each unit daily and that the use of cups with lids placed on at the point of dispensing daily x5 days for 4 weeks then weekly x8 weeks. The audit will include patients with seizure disorder diagnosis for appropriate cup/lid combination. Results will be reported to the QAPI Committee and any variances addressed.</p>		

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F 323	<p>Continued From page 35</p> <p>The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated Resident #19 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as requiring supervision with setup help only.</p> <p>On 3/22/17 at approximately 12:30 p.m. in the Piedmont Unit dining room during lunch, immediately after Resident #31 and #32 received coffee from the industrial coffee maker, the Surveyor #2 asked the Dining Services staff member to obtain the temperature of a cup of coffee. The temperature of the coffee was 160 degrees Fahrenheit. The Dining Services staff member stated to the surveyor, "Staff never temps coffee." There was no staff to assist either resident. Coffee was not removed from the residents after staff had knowledge of extreme hot temperatures.</p> <p>Resident #31 was a 66 year old admitted to the facility on 2/13/17 with diagnoses to include Cerebral Infarction, Muscle Weakness, and Diabetes Mellitus.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with an Assessment Reference Date (ARD) of 2/20/17. The Brief Interview for Mental Status (BIMS) was a 15 out of a possible 15 which indicated Resident #31 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating= the resident was coded as requiring supervision with setup help only.</p>	F 323			

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F 323	<p>Continued From page 36</p> <p>Resident #32 was a 93 year old admitted to the facility on 3/7/17 with diagnoses to include Muscle Weakness.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with an Assessment Reference Date (ARD) of 3/14/17. The Brief Interview for Mental Status (BIMS) was a 14 out of a possible 15 which indicated Resident #32 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as being independent with setup help only.</p> <p>On 3/22/17 at approximately 12:30 p.m. in the Allegheny Unit dining room during lunch Residents #12, #20, #21, #25, #26, and #27 were observed being served and drinking coffee from the industrial coffee maker. The Surveyor asked the Dining Services staff member to obtain the temperature of a cup of coffee from the industrial coffee maker; the coffee temperature was 171 degrees Fahrenheit. Coffee was not removed from the residents after staff had knowledge of extreme temperatures.</p> <p>Resident #12 was a 68 year old admitted to the facility on 8/5/16 with diagnoses to include Cerebral Infarction, Muscle Weakness, Dysphagia, and Seizures (7).</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with an Assessment Reference Date (ARD) of 8/12/16. The Brief Interview for Mental Status (BIMS) was an 8 out of a possible 15 which indicated Resident #12 was moderately impaired with</p>	F 323			

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F 323	<p>Continued From page 37</p> <p>cognitive skills for daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as requiring supervision with setup help only.</p> <p>Resident #20 is a 70 year old admitted to the facility on 9/22/08 with diagnoses to include Hemiplegia, Diabetes Mellitus, and Vascular Dementia (8).</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 8/10/16. The Brief Interview for Mental Status (BIMS) was conducted by a staff assessment which indicated Resident #20 had long and short term memory problems and was moderately impaired with cognitive skills for daily decision making which includes making poor decisions and required cues and supervision. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating= the resident was coded as requiring limited 1 person physical assist. Under G0400 Functional Range of Motion the resident was coded as having upper extremity and lower extremity impairment on 1 side.</p> <p>Resident #21 was a 78 year old admitted to the facility on 10/10/14 with diagnoses to include Cerebral Infarction, Dysphagia, and Aphasia (9).</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 10/16/16. The Brief Interview for Mental Status (BIMS) was conducted by a staff assessment which indicated Resident #21 had long and short term memory problems and was moderately impaired with</p>	F 323			

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F 323	<p>Continued From page 38</p> <p>cognitive skills for daily decision making. Which includes making poor decisions and required cues and supervision . Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as requiring supervision with 1 person physical assist. Under G0400 Functional Range of Motion the resident was coded as having upper extremity and lower extremity impairment on 1 side.</p> <p>Resident #25 was a 83 year old admitted to the facility on 1/25/13 with diagnoses to include Osteoarthritis and Dementia.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 12/3/16. The Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicated Resident #25 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as requiring supervision with setup help only.</p> <p>Resident #26 was a 75 year old admitted to the facility on 9/26/16 with diagnoses to include Muscle Weakness and Dementia.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with an Assessment Reference Date (ARD) of 10/3/16. The Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicated Resident #26 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living</p>	F 323			

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F 323	<p>Continued From page 39</p> <p>(ADL) Assistance, H. Eating = the resident was coded as requiring supervision with oneperson physical assistance.</p> <p>Resident #27 was a 93 year old admitted to the facility on 10/3/13 with diagnoses to include Muscle Weakness and Dementia.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual with an Assessment Reference Date (ARD) of 7/8/16. The Brief Interview for Mental Status (BIMS) was a 9 out of a possible 15 which indicated Resident #27 was moderately impaired with cognitive skills for daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating= the resident was coded as requiring limited one person assistance.</p> <p>On 3/22/17 at approximately 12:20 p.m. in the Shenandoah Unit dining room during lunch Surveyor #3 observed Resident's #29 and #30 being served coffee from the industrial coffee maker. The Surveyor asked the Dining Services staff member to obtain the temperature of a cup of coffee from the industrial coffee maker, the coffee temperature was 167 degrees Fahrenheit. Coffee was not removed from the residents after staff had knowledge of extreme temperatures.</p> <p>Resident #29 was a 95 year old admitted to the facility on 4/2/14 with diagnoses to include Dysphagia, Muscle Weakness, and Dementia.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with an Assessment Reference Date (ARD) of 10/22/16. The Brief Interview for Mental Status (BIMS) was a 00 out of a possible 15 which indicated</p>	F 323		

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F 323	<p>Continued From page 40</p> <p>Resident #29 was severely cognitively impaired and incapable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as requiring supervision with one person physical assistance.</p> <p>Resident #30 was a 86 year old admitted to the facility on 12/8/16 with diagnoses to include Dysphagia, Muscle Weakness, Dementia, and Diabetic Retinopathy (10).</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission with an Assessment Reference Date (ARD) of 12/15/16. The Brief Interview for Mental Status (BIMS) was conducted by a staff assessment which indicated Resident #30 had long and short term memory problems and was moderately impaired with cognitive skills for daily decision making. Which includes making poor decisions and required cues and supervision. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as requiring limited 1 person physical assist.</p> <p>According to an American Burn Association document entitled "Fire and Burn Safety for Older Adults Educator's Guide", under the heading 'General Background Information ...Risk Factors ...Physical Changes', the document read "Older adults experience a myriad of physical and cognitive changes associated with the aging process that makes them more vulnerable to fire and burn injuries... there are significant changes in sensory perception. The ability to see, hear and feel potential fire and burn dangers diminishes proportionally as one gets older...Since older</p>	F 323			

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F 323	<p>Continued From page 41</p> <p>adults also have thinner skin, they may experience a much deeper burn than a younger person, when exposed to the same amount of flame or other burn injury source.. Under the heading 'Working with the Older Adult Population', the document continues "With 12.5 % of the population age 65 and older, there is a need to assess and address injury risks affecting them as they age".</p> <p>According to a document based on the above Burn Association Kit, found at http://www.ameriburn.org/Prevent/2000Prevention/Scald2000PreventionKit.pdf: "The severity of injury with scalds depends on two factors - the temperature to which the skin is exposed and the length of time that the hot liquid is in contact with the skin... When the temperature of a hot liquid is increased to 140o F / 60o C. it takes only five seconds or less for a serious burn to occur. Coffee, tea, hot chocolate and other hot beverages are usually served at 160 to 180o F./ 71-82o C. degrees, resulting in almost instantaneous burns that require surgery to heal". The two factors addressed above are underscored in a Burn Foundation document retrieved from the Internet : Which states "Hot Water Causes a Third Degree Burnsin 1 second at 156° ...in 2 seconds at 149° ...in 5 seconds at 140° ...in 15 seconds at 133°. https://www.burnfoundation.org/programs/resource.cfm?c=1&a=3</p> <p>On 3/22/17 at approximately 1:22 p.m. the Administrator was asked if the facility had a hot</p>	F 323			

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F 323	<p>Continued From page 42</p> <p>liquid policy, and if there had been any resident incidents with hot liquids.</p> <p>On 3/22/17 at approximately 3:40 p.m. the Administrator confirmed that there was no facility policy on hot liquids.</p> <p>On 3/22/17 at approximately 4:00 p.m. the Administrator provided the surveyor with an incident report dated 6/23/16 for Resident #18 which is documented in part, as follows:</p> <p>Incident Location: Resident's Room</p> <p>Incident Description: Private caregiver provided by family reported to the writer that patient spilled hot coffee on self and have burn at 17:30 (5:30 p.m.)</p> <p>Immediate Action Taken: The writer assessed the patient. Noted burn on bilateral lower quad. On the left quad is blister. On right quad is scar. Patient denies any pain. Cold compress applied. MD (Medical Doctor) notified with order for wound consult. R/P (Responsible Party) aware. Supervisor aware.</p> <p>Injuries Observed at Time of Incident: Injury Type: Burn Injury Location: Abdomen</p> <p>Mobility: Wheelchair bound</p> <p>Resident #18 was a 58 year old admitted to the facility initially on 6/10/05 and current admission date of 5/20/14 with diagnoses to include Hemiplegia, Dysphagia, and Epilepsy (11).</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Annual with an</p>	F 323		

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F 323	<p>Continued From page 43</p> <p>Assessment Reference Date (ARD) of 6/3/16. The Brief Interview for Mental Status (BIMS) was a 13 out of a possible 15 which indicated Resident #18 was cognitively intact and capable of daily decision making. Under Section G Functional Status, G0110 Activities of Daily Living (ADL) Assistance, H. Eating = the resident was coded as requiring extensive 1 person physical assist. Under G0400 Functional Range of Motion the resident was coded as having upper extremity and lower extremity impairment on both sides.</p> <p>Resident #18's Care Area Assessment (CAA) of the above MDS signed and dated on 6/7/16 by the facility's Registered Dietitian documented in part, as follows:</p> <p>Is this problem/need: Actual</p> <p>Nature of the problem/condition: Patient with a Body Mass Index (BMI) of 31.8, classified as obese. Patient is on a pureed diet with honey thickened liquids.</p> <p>Functional problems that affect ability to eat: Partial or total loss of arm movement. Functional limitation in range of motion. Hemiplegia/hemiparesis. Inability to perform Activities of Daily Living (ADLs) without significant physical assistance.</p> <p>Cognitive, mental status, and behavior problems that can interfere with eating: Poor memory.</p> <p>Communication problems: Difficulty making self understood. Difficulty understanding others.</p>	F 323			

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F 323	<p>Continued From page 44</p> <p>Care Planning Considerations: Maintain current level of functioning. Minimize risks.</p> <p>Resident #18's current Comprehensive Care Plan with last review date of 3/13/17 documented in part, as follows</p> <p>Focus: (Name of Resident #18) has actual impairment to skin integrity, open blisters on abdomen from hot coffee. Date Initiated: 6/29/16 Created on: 6/29/16 Created by: (Name of Unit Manager LPN (Licensed Practical Nurse) #1) Resolved Date: 9/20/16</p> <p>Goal:</p> <p>(Name of Resident #18) will have no complications r/t (related to) blisters of the abdomen through the review date. Date Initiated: 6/29/16 Created on: 6/29/16 Created by: (Name of Unit Manager LPN #1) Resolved Date: 9/20/16</p> <p>Interventions/Tasks: *Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Date Initiated: 6/29/16 Created on: 6/29/16 Created by: (Name of Unit Manager LPN #1) Resolved Date: 9/20/16</p> <p>*Follow facility protocols for treatment of injury. Date Initiated: 6/29/16 Created on: 6/29/16</p>	F 323		

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F 323	<p>Continued From page 45</p> <p>Created by: (Name of Unit Manager LPN #1) Resolved Date: 9/20/16</p> <p>Focus: Brain injury, disturbed sensory perception. Resident often has varying levels of attention span or ability to focus on a task, safety awareness, sociable communications within recreational activities. Date Initiated: 8/20/14 Created on: 6/29/16</p> <p>Focus: (Name of Resident #18) has Hemiplegia r/t Brain Injury Date Initiated: 3/29/12 Created on: 3/29/12 Revision on: 9/25/12</p> <p>Goal: (Name of Resident #18) will remain free of complications or discomfort related to Hemiplegia through review date. Target Date: 6/4/17</p> <p>Focus: (Name of Resident #18) has Epilepsy r/t Brain Injury. Date Initiated: 3/29/12 Created on: 3/29/12 Revision on: 9/16/16</p> <p>Goal: (Name of Resident #18) will be free of injury from seizure activity through the review date. Date Initiated: 3/29/12 Created on: 3/29/12 Revision on: 6/23/16 Target Date: 6/4/17</p>	F 323			

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F 323	<p>Continued From page 46</p> <p>Focus: (Name of Resident #18), his caregivers and his family will be advised that he remains at risk for burns related to decreased sensation, seizure disorder, thickened liquids when drinking hot liquids (enjoys coffee). Date Initiated: 3/22/17 Created on: 3/22/17 Created by: Director of Nursing</p> <p>Goal: (Name of Resident #18) will remain free from burns related to hot liquids over next review. Date Initiated: 3/22/17 Created on: 3/22/17 Created by: Director of Nursing Target Date: 6/4/17</p> <p>Interventions: *Education will be provided to family and caregivers about risk of injury from hot liquids. *Encourage use of adaptive cup with lid will be advised to decrease risk of injury. Date Initiated: 3/22/17 Created on: 3/22/17 Created by: Director of Nursing</p> <p>Resident #18's Physician Progress Note dated 6/17/16 was reviewed and is documented in part, as follows:</p> <p>Physical Exam: Abdomen: Soft, Normal bowel sounds. Musculoskeletal: Contractures</p> <p>Assessment and Plan:</p> <p>1. S/P (status post) Traumatic Brain Injury (TBI): LTC (long term care) supportive care.</p>	F 323		

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F 323	<p>Continued From page 47</p> <p>2. Seizure</p> <p>5. Dysphagia secondary to TBI: c/w (continue with) pureed diet and honey thick liquid.</p> <p>Resident #18's Braden Scale dated 6/2/16 was reviewed and is documented in part, as follows:</p> <p>SENSORY PERCEPTION:</p> <p>3. Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or the need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.</p> <p>Resident #18's Abnormal Involuntary Movement Scale (AIMS) dated 5/23/16 was reviewed and is documented in part, as follows:</p> <p>Examination Procedure:</p> <p>3. Have resident sit in chair with hands on knees, legs slightly apart, and feet flat on floor. Look at entire body for movements while in this position. *Resident unable to perform.</p> <p>7. Ask resident to tap thumb, with each finger, as rapidly as possible for 10-15 seconds: separately with right hand, then with left hand. *Resident unable to perform.</p> <p>8. Flex and extend resident's left and right arms, one at a time. Note any rigidity and rate it. *Right side rigid 3/10</p> <p>Extremity Movements:</p> <p>5. Upper (arms, wrists, hands, fingers). Include movements that are choreic (rapid, objectively purposeless, irregular, spontaneous) or athetoid</p>	F 323		

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F 323	<p>Continued From page 48 (slow, irregular, complex, serpentine). Do not include tremor (repetitive, regular, rhythmic movements). *1. Minimal (may be extreme normal)</p> <p>Resident #18's Body Audits were reviewed and is documented in part, as follows:</p> <p>Date: 6/17/16 Skin integrity intact: 1) yes</p> <p>Date: 6/24/16 Skin integrity intact: 2) No Site: 14) Abdomen Description: Open area on bilateral lower quad (Burn) Signed By: LPN #3</p> <p>Date: 7/1/16 Skin integrity intact: 2) No Site: 19) Right iliac crest (front), Other: Description: opened area-tx (treatment) in place Site: Other: Middle lower abd (abdomen), Description: opened area, tx in place.</p> <p>Date: 7/8/16 Skin integrity intact: 2) No Site: Other Description: Open area on abdomen, treatment in place.</p> <p>Date: 7/15/16 Skin integrity intact: 2) No Site: 14 Abdomen Description: Opened area, treatment in place.</p> <p>Date: 7/23/16 Skin integrity intact: 2) No</p>	F 323		

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F 323	<p>Continued From page 49</p> <p>Site: Other Description: Opened area on abdomen, almost healed.</p> <p>Date: 7/30/16 Skin integrity intact: 2) No Site: 14 Abdomen Description: Open area (Tx in place)</p> <p>Date: 8/6/16 Skin integrity intact: 2) No Site: Other Description: 2 reddened areas on abdomen.</p> <p>Date: 8/20/16 Skin integrity intact: 2) No Site: 14 Abdomen Description: Old burn scars.</p> <p>Date: 8/17/16 Skin integrity intact: 1) yes</p> <p>Resident #18's Dietary Meal Preference slip was reviewed and is documented in part, as follows:</p> <p>Texture: Pureed Special Diets: Thick Fluids-Honey</p> <p>Breakfast: 6 fluid ounces Coffee-Honey Alerts: Blank Lunch: 6 fluid ounces Coffee-Honey Alerts: Blank Dinner: 6 fluid ounces Coffee-Honey Alerts: Blank</p> <p>Resident #18's Nursing Progress Notes were reviewed and are documented in part, as follows: 6/22/16 11:30 a.m.: Resident had a seizure that</p>	F 323		

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F 323	<p>Continued From page 50</p> <p>lasted less than 10 seconds. MD and RP (responsible party) notified. Will continue to monitor.</p> <p>6/24/16 12:10 a.m.: Private caregiver provided by family reported to the writer that patient spilled hot coffee on self and have burn at 17:30 (5:30 p.m.) The writer assessed the patient. Noted burn on bilateral lower quad. On the left quad is blister. On right quad is scar. Patient denies any pain. Cold compress applied. MD (Medical Doctor) notified with order for wound consult. R/P (responsible party) aware. Supervisor aware. Signed: LPN #3</p> <p>6/24/14 11:44 a.m.: Assessed skin on left upper thigh. Small area of discoloration of skin noted, no open areas or blister noted today. Resident denied any discomfort. Signed: LPN #1 Unit Manager</p> <p>6/28/16 23:32 (11:32 p.m.): abrasions noted on his stomach, was seen by evening cna (Certified Nursing Assistant), endorsed to night on duty nurse.</p> <p>6/29/16 12:27 p.m.: Wound nurse asked to assess open areas on abdomen. Two open areas noted on abdomen that appear to be open areas from a previous blister, areas cleaned and foam dressing applied. Call place to resident's mother, undated on open areas and treatment. Mother voiced understanding. Talked with mother about the possibility of the seat belt of wheelchair causing the blister. Signed: LPN #2 Wound Nurse at time.</p> <p>6/29/16 12:44 p.m.: (Name of Nurse Practitioner) made aware of open areas on abdomen and new</p>	F 323			

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F 323	<p>Continued From page 51 treatment. Signed: LPN #2 Wound Nurse at time.</p> <p>3/22/17 18:52 (6:52 p.m.): This writer and social worker spoke with patient and his full time caretaker, patients mother and father on the precautions needed when consuming hot liquids. Lids will be used so it cannot be as easily spilled and other precautions will be put in place. All were in agreement and understood. Signed By: LPN #1 Unit Manager.</p> <p>3/23/17 14:12 (2:12 p.m.): This nurse measured scarring to the patient lower abdominal area.</p> <p>Site #1-is to the RLQ (right lower quadrant) of abdomen measures: 6.0 x 7.5 x 0 centimeters the skin is intact, no observable tenderness to the area, no redness or thickening observed.</p> <p>Site #2- is beneath the umbilicus to the LLQ (left lower quadrant) measures: 3.3 x 3.0 x 0 centimeters the skin is intact, no observable tenderness to the area, no redness or thickening observed. Signed By: LPN #4 Current Wound Nurse</p> <p>Resident #18's Telephone Physician Order dated 6/23/16 at 7:00 p.m. and signed by the Physician on 6/24/16 was reviewed and is documented in part, as follows:</p> <p>6/23/16: Wound Consult: DX (diagnosis) Burn (bilateral lower quad)</p> <p>On 3/22/17 at approximately 4:15 p.m. an interview was conducted with Resident #18's</p>	F 323			

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F 323	<p>Continued From page 52</p> <p>Attending Physician that ordered the above Wound Consult on 6/23/16. The Attending Physician was asked, "When you give and order for a Wound Consult what is your expectation of the facility?" The Attending Physician stated, "For the Wound Doctor to be called to come in and assess the resident's wound. This facility has a Wound Doctor that comes in to the facility weekly." The Surveyor asked, "So it's not your intention for the facility wound nurse to assess the wound based on that order?" The Attending Physician stated, "No, the Wound Doctor should access the wound." The Attending Physician was made aware that the Wound Doctor was never made aware of the order and never treated the resident and if he had been made aware that his order had not been followed and carried out. The Attending Physician stated, "No, I was not aware."</p> <p>Resident #18's Treatment Administration Record for June 2016 was reviewed and only indicated one treatment order for the month and is documented in part, as follows:</p> <p>Foam dressing to open blister areas on abdomen every 3 days to prevent infection. Start Date: 6/30/16 at 9:00 a.m. Discontinue Date: 8/5/16 at 7:49 p.m.</p> <p>On 3/23/17 at 9:20 a.m. a phone interview was conducted with Resident #18's mother. The surveyor asked her about her knowledge of a coffee spill in June 2016. Resident #18's mother stated, "They told me he had a hot coffee spill on his stomach. When (Name of caregiver) brought him home to visit I saw his stomach and I was shocked because it was so bad of a burn. It took a long time to heal. His belly it was big, open, and bleeding. It was awful for a long time. They</p>	F 323			

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F 323	<p>Continued From page 53</p> <p>said it happened and it was no ones fault. He is an epileptic, he has seizures. They are not supposed to leave him with hot things because his seizures can happen anytime, any place, and any day. Some days he has 2-3 seizures he should be with somebody. I don't like it what happened, but I'm elderly, that's why we have a caregiver for him since day one."</p> <p>On 3/23/17 at 10:15 a.m. an interview was conducted with Unit Manager LPN #1. The Unit Manager was asked to tell the surveyor what happened on 6/23/16 when Resident #18 got burned. The Unit Manager stated, "(Name of Resident's private caregiver) went to get coffee and poured thickener in it, took it to the room and handed it to the resident. The resident went to drink it and dropped it on his lower abdomen. Basically he is a brain injury resident and his last seizure was on 22 of June. I saw the area the next day and the area was red and the blister was still there. The Wound Nurse looked at it and put things in place." The surveyor asked, "What was put into place?" The Unit Manager stated, "Leave it open to air." The surveyor asked, "What does the facility do when a Physician gives an order for a Wound Consult and if anyone had ever clarified it with a Physician?" The Unit Manager stated, "We get the wound nurse to look at it and no, I have never asked the doctor." The Surveyor asked, "What caused the resident's burn and what degree of a burn was it?" The Unit Manager stated, "He spilt the coffee and he got burned, it was a 3rd or 2nd degree burn."</p> <p>On 3/23/17 at 10:30 a.m. an interview was conducted with LPN #2 previous Wound Nurse and the Director of Nursing asked to be present as well. LPN #2 was asked to explain what was</p>	F 323			

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F 323	<p>Continued From page 54</p> <p>observed when she accessed Resident #18's burn. LPN #2 stated, "I read the nurse's note from the previous night and it said burn on quad. I thought it was on the leg so I went to look and I didn't see anything on the leg so I didn't proceed. The someone said a few days later he had areas on his abdomen an I went up and looked. It was two blistered areas that had opened. I called his mom with an update and told her the blister areas had opened and it had been reported by the CNA the night before. I got a new order. It took a while to heal. What happened was I just looked at the wrong area at first, I looked at his leg because I was thinking quad was leg and I never looked at his abdomen where the burn had occurred. That's how I missed it." The surveyor asked, "Did you ever measure the two open blister burn areas so you could monitor for healing?" LPN #2 stated, "No, I never measured them." The surveyor asked, "Was the blister areas from a seatbelt?" LPN #2 stated, "No, they were from the coffee burn." The surveyor asked, "Did the Wound Doctor ever assess the resident 's burn wounds as ordered by the Attending Physician?" LPN #2 stated, "No."</p> <p>The Director of Nursing stated, "He should have been assessed by the Wound Doctor as ordered." After LPN #2 left the room the Director of Nursing stated, "It's because of things like that she failed to do why she is no longer in the Wound Nurse position."</p> <p>On 3/23/17 at 1:10 p.m. an interview was conducted with LPN #3. LPN #3 was asked to explain what happened to Resident #18 on 6/23/16. LPN #3 stated, "(Name of Private Caregiver) came to me around 5:30 p.m. because the resident has spilled his coffee . The</p>	F 323			

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F 323	<p>Continued From page 55</p> <p>caregiver had gotten the coffee from the kitchen and he had spilled it. So I pulled his shirt up to do an assessment. I looked at the left and right quads. The left quad had a blister and the right had a scar from the burn it was pink. After I did my assessment I called the doctor and his mom and dad. The doctor gave an order for a Wound Consult and I left a message for the wound nurse."</p> <p>On 3/23/17 at 1:30 p.m. a interview was conducted with Resident #18's Private Caregiver. The Caregiver was asked to explain what happened the night Resident #18 was burned from a coffee spill. The Caregiver stated, "(Name of Resident #18) has seizures. That day he said he liked to drink some coffee, so I went to the kitchen and got the coffee from the machine and I put thickener in it. After that I gave it to him and he had a seizure. His hand went down and the coffee went all over his abdomen. I toweled him off and told the nurse he had a seizure and spilt his coffee. Every time he has a seizure I tell the nurse. She came in any checked him; he had blisters all over his belly. They never put anything on it. But the belly got worse bleeding and raw. It was 3-4 days later they came in and put a bandage on it, his skin had two open spots. It took more than a month to heal. It would bleed and when I took him to the shower he said I have pain and pointed to his belly. I have been with him for over 10 years, he is like a brother to me." The surveyor asked if anyone had said anything to him about giving the resident coffee recently . The Caregiver stated, "Yes, yesterday (Name of Unit Manager) told me if I give him coffee just put a lid on it."</p> <p>On 3/23/17 at 2:00 p.m. an interview was</p>	F 323		

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F 323	<p>Continued From page 56</p> <p>conducted with Resident #18. The resident was asked about the day he spilled his coffee on his belly. Resident #18 stated, "(Name of caregiver) got me some coffee and when I started to drink it I had a seizure and dropped my coffee in my lap and it burned me. I'm scared to drink it by myself now." Resident asked if surveyor could look at his abdomen, he agreed and his caregiver lifted his shirt revealing the abdomen. The surveyor noted two well defined lower abdominal scars and asked the caregiver if they were the burn scars from the result of the hot coffee spill. The Caregiver stated, "Yes, those are the scars from the hot coffee."</p> <p>CDC (Centers for Disease Control) DEFINITION OF TYPES OF BURNS: (2)</p> <p>First-Degree Burns: First-degree burns involve the top layer of skin. Sunburn is a first degree burn.</p> <p>Signs:</p> <ul style="list-style-type: none"> * Red * Painful to touch * Skin will show mild swelling <p>Second-Degree Burns: Second-degree burns involve the first two layers of skin.</p> <p>Signs:</p> <ul style="list-style-type: none"> * Deep reddening of the skin * Pain * Blisters * Glossy appearance from leaking fluid * Possible loss of some skin <p>Third-Degree Burns: A third-degree burn penetrates the entire thickness of the skin and permanently destroys tissue.</p>	F 323		

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F 323	<p>Continued From page 57</p> <p>Signs:</p> <ul style="list-style-type: none"> * Loss of skin layers * Often painless * Skin is dry and leathery * Skin may appear charred or have patches that appear white, brown, or black <p>The Administrator was asked to see a copy of the Facility Reported Incident (FRI) that was sent to the Office of Licensure and Certification regarding Resident #18's burn from the hot coffee on 6/23/16. The Administrator stated, "I didn't do a FRI." The surveyor asked if a resident burn was considered an unusual occurrence, was she aware of Resident #18 burn and why wasn't a FRI completed. The Administrator stated, "Yes, it's is an unusual occurrence. I knew about the burn from our daily meetings. As to why a FRI was not done I can't answer that, I don't have anything else to add." The Administrator was then asked to see the investigation documentation done and plan put in place by the facility for Resident #18's burn from hot coffee on 6/23/16. The Administrator stated, "We didn't do an investigation and we didn't put a plan in place." The surveyor asked, "Why?" The Administrator stated, "I don't have a response right now."</p> <p>On 3/22/17 at 4:20 p.m. the survey team called the Office of Licensure and Certification, State Department of Health, and informed the supervisors of the above findings and the concern for an Immediate Jeopardy situation due to hot coffee currently still being served in the facility in all 4 resident dining room and the identification of a resident with a 2nd Degree Burn from a hot coffee spill on 6/23/16 with no FRI, investigation, or plan of correction having been completed. The supervisors confirmed Immediate Jeopardy in the</p>	F 323			

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F 323	<p>Continued From page 58</p> <p>facility for failure to ensure an environment free from accidents and hazards in regards to hot coffee being served and available at sufficient temperatures to cause tissue injury to residents. At 4:39 p.m. the Administrator, Director of Nursing and Clinical Services Specialist were called into the conference room for a briefing informed of the above findings and Immediate Jeopardy was called at 4:43 p.m. The Director of Nursing excused herself from the room stating she needed to let staff know not to serve coffee for the supper meal that was beginning to start. Based on review and acceptance of the Facility Plan of Action dated 3/22/17, the Immediate Jeopardy was removed on 3/22/17 at 9:29 p.m.</p> <p>The facility Plan Of Action dated 3/22/17 accepted at 9:29 p.m. is documented in part, as follows:</p> <p>1. During beverage temperature checks for annual survey, surveyors along with the Dietary Manager determined that the coffee on Tidewater unit was 169.3 degrees Fahrenheit; Piedmont was 160 degrees Fahrenheit, Shenandoah was 167 degrees Fahrenheit, and Allegheny was 171 degrees Fahrenheit.</p> <p>As a result of these findings, the Maintenance Director and Assistant Administrator reduced the brew temperature on the automatic coffee machines to 150 degrees Fahrenheit at 2:56 p.m.. The current coffee temperature readings were taken at 5:40 p.m. and are as follows:</p> <p>Piedmont: Regular: 141.8 Decaf: 142.8 Water: 135.6</p>	F 323			

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F 323	<p>Continued From page 59</p> <p>Tidewater: Not currently working</p> <p>Shenandoah: Regular: 138.8 Decaf: 143.5 Water: 142.5</p> <p>Allegheny: Regular: 142 Decaf: 140 Water: 138</p> <p>Coffee and hot water from automatic dispenser will be checked and documented by dietary staff prior to meals and nursing supervisor at night on each unit daily ongoing.</p> <p>Resident/Patients on Tidewater unit will be provided with hot beverages via carafe from Piedmont unit until Tidewater machine is fixed and temperature is adjusted. The temperature of the beverages contained within the carafe will be checked prior to each meal and as needed during night shift.</p> <p>(Name of Resident #18), his parents and his private caregivers will be educated regarding the risk of drinking hot beverages due to decreased sensation, seizure disorder and need for thickened liquid. His care plan has been updated to include recommendation of a cup with a lid due to this risk.</p> <p>A barrier device will be installed to prohibit residents/patients from access to automatic coffee machines.</p> <p>Compliance date 3/23/17</p>	F 323		

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F 323	<p>Continued From page 60</p> <p>2. Residents who request and are given hot liquids to drink are at increased risk for injury if liquids are served at temperatures greater than 150 degrees Fahrenheit.</p> <p>An audit will be done to ascertain patients/residents who request hot liquids to drink.</p> <p>Resident council will be educated regarding new process involving hot liquid service.</p> <p>Resident concerns will be monitored for complaints of beverages either too hot or too cold.</p> <p>Current residents/patients with impaired upper extremity mobility will be assessed at this time, quarterly and then with significant change of condition to ascertain need for therapy referral for adaptive equipment.</p> <p>The general patient/resident population will receive hot beverages in cups with lids.</p> <p>Compliance Date: 3/23/17</p> <p>3. Coffee and hot water from automatic dispenser will be checked and documented by dietary staff prior to meals and nursing supervisor at night on each unit daily ongoing.</p> <p>Newly admitted residents/patients will be assessed for upper extremity mobility/ability to manage hot liquids contained within a cup with lid.</p> <p>100% Dietary staff will be educated to check</p>	F 323		

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F 323	<p>Continued From page 61</p> <p>temperature of coffee and water from automatic dispenser daily prior to meals on each unit and record on log. Any temperatures taken greater than 150 degrees Fahrenheit should be brought to the attention of the maintenance department and liquids withheld from resident/patient use until temperature is lower than 150 degrees Fahrenheit.</p> <p>100% Night shift supervisors will be educated to check temperatures of coffee and hot water from automatic dispenser nightly and record on log. Any temperatures taken greater than 150 degrees Fahrenheit should be brought to the attention of the maintenance department and liquids withheld from resident/patient use until temperature is lower than 150 degrees Fahrenheit.</p> <p>100% of Staff, private caregivers and volunteers will be educated regarding changes to hot liquid service as they report to duty. This education will include need to serve hot beverages in a cup with lid, temperature should not exceed 150 degrees Fahrenheit, if assistance is provided to place cream and/or sugar-lid should be re-placed on the cup.</p> <p>Compliance Date: 3/29/17</p> <p>4. Administration/designee will audit temperature logs to ensure completion and that temperature does not exceed 150 degrees Fahrenheit without corrective action for each unit daily 7 days/week x 4 weeks, then weekly x 8 weeks. Variances will be addressed through QAPI (Quality Assurance Performance Improvement) committee.</p> <p>The following facility posting was identified on the</p>	F 323			

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F 323	<p>Continued From page 62</p> <p>Nursing Units and in the two elevators on 3/23/17 documented in part, as follows:</p> <p>Welcome to Potomac Falls March 23, 2017 Please be aware that we are in the process of making changes to our Hot Beverage service. We ask that no one provide hot beverages other than the staff of Potomac Falls. If your loved one is requesting hot beverage, please ask for a member of our staff to assist. -Thank you for your cooperation.</p> <p>On 3/23/17 Facility Hot Beverage Temperature Logs for all 4 units dated 3/2017 were provided to the surveyor and are document in part, as follows:</p> <p>Piedmont: 3/23/17 Night Nurse: Coffee: 142 degrees, Decaf Coffee: 142 degrees, Hot Water: 127 degrees Breakfast: Coffee: 133 degrees, Decaf Coffee: 137 degrees, Hot Water: 135 degrees Lunch: Coffee: 138 degrees, Decaf Coffee: 140 degrees, Hot Water: 138 degrees</p> <p>Tidewater: 3/23/2017 Night Nurse: Not working Breakfast: Coffee: 150 degrees, Decaf Coffee: 140 degrees, Hot Water: 147 degrees Lunch: Coffee: 130 degrees, Decaf Coffee: 122 degrees, Hot Water: 111 degrees</p> <p>Shenandoah: 3/23/17 Night Nurse: Coffee: 140 degrees, Decaf Coffee: 144 degrees, Hot Water: 128 degrees</p>	F 323		

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F 323	<p>Continued From page 63</p> <p>Breakfast: Coffee: 138 degrees, Decaf Coffee: 144 degrees, Hot Water: 134 degrees Lunch: Coffee: 139 degrees, Decaf Coffee: 144 degrees, Hot Water: 135 degrees</p> <p>Allegheny: 3/23/17 Night Nurse: Coffee: 144 degrees, Decaf Coffee: 142 degrees, Hot Water: 130 degrees Breakfast: Coffee: 139 degrees, Decaf Coffee: 140 degrees, Hot Water: 137 degrees Lunch: Coffee: 140 degrees, Decaf Coffee: 142 degrees, Hot Water: 120 degrees</p> <p>The facility policy titled "BURNS" last reviewed 10/26/16 is documented in part, as follows:</p> <p>Purpose: All burns and scalds are treated immediately to provide comfort and prevent infection.</p> <p>Policy: 3. All burns and scalds should be seen by a physician.</p> <p>Procedure: 6. Assess the burned area: a) First Degree: Redness; not serious unless a large area of the body is involved. b) Second Degree: Blisters form; superficial layers of skin are destroyed; hospitalization may be required if large area of the body are affected; classified as a major burn if over 30% of the body is burned. c) Third Degree: Destruction of full thickness of the skin, and often underlying fat, muscles and bone; hospitalization is required immediately; classified as a major burn if over 10% of the body</p>	F 323		

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F 323	<p>Continued From page 64</p> <p>is burned.</p> <p>8. Protect the burn area as quickly as possible with a sterile dressing.</p> <p>13. Document in detail in Nursing Notes and on 24-Hour Report.</p> <p>14. Update the Care Plan.</p> <p>15. Complete incident report.</p> <p>16. The DON or designee will report to the state health department if appropriate.</p> <p>The facility policy titled "Investigative Analysis of Incidents" last reviewed 10/26/16 is documented in part, as follows:</p> <p>Purpose: It is the intent of the center to maintain a safe and abuse-free environment for all residents. The facility is committed to a comprehensive investigation of all incidents or unusual occurrences. Corrective and preventive action to minimize recurrence will be developed and implemented on an individual resident and center basis. Outside entities, including regulatory agencies, ombudsman, protective services, and legal investigators will be notified and involved as appropriate to the situation.</p> <p>Procedure:</p> <p>4. Upon completion of the investigation, the QA (Quality Assurance) Committee will review the incident and facility response to the incidents or unusual occurrences. The meeting may be at the discretion of the administrator and/or corporate representative, but consideration should be given for the potential of recurrent risk or risk to other residents.</p> <p>The facility policy titled "Unusual Occurrences" last reviewed 10/26/16 is documented in part, as</p>	F 323		

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F 323	Continued From page 65 follows: Policy: Unusual incidences or occurrences will be investigated and, if applicable, reported to the Office of Licensure and Certification, Adult Protective Services, local Ombudsman, and possibly law enforcement. Examples of Unusual Occurrences may include: 6. Accidents or injuries of known origin that are unusual, such as a resident falling out of a window, a resident exiting the facility and sustaining an injury on facility property, or a resident being burned. Procedure: 2. The Administrator or Director of Nursing is to be notified immediately. 4. The Administrator, Director of Nursing, or their designee, must begin a documented investigation of the cause of the unusual occurrence using the Commonwealth Care Investigative Report form. 5. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors, or volunteers which may have had contact with the resident and may help with the investigation. 6. The Office of Licensure and Certification must be notified immediately (within 24 hours of knowledge of the event) by faxing the Facility Self Report form. 8. A complete investigation must be initiated by the Administrator. Every effort is to be made to determine the cause of the unusual occurrence. 9. A letter outlining the findings of the investigation, conclusions drawn, actions taken, and steps to prevent future reoccurrence will be submitted to the Office of Licensure and	F 323			

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F 323	<p>Continued From page 66</p> <p>Certification within 5 working days.</p> <p>On 3/23/17 at 5:30 p.m. a Pre-exit debriefing was conducted with the Administrator, the Director of Nursing, the Clinical Services Specialist, and the Regional Director of Operations where the above findings were presented. The Clinical Services Specialist stated, "Life isn't without risk, everyone has the opportunity to drop coffee, I don't think it's considered an unusual occurrence." While this surveyor was reading the interviews verbatim to the attendees regarding the investigation of Resident #18's second degree abdominal burns from a hot coffee spill during a seizure the Regional Director of Operations stated, "We get it, we understand this is getting emotional for us. We take it personal."</p> <p>Prior to exit no further information was shared.</p> <p>(1) Cerebral Vascular Accident (Cerebral Infarct): an abnormal condition of the brain characterized by occlusion by an embolus, thrombus, or cardiovascular hemorrhage or vasospasm, resulting in ischemia of the brain tissues normally perfused by the damaged vessels.</p> <p>(2) Hemiplegia: paralysis of one side of the body.</p> <p>(3) Dysphagia: difficulty in swallowing, commonly associated with obstructive motor disorders of the esophagus.</p> <p>(4) Muscle Weakness: a weakness in muscle tissue.</p> <p>(5) Diabetes Mellitus: a complex disorder of carbohydrates, fat, and protein metabolism that is</p>	F 323			

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F 323	Continued From page 67 primarily a result of a deficiency or complete lack of insulin secretion by the beta cells of the pancreas or resistance to insulin (6) Osteoarthritis: a form of arthritis in which one or many joints undergo degenerative changes, including bony sclerosis, loss of cartilage, bone spurs, and cartilage in the joints. (7) Seizures: a hyperexcitation of neurons in the brain leading to abnormal electric activity that causes a sudden, violent involuntary series of contractions of a group of muscles. (8) Dementia: a progressive organic mental disorder characterized by chronic personality disintegration, confusion, disorientation, stupor, deterioration of intellectual capacity and function, and impairment of control of memory, judgement and impulses. (9) Aphasia: an abnormal neurologic condition in which language function is disordered or absent because of an injury to certain areas of the cerebral cortex. (10) Diabetic Retinopathy: a disorder of retinal blood vessels. (11) Epilepsy: a group of neurologic disorders characterized by recurrent episodes of convulsive seizures, sensory disturbances, abnormal behaviors, loss of consciousness, or all of these. The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.	F 323			
F 328	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE	F 328		5/2/17	

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F 328 SS=D	Continued From page 68 FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to ... prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 328			

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F 328	<p>Continued From page 69</p> <p>(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>(j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure the safe storage and transportation of oxygen cylinders.</p> <p>On 3/22/17 at approximately 10:10 a.m., during the General Observation Tour with the Assistant Administrator and the Director of Maintenance one full small oxygen cylinder was observed in the oxygen storage room, stored standing on boxes of supplies and not secured in a rack to prevent the cylinder from the potential of becoming airborne if it were to fall. The Oxygen Storage Room was observed not being directly beside or across from a resident room.</p> <p>During the observation of the oxygen cylinder, the Maintenance Director placed the one cylinder into</p>	F 328	<ol style="list-style-type: none"> 1. The oxygen tank in the oxygen storage room was corrected at the time of observation on 3/22/2017. The empty oxygen tank carried by the physical therapy assistant was properly stored immediately following the surveyor observation on 3/22/2017. 2. Any resident is at risk if the oxygen tanks are not stored and/or transported per recommendations. A review was done of storage areas within the facility to ensure storage is appropriate and transport carriers were available for use and in sufficient number. 3. Nursing, materials management, maintenance and therapy staff will be educated on the proper storage and transportation of oxygen to ensure safety. 4. The Administrator or designee will audit the oxygen storage room to ensure proper 		

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F 328	<p>Continued From page 70</p> <p>the storage rack for oxygen cylinders.</p> <p>On 3/23/17 at approximately 12:55 p.m., a Physical Therapy Assistant #3 was observed walking out of the Rehabilitation gym carrying one empty small oxygen tank in her left hand over her shoulder. The Physical Therapy Assistant was observed not carrying an oxygen carrier. One empty oxygen carrier was observed in the Rehab Gym.</p> <p>On 3/22/17 at approximately 10:10 a.m., during the General Observation Tour, when asked how oxygen tanks should be stored, the Assistant Administrator stated that they should be secured in a rack or oxygen holder. The Maintenance Director was asked how oxygen tanks should be stored and he stated that they should be stored in an oxygen holder. The surveyor stated, "This could be potentially very dangerous." The Assistant Administrator stated: "Yes, it could."</p> <p>On 3/23/17 at approximately 12:55 p.m. the Physical Therapy Assistant #3 was observed coming out of the Rehab Gym carrying a small oxygen cylinder over her shoulder. The Physical Therapy Assistant was observed with the oxygen cylinder walk around the corner. On 3/23/17 at approximately 1:00 p.m. the Physical Therapy Assistant #3 returned to the Rehab Gym from the Oxygen Storage room carrying a new full small tank with one hand without an oxygen carrier.</p> <p>The Maintenance Director stated after being asked where and how an oxygen tank should be carried: "In a carrier. We have carriers in the Rehab Gym." The Maintenance Director</p>	F 328	<p>storage daily 5x/week for 2 weeks, weekly x 10 weeks. The Administrator or designee will audit staff throughout the Center via observation to ensure proper transport daily 5x/week x12 weeks. Results will be reported to the QAPI Committee and any variances addressed.</p>		

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F 328	Continued From page 71 informed the Physical Therapy Assistant #3, "You need to transport it in a carrier because it is dangerous if it falls." The Physical Therapy Assistant stated: "It was empty. I went to get a full one." The oxygen cylinder the Physical Therapy Assistant #3 had when she returned was observed to be a full tank and she was not transporting it in a carrier. The web site (https://www.patientsafety.va.gov/professionals/hazards/oxygen.asp) documents hazards of oxygen cylinders if dropped and fractured could propel as a missal.	F 328			
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents	F 371		5/2/17	

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F 371	<p>Continued From page 72 from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility document review, the facility staff failed to store and prepare foods in a sanitary manner.</p> <p>The facility staff failed to ensure an open 25 pound bag of panko (bread crumbs) was stored in a sealed container to prevent physical contaminants from inadvertently entering the food, failed to ensure an open date and use by dated was placed on a 35 ounce open bag of toasted oats, and failed to ensure two deep fryer baskets were free from cross-contamination that were in contact with a trash can.</p> <p>The findings included: On 3/21/17 at 2:40 p.m. a Kitchen/Food Service tour was conducted with the Director of Dietary Services. During the kitchen tour the following observations were made:</p> <p>1. In the Dry Storage Room an open unsealed 25 pound bag of panko (bread crumbs) with an opened of date of 2/14/17 and use by date of 5/14/17 with only a piece of loose plastic wrap lying over the opening of the bag was observed.</p>	F 371	<ol style="list-style-type: none"> 1. The bread crumbs and toasted oats in the dry storage room were discarded at the time of the surveyor observation on 3/21/2017. The two deep dryer baskets were removed from the shelf and placed in the dishwasher at the time of the surveyor observation on 3/21/2017. 2. Any resident has the potential to be affected if food is not stored and prepared in a sanitary manner. 3. All dietary staff will be re-educated on proper food storage and preparation processes. 4. The Administrator or designee will be audit food storage and clean cooking materials storage areas daily 5x/week X 4 weeks and weekly x8 weeks. Results will be reported to the QAPI committee and any variances addressed. 		

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F 371	<p>Continued From page 73</p> <p>2. In the Dry Storage Room an opened 35 ounce bag of toasted oats was identified with no open or use by date present.</p> <p>The Director of Dietary Services was asked by the surveyor what was the expectation of opened food items in the Dry Storage Room. The Director of Dietary Services stated, "Items should be labeled and dated after opening and the bag of panko should have been taken down and put in a bins so the leftovers are thoroughly sealed."</p> <p>On 3/22/17 at 11:30 a.m. in the Kitchen/Food Service area with the Director of Dietary Services present an observation was made of a trash can sitting in between 2 metal carts that contained clean cooking pots, pans, and two deep fryer baskets. The trash can was touching the two deep fryer baskets on the left sided metal cart. The Director of Dietary Services was asked by the surveyor if dirty items should be near or touching clean items that were to be used for cooking. The Director of Dietary Services stated, "The trash can was just emptied and it has a lid on it." The Director of Dietary Services removed the two deep fryer baskets from the shelf to be washed.</p> <p>According to the Food and Drug Administration Food Code 2009, Preventing Contamination from the Premises 3-305.00 Food Storage documented in part, as follows:</p> <p>Food shall be protected from contamination by storing the FOOD: (2) Where it is not exposed to splash, dust, or other contamination.</p> <p>Storing 4-903.11 Equipment, Utensils, Linens,</p>	F 371		

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F 371	<p>Continued From page 74 and Single-Service and Single-Use Articles:</p> <p>(A) Cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored:</p> <ol style="list-style-type: none"> 1. In a clean, dry location. 2. Where they are not exposed to splash, dust, or other contamination. <p>4-903.12 Prohibitions</p> <p>(A) Cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES may not be stored:</p> <ol style="list-style-type: none"> 3. In garbage rooms. 8. Under other sources of contamination. <p>www.foodsafety.gov Food Storage: Dry Storage * Opened foods and ingredients should be sealed and dated, denoting when they were opened. * Bulk dry goods like flour, cornmeal, and sugar should be in pert-resistant containers that are covered and have no cracks.</p> <p>The facility policy titled "Dietary Services Policy and Procedure Manual" last revised 7/13 documented in part, as follows:</p> <p>Dry Goods:</p> <ol style="list-style-type: none"> 4. Open packages must be dated with a "use by" date of 3 months from the date opened. Package may be stored in NSF (National Sanitation Foundation) approved container with tight fitting lid, a zip lock bag or closed with masking tape or plastic tie. <p>The facility policy titled "Dietary Department</p>	F 371		

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F 371	Continued From page 75 Guidelines" last revised 4/2005 documented in part, as follows: "The facility must store, prepare and distribute food under sanitary conditions..." The Facility: The Dietary Department will be maintained in a clean and sanitary manner to prevent foodborne illness. Food: All food items should be labeled and dated to allow for rotation of supplies. Equipment: All food preparation equipment, dishes, and utensils must be maintained in a clean, sanitary, and safe manner and used and repaired according to manufacturer's recommendations. Trash: All trash collection containers are to be kept away from food preparation areas. On 2/23/17 at 5:30 p.m. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing, the Clinical Services Specialist, and the Regional Director of Operations where the above finding were presented.	F 371			
F 441 SS=E	Prior to exit no further information was provided. 483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention	F 441		5/2/17	

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F 441	<p>Continued From page 76 and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);</p> <p>(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p>	F 441			

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F 441	Continued From page 77 (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. (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 observation, staff interviews, and facility document review the facility staff failed to ensure that a single use wound care product was discarded after resident use for 1 of 47 residents in the survey sample, Resident #3, and failed to prevent the potential for the transmission of infection with the storage of clean supplies. 1. The facility staff failed to ensure that a single use Calcium Alginate Wound care product was discarded after wound care was completed on Resident #3. 2. The facility staff failed to ensure the storage of clean supplies in a manner to prevent the potential for transmission of infection.	F 441	1. The single use calcium alginate wound care product was discarded on 3/22/2017. The supplies in the oxygen storage room were removed from the floor immediately following the surveyor observation on 3/22/2017. The three resident shower rooms were cleaned and restocked with soap immediately following the surveyor observation on 3/22/2017. 2. Any resident who receives wound care treatment is at risk to be affected if single use products are used for multiple treatments. Any resident who uses products or equipment stored are at risk if supplies are not stored properly. 3. Licensed nurses will be re-educated on		

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F 441	<p>Continued From page 78</p> <p>The findings included:</p> <p>1. Resident #3 was a 59 year old admitted to the facility on 11/2/10 with diagnoses to include Multiple Sclerosis (1), Unstageable Pressure Ulcer (2), and Paraplegia (3).</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was a Significant Change with an Assessment Reference Date (ARD) of 2/3/17. The Brief Interview for Mental Status (BIMS) was a 14 out of a possible 15 which indicated that Resident #3 was cognitively intact and capable of daily decision making. Under Section M Skin Conditions Resident #3 was coded as having 1 Unstageable Pressure Ulcer and was coded as receiving pressure ulcer care.</p> <p>Resident #3's Physician Order dated 3/14/17 is documented in part, as follows:</p> <p>Cleanse wound with wound cleanser, apply Calcium Alginate to wound bed, secure with foam dressing change every day and as needed should dressing become soiled or displaced.</p> <p>On 3/22/17 at 10:00 a.m. a wound care observation was completed on Resident #3's right ischium with Wound Nurse LPN (Licensed Practical Nurse) #4 following the above mentioned Physician Order. Prior to beginning the wound care LPN #4 had cut two strips of Calcium Alginate and placed on her clean setup . LPN #4 was asked where was the remainder of the Calcium Alginate that was unused. LPN #4 stated, "I opened a brand new one and put the remainder back in the treatment cart, I rolled the top of the package over and I usually but it in a</p>	F 441	<p>the proper use of single use products to prevent the spread of infection. Nursing, medical supply and environmental services staff will be re-educated on the process to clean and maintain supplies in the resident shower rooms to prevent the spread of infection. Nursing, medical supply staff and environmental services staff will be educated on cleaning and storage of equipment.</p> <p>4. The Director of Nursing or designee will audit the wound care treatment carts to ensure single use products are unopened daily x5 days/week x 4 weeks, and then monthly x2 months. The Administrator or designee will audit the oxygen storage room, soiled utility rooms, supply and patient equipment storage rooms to ensure proper storage of supplies and equipment daily x5 days/week x 4 weeks and weekly x8 weeks. The Administrator or designee will audit all resident shower rooms and soiled utility rooms to ensure they are clean and stocked with soap daily 5x/week x 4 weeks and weekly x8 weeks. Results will be reported to the QAPI Committee and any variances addressed.</p>	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/23/2017
NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARY BYRD HIGHWAY STERLING, VA 20164		
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F 441	<p>Continued From page 79</p> <p>zip lock baggie but I don't have any in my cart right now. Wound care is not sterile and I only take out what I'm going to use and save the remainder." After Resident #3's wound care treatment was completed LPN #4 went to the storage room and obtained a zip lock bag and placed the remainder if the Calcium Alginate that had been used on Resident #3 inside and labeled it with the residents name.</p> <p>The facility Algicell dressing front package documented in part as follows:</p> <p>Calcium Alginate Dressing: *Sterile unless opened or damaged.</p> <p>At the bottom of the package revealed the following symbol: the #2 circled with a line crossed through it.</p> <p>The symbol with the #2 circled and a line crossed through it symbolizes "do not use", "single use", or "use only once". Derived from http://www.fda.gov/Regulatory/Information/Guidance.</p> <p>Wound Nurse LPN #4 and Unit Manager LPN #1 were shown the front of the Calcium Alginate package and asked by surveyor if they could explain what the symbol #2 circled with a line crossed through it stood for. Both LPN's replied, "I don't know."</p> <p>The facility produced Manufacturer Recommendations titled "Calcium Alginate Dressings" is documented in part, as follows:</p> <p>Indications: Wounds with moderate to heavy exudate. May help absorb minor bleeding.</p>	F 441			

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F 441	<p>Continued From page 80</p> <p>Calcium Alginate Dressing Features and Benefits: *Sterile *Do Not Reuse</p> <p>On 3/22/17 at 10:30 a.m. an interview was conducted with the Administrator, the Director of Nursing (DON), and the Clinical Services Specialist present. The surveyor asked, "What is the facility practice for the opened left over Calcium Alginate wound supply after the resident's treatment is completed?" The DON stated, "It is our practice to reuse the left over product." All 3 staff members were asked if they knew what the symbol #2 circled with a line crossed through it on the Calcium Alginate package stood for. The Administrator stated, "No, I don't know." The DON stated, "No, I know what it means." The Clinical Services Specialist stated, "No, I don't know." The surveyor explained that it was the universal symbol for a single use device and asked, "What does that imply to you?" The DON stated, "It should be discarded after opening and we should not reuse it. We need to order new sizes and educate."</p> <p>The facility policy titled "General Infection Control Nursing Policies" revised 4/2005 is documented in part, as follows"</p> <p>All medical supplies, including medications and wound care items will be monitored for expiration date and will be discarded and replaced as indicated.</p> <p>The facility was asked for a policy and procedure for single use products and one was not available per the Administrator.</p>	F 441			

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F 441	<p>Continued From page 81</p> <p>On 2/23/17 at 5:30 p.m. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing, the Clinical Services Specialist, and the Regional Director of Operations were the above finding were presented.</p> <p>Prior to exit no further information was provided.</p> <p>(2) Unstageable Pressure Ulcer: Suspected deep tissue injury in evolution.</p> <p>The above definition is derived from the Minimum Data Set (MDS) Version 3.0 Resident Assessment and Care Screening.</p> <p>(1) Multiple Sclerosis: a progressive disease characterized by disseminated demyelination of nerve fibers of the brain and spinal cord.</p> <p>(3) Paraplegia: paralysis characterized by motor or sensory loss in the lower limbs or trunk.</p> <p>The above definitions are derived from Mosby's Dictionary of Medicine, Nursing, and Health Professions 8th Edition.</p> <p>2. On 3/22/17 at approximately 10:00 to 11:00 a.m. during the General Observation tour of the facility the surveyor observed the following items:</p> <p>A. Soiled Shower rooms (3B, 2B, 2A) B. Supplies and equipment stored on the floor C. No soap in the soap dispenser in the Soiled Utility Room</p> <p>A. On 3/22/17 during the General Observation tour of the facility from 10:00 to 11:00 a.m. 3B Resident Shower Room was observed soiled.</p>	F 441		

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F 441	<p>Continued From page 82</p> <p>Used towels were observed lying in the shower room. The Shower room bench was observed with torn rough edges on the padded seat.</p> <p>On 3/22/17 during the General Observation tour of the facility from 10:00 to 11:00 a.m. 2B shower room was observed to be soiled. A used towel was observed lying in the shower room. The shower room bench was observed with torn rough edges.</p> <p>On 3/22/17 during the General Observation tour of the facility from 10:00 to 11:00 a.m. 2A shower room was observed to be soiled. A used brief was observed on the floor and a used glove was observed on the floor. Used towels were observed on the shower bench. A round brown ball that looked like feces and a wet washcloth were observed laying on the shower floor. The Bathtub was observed soiled with apparent grime and what looked to be a dried up white sponge pad in the bottom of the tub. The sink was covered with items around the faucets (knife, toilet paper roller, and sharp edged broken plastic part from the toilet paper roller).</p> <p>During the observations of all three showers, the Maintenance Director picked up soiled items. Both the Maintenance Director and the Assistant Administrator agreed that the shower rooms were "dirty".</p> <p>B. On 3/22/17 during the General Observation tour of the facility from 10:00 to 11:00 a.m. multiple supplies and equipment were observed stored on the floor. In the oxygen storage room, 1 card board box of 3 XL briefs were observed stored on the floor. The box contained 4 bags of</p>	F 441			

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F 441	<p>Continued From page 83</p> <p>8 briefs. In addition to the briefs, a large Pump was stored on the floor along with a nebulizer compressor.</p> <p>On 3/23/17 at approximately 10:00 to 11:00 a.m. during the general observations tour, a storage room was observed with multiple isolation door hanging kits. Three of these isolation kits were observed sitting on a heavily dusty floor.</p> <p>C. In the soiled Linen Room (Utility Room) it was observed that the soap dispenser had no soap. The sink was observed to be dry. The sink was observed to look soiled (stainless steel sink spotted with white specks).</p> <p>The Policy and Procedure titled, "General Infection Control Policies" with a revision date of 02/13 was reviewed. The Policy documented the following:</p> <p>Specialty bathing tubs and chairs are cleaned between each resident with a germicidal cleaner. Shower chairs are cleaned by housekeeping with germicidal cleaner daily and by CNA's (Certified Nursing Assistants) as needed with soiled. No item (clean or soiled linen, clothing, personal items, etc.) are to touch the floor. No personal clothing, toilet articles, or clean or soiled linen are to be left in the bathing areas.</p> <p>The Policy and Procedure titled, "General Infection Control Nursing Policy" with a revision date of 4/05 documented the following:</p> <p>All resident care items will be cleaned and disinfected before being used for another</p>	F 441			

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F 441	Continued From page 84 resident.....other common used items will be cleansed according to the manufacturer's recommendations between resident uses. All resident common areas will be maintained in a clean and orderly manner and will be free of obvious hazards such as fall hazards, chemical hazards, etc. During the observations of the soiled areas, the Maintenance Director, picked up soiled items and discarded as the tour progressed. The Maintenance Director stated that he would be able to fix the remaining soiled areas. The facility administration was informed of the findings during a briefing on 3/23/17 at approximately 5:30 p.m. to 6:30 p.m. The facility did not present any further information about the findings	F 441			
F 498 SS=E	483.35(c); 483.95(g)(1)(2)(4) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS 483.35 (c) Proficiency of Nurse Aides The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. 483.95 (g) Required in-service training for nurse aides. In-service training must- (g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.	F 498		5/2/17	

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F 498	<p>Continued From page 85</p> <p>(g)(2) Include dementia management training and resident abuse prevention training.</p> <p>(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation review, the facility staff failed to ensure continuing competency of nursing aides with training hours no less than 12 hours a year.</p> <p>Specifically, the facility staff failed to ensure that five out of 46 CNAs (Certified Nursing Assistants) had completed at least 12 hours of training per year per hire anniversary date for each CNA.</p> <p>The findings included:</p> <p>On 3/23/17, the facility documentation was reviewed. A list of 46 CNAs with training hours per hire anniversary year was reviewed. Five out of 46 CNAs did not have at least 12 hours of training since their one year hire anniversary date.</p> <p>Also training transcripts were reviewed for all 46 CNAs. The training transcripts documented the course topic and the amount of hours completed for each CNA. The hours were totaled by two surveyors and five CNAs were below 12 hours within the year of the hire anniversary date.</p> <p>On 3/23/17 at approximately 4:15 p.m., a human resource staff member (Others #4) was interviewed. Others #4 explained that it was the responsibility of the Unit Managers and Human</p>	F 498	<ol style="list-style-type: none"> 1. The five CNAs completed their required 12 hours of training. 2. Any resident has the potential to be at risk if CNAs do not complete their required 12 hours of training annually. 3. All CNAs will be re-educated on the requirement to complete 12 hours of training annually and how to use the online learning environment and how to record other hours provided by other means of delivery. The Senior Human Resources Generalist, Director of Nursing, Assistant Director of Nursing and Unit Managers will be re-educated on the importance of monitoring the completion of CNAs required 12 hour of annual training. Validation the annual training requirement will occur at the time the annual evaluation is completed for each nursing assistant and any noncompliance addressed and reported to the Administrator. 4. The Administrator or designee will audit the timely completion of training records for CNAs monthly for 12 months. Results will be reported to the QAPI Committee and any variances addressed. 		

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F 498	<p>Continued From page 86</p> <p>Resources to monitor completion of training. Others #4 stated, "All staff receive email reminders for the training [program name] to complete hours assigned." Others #4 also explained that staff are reminded at a monthly staff meeting to complete all training hours. Others #4 also stated, "All staff attend annual in-services, newly hired staff receive training and all staff receive training with any changes." Others #4 stated, "I monitor the training in [name of training program] every couple of months and email the results to the unit managers to remind staff to login and complete training." Others added, "It is up to the staff [CNAs] to complete their training hours." Others #6 was given some time to review other documentation to locate any additional hours for the five CNAs that had less than 12 hours per one year hired anniversary date.</p> <p>No additional training hours were located by Others #6.</p> <p>On 3/23/17 at approximately 5:30 p.m. the Director of Nursing (DON) was interviewed. The DON explained that all the units and staff had just received access last week to see how many training hours are logged in. The DON also stated, "A report is run monthly for managers to track and monitor the hours." A facility policy was asked for regarding the training hours.</p> <p>On 3/23/17 at 5:30 p.m. the Director of Operations was interviewed. The Director of Operations provided a signed policy that documented a general description of training. The Director of Operations stated, "The policy does not have the regulation, we give them [CNAs] 12 hours [of training] required by regulations, we</p>	F 498			

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F 498	Continued From page 87 follow the SOM [State Operations Manual]." On 3/23/17 at 5:30 p.m. the administrator was interviewed. The Administrator stated, "My expectation is for 12 hours per anniversary date annually and thereafter." On 3/23/17 at 5:45 p.m. The Director of Operations stated, "We don't have any more hours [documentation of training hours for the five CNAs below the required 12 hours]." The facility administration was informed of the findings during a briefing on 3/23/17 at approximately 5:30 p.m. The facility did not present any further information about the findings.	F 498			
F 518 SS=D	483.75(m)(2) TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS The facility must train all employees in emergency procedures when they begin to work in the facility; periodically review the procedures with existing staff; and carry out unannounced staff drills using those procedures. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review, the facility staff failed to ensure that all staff were trained in emergency procedures, specifically use of a fire extinguisher. On 3/22/17 at approximately 11:20 a.m. a Certified Nursing Assistant (CNA) was questioned on use of a fire extinguisher. The CNA #1 stated that to use a fire extinguisher she would take the extinguisher out of the wall unit, then squeeze the handle and aim at the bottom of the fire. When CNA #1 was asked what she would do if nothing	F 518	1. CNA #1 was re-educated on emergency procedures, specifically the use of a fire extinguisher. 2. Any resident has potential to be at risk if staff are not educated on emergency procedures, specifically the use of a fire extinguisher. 3. All staff will be re-educated on emergency procedures, specifically the use of a fire extinguisher and will be part of annual training for each staff member. 4. The Administrator or designee will audit	5/2/17	

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F 518	<p>Continued From page 88</p> <p>came out of the nozzle when she squeezed the handle, she had no response. When CNA #1 was asked what she would do if she was not able to squeeze that handle, CNA had no response. The CNA and surveyor were standing in front of an extinguisher while questions were asked. Answers to "PULL THE PIN" were written on the extinguisher. CNA never was able to state, "Pull the Pin" to get the fire extinguisher to work.</p> <p>A copy of CNAs education completed on the computer system (type of training) was provided by the facility, and it did not document that Fire Safety had been completed. Although a hire date was not obtained, the first documented date of CNAs (type of training) began on 2/9/16.</p> <p>A copy of "New Hire Orientation" was provided and it documented: "Fire and Emergency Preparedness is to be completed on day one of orientation."</p> <p>A copy of Fire Safety: The Basics from orientation Relias training was provided. It documented the following: Remember P.A.S.S.</p> <p>P - Pull the safety pin out of the handle. A- Aim the extinguisher nozzle or hose at the base of the fire. not at the flames. S - Squeeze the handle slowly to discharge the agent. S - Sweep side to side, a safe distance from the fire until expended.</p> <p>The facility administration was informed of the findings during a briefing on 3/23/17 at approximately 5:30 p.m. to 6:30 p.m. The facility</p>	F 518	<p>a random sample of staff throughout the Center via questions to ensure knowledge of emergency procedures, specifically the use of a fire extinguisher weekly x12 weeks. Results will be reported to the QAPI Committee.</p>	

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F 518	Continued From page 89 did not present any further information about the findings	F 518			

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{F 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit survey was conducted 5/9/17 through 5/11/17 to the standard survey ending 3/23/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 150 certified bed facility was 135 at the time of the survey. The survey sample consisted of 15 current record reviews (Residents #101 through 115).	{F 000}			
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 157		5/12/17	

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

TITLE

(X6) DATE

Electronically Signed

05/19/2017

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 05/11/2017
NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARY BYRD HIGHWAY STERLING, VA 20164		
(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 157	<p>Continued From page 1</p> <p>resident from the facility as specified in §483.15(c)(1)(ii).</p> <p>(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.</p> <p>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-</p> <p>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or</p> <p>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.</p> <p>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by:</p> <p>The facility staff failed to notify the physician and or designee and the Power of Attorney of a change in physical, mental, or psychosocial status for 1 of 15 residents in the survey sample, Resident #115.</p> <p>The facility staff failed to notify the physician and or designee and the Power of Attorney that Resident #115 was not receiving the dietary supplement (Pure Aloe Force) as ordered by the physician and the resident was refusing the anti-platelet medication Aggrenox.</p> <p>Aggrenox is used to reduce the risk of stroke in</p>	F 157	<p>1. Resident #115's physician and/or designee and POA have been notified that the resident did not receive the dietary supplement (Pure Aloe Force) and the resident was refusing her antiplatelet medication Aggrenox. The Pure Aloe Force and Aggrenox were both discontinued per physician order on 5/11/2017 and 5/12/2017 respectively.</p> <p>2. Any resident is at risk if the physician and/or designee and POA are not properly notified when a resident has change in the plan of care.</p> <p>3. Licensed nurses and IDT will be</p>		

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F 157	<p>Continued From page 2</p> <p>people who have had blood clots or a "mini-stroke".</p> <p>The findings included:</p> <p>Resident #115 was originally admitted to the facility 3/14/07 and readmitted 4/27/16 after an acute hospital stay. The current diagnoses included: stroke with right hemiparesis, cardiovascular disease, hypertension, and dementia. The clinical record also contained a document dated 1/16/17 and signed by a physician which stated; "given level of patient's impairment, in my opinion, she lacks capacity to manage her own medical and financial matters". Based on the preceding information the Durable Power of Attorney (POA), appointed 9/12/07 was initiated.</p> <p>The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/31/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This indicated Resident #115's cognitive abilities for daily decision making were moderately impaired.</p> <p>The 3/31/17 MDS assessment was also coded that the resident had no mood or behavior problems, required supervision after set-up with eating and supervision with one person assistance with off unit locomotion. The 3/31/17 MDS assessment further revealed the resident required extensive assistance of 1 person with bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene. The 3/31/17 MDS assessment revealed the resident</p>	F 157	<p>re-educated to the process to notify physicians and/or designee and POA when a resident has a change in the plan of care including refusal of medications.</p> <p>4. Director of Nursing or designee will audit the EMR for any change in plan of care including medication refusals without notification of MD and POA/RP documentation daily 5x/week x2 weeks, weekly x2 weeks and monthly x2months. Results will be reported to the QAPI Committee and any variances addressed.</p>		

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F 157	<p>Continued From page 3 required total care with bathing.</p> <p>The current and active physician order summary revealed an order dated 4/26/17 reading; Aggrenox capsules Extended Release 12 hour 25/200 milligrams (Aspirin-Dipyridamole ER) Give one capsule by mouth two times a day for Deep Vein Thrombosis (DVT) prevention.</p> <p>Review of the Medication Administration Record (MAR) for May 2017 revealed Resident #115 refused the medication 5/2/17 at 9:00 p.m., 5/6/17 at 9:00 p.m., and 5/7/17 at 9:00 p.m. The April 2017 MAR revealed the medication Aggrenox was refused by the resident 4/13/17 at 9:00 p.m., 4/15/17 at 9:00 p.m., 4/21/17 at 9:00 a.m., 4/24/17 at 9:00 a.m., 4/26/17 at 9:00 p.m., 4/29/17 at 9:00 p.m., and 4/30/17 at 9:00 p.m.</p> <p>Further review of the MAR revealed the medication was not offered 4/24/17 at 9:00 p.m. through 4/26/17 at 9:00 a.m. The clinical record revealed the daughter (non-POA) "requested that medication shouldn't be given to mom and she wanted it deleted, because it was harming her mom.</p> <p>The progress note dated 4/26/17 at 6:56 p.m., stated the POA was notified of the discontinuation of the Aggrenox on 4/24/17 upon the sisters request. The POA informed the nurse she wanted the resident back on the medication, Aggrenox.</p> <p>An interview was conducted with the POA on 5/11/17 by telephone at approximately 9:15 a.m. The POA stated no one from the facility had</p>	F 157			

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F 157	<p>Continued From page 4</p> <p>informed her that Resident #115 was not taking the medication Aggrenox. The POA further stated she thought after the conversation with the Unit Manager approximately 2 weeks ago she was under the impression the issues with the medications were resolved. Neither had the facility staff informed the POA that the supplement Pure Aloe Force was not administered as ordered because it was not available for administration.</p> <p>An interview was also conducted with the Nurse Practitioner (NP) on 5/11/17 at approximately 10:00 a.m.. The NP stated that she was in the building daily but would not state if she or the physician had been informed that the resident was not accepting the medication Aggrenox as prescribed. The NP stated residents refuse medications for many reason and she did not feel it was a concern. The NP further stated it was "the nurse's judgment, there is no set protocol, no set number of doses missed or policy when to notify the physician or her of medication refusals".</p> <p>The NP also stated the dietary supplement was ordered solely because the daughter requested it. She did not respond when asked if she was aware the resident had not had the supplement consistently for several days but she repeated it was ordered because the daughter wanted it.</p> <p>The NP was unable to direct the surveyor to documentation indicating the facility staff had notified the practice of the inability to procure the dietary supplement or documentation the practice was notified that the resident often refuses to accept the medication, Aggrenox and what the plan was related to the refusals and inability to</p>	F 157			

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F 157	Continued From page 5 acquire the dietary supplement. No documentation was observed in the clinical record that the physician, NP or facility staff had informed the POA or attempted to educate the resident, POA, or daughter regarding not having the dietary supplement or of the potential complications related to refusals of the medication, Aggrenox. An interview was conducted with the Director of Nursing (DON) on 5/11/17 at approximately 11:45 a.m. The DON stated the facility staff should notify the physician and or designee and POA whenever a resident refuses medications or the facility does not have the ordered product. The facility's undated policy titled "Notification of Physician Required" read; The physician must be notified of any of the following or any other need for physician's intervention or awareness. 1. Change in resident's condition. 2. Any type of incident, accident, abuse or neglect. 3. Room changes. 4. Refusal of two or more doses of medication. 5. Pressure sore development. 6. Medication errors. 7. Results of all diagnostic services, including laboratory, x-ray, etc. The above information was shared with the Administrator, Director of Nursing, Registered Dietitians and Corporate Consultant on 5/11/17 at approximately 1:15 p.m. No additional information was provided prior to the survey team's exit.	F 157			
F 250	483.40(d) PROVISION OF MEDICALLY	F 250		5/12/17	

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F 250 SS=E	Continued From page 6 RELATED SOCIAL SERVICE (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: The facility failed to provide medically related social services for 1 out of 15 residents as evidenced by the facility choosing not to follow the wishes of the legal power of attorney (POA) but following the wishes of the non-POA for her mother's diet. The findings included: Resident #115 was originally admitted to the facility 3/14/07 and readmitted 4/27/16 after an acute hospital stay. The current diagnoses included; dementia, legal blindness, diabetes, stroke with right hemiparesis, cardiovascular disease, osteoporosis, hypertension, glaucoma and macular degeneration. The clinical record also contained a document dated 1/16/17 and signed by a physician stated; "given level of patient's impairment, in my opinion, she lacks capacity to manage her own medical and financial matters". Based on the preceding information the Durable Power of Attorney (POA), appointed 9/12/07 was initiated. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/31/17 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 9 out of a possible 15. This	F 250	1. Social Services has invited Resident #115 and her POA to attend a care plan meeting on 5/23/2017; the purpose of the care plan meeting is to review and coordinate medically related social services. 2. Any resident is at risk if facility staff fails to follow the wishes of the legal power of attorney in accordance with the resident's wishes. Current resident's medical record will be audited for assignment of primary POA and appropriate listing in the record for the purpose of plan of care changes and notification. The IDT will be re-educated to relay information when appropriate as changes of condition occur and with care conferences to the primary POA to establish a plan of care that is in accordance with the residents wishes. 3. Administrator or designee will audit the EMR for documentation discussion with the primary POA of changes in condition and care conferences weekly x4 weeks and monthly x6 months. Results will be reported to the QAPI Committee and variances addressed.		

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F 250	<p>Continued From page 7</p> <p>indicated Resident #115's cognitive abilities for daily decision making were moderately impaired.</p> <p>The 3/31/17 MDS assessment was also coded that the resident had no mood or behavior problems, required supervision after set-up with eating and supervision with one person assistance with off unit locomotion. The 3/31/17 MDS assessment further revealed the resident required extensive assistance of 1 person with bed mobility, transfers, locomotion on the unit, dressing, toilet use, and personal hygiene. The 3/31/17 MDS assessment then revealed the resident required total care with bathing.</p> <p>Review of the current and active care plan dated 4/11/12 included a nutrition problem which read "Altered nutritional needs related to diagnosis of CVA (stroke), diabetes, hypertension, urinary tract infection, history of disordered eating as related to only eating a few foods, history of significant weight loss, patient will not eat if blood sugars are elevated. Family refuses Boost supplement, Lactose free, patient eats using hands per preference, improvement in hemoglobin A1C (a test which shows the average level of glucose in your blood for the past 3 months), vegan diet, limited food acceptance, significant weight loss, daughter wants patient to drink 3 cups water prior to meals, daughter refuses insulin coverage at times".</p> <p>The goals read; (name of resident) will not have significant weight loss through review date 6/3/17 and (name of resident) will have no negative outcomes due to blood sugar fluctuations through 6/3/17.</p>	F 250			

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F 250	<p>Continued From page 8</p> <p>The interventions included; diet as ordered. Encourage healthy food choices and food acceptance. Encourage by mouth and fluid intake. High calorie supplements as ordered. Honor food requests. Large portions at meals. Monitor intake. Monitor lab values. Monitor weight. Speech Language Pathologist interventions, as needed. Snacks per nutrition protocol.</p> <p>An interview was conducted with the POA by telephone on 5/11/17 at approximately 9:15 a.m. The POA stated the facility staff complies with her sister's suggestions when she has made her wishes known.</p> <p>The POA provided a letter dated 10/25/16, signed by the NP which stated the facility's staff had concerns with the "restrictive diet" requested by the non-POA daughter and the POA hesitation to proceed with the restrictive vegan diet. The final paragraph of the letter dated 10/25/16 read; "(name of resident) has had consistent weight loss since May 2016. As of September 2016, (name of non-POA) has been requesting that the staff provide her mother with three full glasses of water prior to meals, in order to decrease her appetite, (name of facility, staff), is in agreement, as well as (name of the resident) doctor and NP, (name of NP), that medically, this is not in the (name of the resident) best interest. In October 2016, (name of resident) and POA met with the UM and RD #1 to discuss the consistent weight loss and about the concerns her diet was not providing adequate nutrition. The POA voiced her concerns but the resident stated she wished to continue with the limited diet providing inadequate</p>	F 250			

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F 250	<p>Continued From page 9</p> <p>nutrition. The facility staff made the resident aware of the potential consequences of the restrictive diet.</p> <p>Review of Resident #115 individual diet card revealed the following information; "can have zucchini, broccoli or cauliflower, no corn, no squash, no bread, 1 Lactaid, 1 iced water, orange wedges only. May have Beyond Meat meat substitutes, no meat, pasta or rice, Please provide sweet potato or potato cut up. Likes lentils or Quinoa. Standing orders: 3 x 8 fluid ounces of water".</p> <p>Observation of Resident #115's meal plate on 5/10/17 at approximately 12:30 p.m. revealed a sweet potato and broccoli. On the side was a dessert cup of orange slices and milk. The daughter was seated beside Resident #115 with a sealed container of greenish liquid and a jar of greenish liquid from which the daughter drank.</p> <p>An interview was conducted with Registered Dietitian (RD) #1 on 5/10/17 at approximately 1:10 p.m. RD #1 stated there was only one vegan resident in the facility and that was Resident #115. RD #1 stated Resident #115's protein for the lunch meal on 5/10/17 was supplied by the daughter. It was a lentil soup with sausage. The Administrator stated during this interview; "should we serve her the meat, just for it to be thrown away?"</p>	F 250			

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F 250	<p>Continued From page 10</p> <p>The facility documented again on 1/27/17 at 4:29 p.m., that the POA "stated she would like for her mom to receive meat and other items to ensure adequate nutrition is delivered at meal times. The non-POA daughter was made aware of the POA's decision regarding Resident #115's diet by the facility staff on 1/27/17. The facility's documentation stated the non-POA daughter became "irate about the decision and made clear that she does not agree with the decision and would like her mom to continue to follow a vegan diet". The facility staff telephoned and informed the POA of her sister's statement and expressed their desire to start the new diet on Monday instead of over the weekend to help prevent excess burden on the staff" over the weekend.</p> <p>The above information was shared with the Administrator, Director of Nursing, Registered Dietitians and Corporate Consultant on 5/11/17 at approximately 1:15 p.m.</p>	F 250		

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E 000	Initial Comments	E 000			
F 000	<p>An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted offsite from 4/21/20 through 4/24/20/20 onsite from 6/24/20 through 6/25/20. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities</p> <p>INITIAL COMMENTS</p> <p>An unannounced COVID-19 Focused Survey was conducted offsite from 4/21/20 through 4/24/20 and onsite from 6/24/20 through 6/25/20. The facility was in compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirements.</p> <p>The census in this 150 bed facility was 107 at the time of survey. The total number of COVID-19 positive residents as of the date of the survey were 43, and 22 of those residents recovered. There were no active cases at the time of the survey. The total number of COVID-19 positive staff cases was 41, 40 staff had returned to work.</p>	F 000			

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

TITLE

(X6) DATE

Electronically Signed

07/10/2020

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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PRINTED: 11/13/2018
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E 000	Initial Comments	E 000		
F 000	An unannounced Emergency Preparedness survey was conducted 10/9/18 through 10/ 11/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long Term Care Facilities. No emergency preparedness complaints were investigated during the survey. INITIAL COMMENTS	F 000		
F 558 SS=D	An unannounced Medicare/Medicaid standard and complaint survey was conducted 10/9/18 through 10/11/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. 8 complaints were investigated during the survey. The census in this 150 certified bed facility was 147 at the time of the survey. The survey sample consisted of 32 current Resident reviews and 8 closed record reviews. Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, medical record review and facility documents the facility staff failed to provide for the accommodation of needs to maintain independence and to ensure the safety for 1 of 40 residents in the survey sample, Resident	F 558	1. Resident #154's call bell was checked for placement upon notification by surveyor. 2. Any resident may be at risk if a call bell is not within reach. An audit of call bell	11/23/18

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

TITLE

(X6) DATE

Electronically Signed

11/01/2018

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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F 558	<p>Continued From page 1 #154.</p> <p>For Resident #154, he facility staff failed to ensure the call bell was placed within reach.</p> <p>The findings included:</p> <p>Resident # 154 was a 78 year old admitted to the facility on 09/28/2018 with diagnoses to include contusion of the lung, multiple fractures of ribs S/P fall, subsequent encounter for fracture with routine healing, Type 2 Diabetes Mellitus, Epilepsy, unsteadiness on feet, lack of coordination, muscle weakness, frontal lobe and executive deficit.</p> <p>The admission Minimum Data Set (MDS) had not been due/completed. Information was gathered from the Resident's baseline Care Plan.</p> <p>Focus: Name (Resident # 154) has an ADL (Activities of Daily Living) Demonstrates the need for ADL assistance r/t (related to) multiple rib fracture, s/p (status post) fall. Date Initiated: 09/28/18 Revision on: 10/05/18</p> <p>Interventions: *Provide assistance for bed mobility as needed. *Provide assistance for locomotion as needed. *Provide assistance for toileting as needed. *Provide assistance with transfers as needed. *Provide assistance with bathing and dressing as needed.</p> <p>Focus: Risk for falls r/t epilepsy and h/o falls. Date Initiated: 09/28/18 Revision on: 10/02/18</p> <p>Interventions: *Orient patient and family to room, call bell,</p>	F 558	<p>clips and cord length in relationship to seating in room will be conducted to ensure ability for call be to be within reach.</p> <p>3. Education will be conducted for licensed and non-licensed staffmembers and the Facility's call bell policy will be reviewed to ensure the importance and need for all residents to have call bell in reach.</p> <p>4. Leadership Team members or designee will do random call bell placement checks on 20 residents call bells per week for four weeks and then monthly for 2 months. The results will be reviewed weekly in the standup meeting and results will be reported to our facility's monthly QAPI meeting with any variances addressed</p>	

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F 558	<p>Continued From page 2</p> <p>lighting, and bathroom.</p> <p>*Orient to call bell and encourage use to request assistance.</p> <p>*Frequent patient checks during adjustments period to new surroundings and while assessing/ observing patient's routine.</p> <p>*Pt. re-educated on the importance of making sure walker is locked when using to stand or transfer, before using it for mobility.</p> <p>Focus: At risk for falls Unsteady gait. Date Initiated: 10/06/18 Created on: 10/06/18</p> <p>Interventions:</p> <p>*Anticipate and meet needs.</p> <p>*Be sure call light is within reach and encourage to use it for assistance as needed.</p> <p>During the survey the following observations were made:</p> <p>On 10/09/18 at 2:38 PM the call bell was observed on the bed while Resident # 154 was sitting in the recliner chair, not within reach.</p> <p>On 10/09/18 at approximately 3:40 PM, Resident # 154 said that she had fallen since being admitted to rehab. on 10/06/18, call bell was on Resident # 154's bed while she sat on the further side of the room, not within reach.</p> <p>On 10/10/18 at approximately 10:39 AM a visit was made to Resident # 154 room. She stated that she was having "headache pain that feels like it's affecting my eyes" as well as pain from her fractured ribs. The resident said that she had spoken to the doctor earlier and requested to have xrays of her head. The Resident was sitting in her recliner, the call bell was laying on the bed out of reach.</p>	F 558			

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F 558	<p>Continued From page 3</p> <p>On 10/10/18 at approximately 10:58 AM Resident # 154 said that her blood sugar was 105 this morning and that she feels dizzy most of the time. She also said that the staff is aware. The Resident was sitting in her recliner, the call bell was laying on the bed, out of reach.</p> <p>On 10/10/18 11:20 AM Call bell was observed not in reach while Resident # 154 was sitting in the recliner not within reach.</p> <p>On 10/10/18 1:29 PM In to see resident in room, call bell on the bed while Resident # 154 was sitting in the recliner out of reach. Resident was watching tv.</p> <p>On 10/10/18 2:28 PM Resident was observed on the phone talking. Her call bell remained on the far side of her bed out of reach.</p> <p>On 10/10/18 2:30 PM an interview was conducted with LPN (Licensed Practical Nurse) # 1. LPN #1 was asked if she had been the nurse for the Resident #154 any this week. LPN #1 stated, "Yes!" LPN #1 was asked if she was aware that Resident # 154 call bell was on her bed while she sat in the recliner on the further side of the room yesterday and today. LPN # 1, shook her head, "No." She stated that CNA (Certified Nurses Aide) # 1 was Resident # 154 aide today. (10/10/18).</p> <p>On 10/10/18 02:40 PM an interview was conducted with Certified Nursing Assistant (CNA) #1. She was asked if she noticed that Resident # 154 call bell was out of reach on her bed while she was sitting in her recliner on the further side of the room. CNA # 1, stated that she was not aware and that she had educated Resident # 154</p>	F 558			

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F 558	<p>Continued From page 4</p> <p>to the call bell. CNA # 1 also said that the call bell should be near the resident.</p> <p>On 10/10/18 2:38 PM Entered residents room call bell remained on the far side of Resident's bed while she sat in the recliner.</p> <p>On 10/10/18 3:00 PM Entered residents room, Resident # 154 sitting in her recliner. Call bell was still on Resident #154's bed.</p> <p>On 10/10/18 3:15 PM Resident # 154 was seen ambulating with her walker to the restroom. Call bell on the bed.</p> <p>On 10/10/18 3:42 PM The administrator was notified that the call bell had been observed since yesterday out of reach on Resident #154's bed while she sat in her recliner.</p> <p>On 10/10/18 at approximately 3:42 PM, the Administrator was asked for call bell policy.</p> <p>The facility's policy titled CALL-BELL/LIGHT SYSTEM states that a well-functioning call-bell light shall be provided;so that each resident will have a way to communicate his/her needs to the Nursing staff. (1). Every call-bell/light should be acknowledged ASAP. The bathroom emergency lights must be answered immediately. (2.). The signal cord or button must be kept within the reach of the resident at all times. (3).If a resident is not within reach of his/her call-bell/light...unable to use the call bell-inactivate. The resident must have a way to call for help that is within reach;that meets their needs.</p> <p>On 10/11/18 at 3:00 PM a pre-exit interview was conducted with the Administrator and the Director</p>	F 558			

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F 558	Continued From page 5 of Nursing where the above information was shared. The Director Of Nursing and Administrator were addressed with call bell concerns due to Resident # 154 having a history of falls, feeling dizzy, and being unsteady on her feet at times, as well as, having headaches, not having her call bell within reach. The Director Of Nursing was asked what she would have expected the staff to do with Resident # 154 call bell. The Director of Nursing stated, "The call bell should have been left in reach in order for the resident to maintain her safety and independence." No further information was provided by the facility staff.	F 558			
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, clinical record review and facility documentation review, the facility staff failed to notify one of 40 residents (Resident #19) of a change in roommate.	F 559	1. Facility staff met with Resident #19 to discuss his concerns. 2. Any resident or patient located in a semi-private room within the facility has the potential to be affected if not properly	11/23/18	

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F 559	<p>Continued From page 6</p> <p>The facility staff failed to inform Resident #19 in advance, of a roommate change of a resident that was transferred to his room from another unit in the facility.</p> <p>The findings included:</p> <p>Resident #19 was admitted to the nursing facility on 7/23/13 with diagnoses that included paraplegia.</p> <p>The most recent Minimum Data Set Assessment was an annual assessment dated 8/20/18 and coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated no cognitive impairment.</p> <p>During an interview with Resident #19 on 10/10/18 at 10:40 a.m., he stated he had several roommates move in and out of his room and was never approached by anyone to let him know of the change in roommates. He stated the roommates were transferred into his room from another unit within the facility. He stated, "I felt I was not important to them at all. It didn't mean I would not accept another roommate, just that it would have been respectful."</p> <p>On 10/10/18 at 2:00 p.m., the social worker verified Resident #19 had three roommates transferred into his room from within the facility on 6/21/18, 7/13/18, and 7/31/18. She stated she did not have any documentation that she approached the resident to inform him in advance of a change in roommate and indicated there was ample time to have let him know.</p>	F 559	<p>notified of an incoming resident or patient who will be moved into the room from another unit from within the facility.</p> <p>3. IDT and licensed nurses will be educated on the process of roommate change or incoming patient notification and documentation.</p> <p>4. The Social Services Director or designee will audit the EMR to ensure that notification is taking place as well as the notation in the resident's or Patient's EMR of room changes for the past 30 days and will conduct an audit of notification of roommate changes weekly for three months. Results of these audits will be analyzed and discussed for further recommendations during the facilities monthly Quality Assurance process, Results will be reported in QAPI committee and any variances addressed.</p>		

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F 559	Continued From page 7 On 10/11/18 at 1:50 p.m., the aforementioned issue was brought to the attention of the Administrator, Regional Director of Operations and Director of Nursing (DON). No further information was brought forward prior to survey exit. The facility's policy and procedure titled Patient/Resident Room Changes dated 11/2017 indicated prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as possible.	F 559			
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those	F 582		11/23/18	

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F 582	<p>Continued From page 8</p> <p>services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p> <p>(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a complaint investigation, record review, family interviews, staff interviews, and facility document review the facility failed to issue a Notice of Medicare Non-Coverage (NOMNC) prior to discharge for 1 of 40 residents in the survey sample, Resident #148.</p> <p>The facility staff failed to issue a Medicare Notice</p>	F 582	<p>1. Resident 148 no longer resides at the facility. It is duly noted facility failed to issue a notice of non-coverage letter prior to discharge resident #148. Notices of non-coverage were audited for patients discharged in the past 30 days.</p> <p>2. Any resident who is under Medicare or Commercial Insurance coverage has the</p>	

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F 582	<p>Continued From page 9 of Non-Coverage prior to Resident #148's discharge that was facility planned on 8/8/17 however occurred on 8/9/17.</p> <p>The findings included:</p> <p>Resident #148 was admitted to the facility on 7/16/17 with diagnoses to include Left Femur Fracture, Atrial Fibrillation and Dementia. On the facility Admission Record Resident #148's son was listed as her Responsibility Party and Guardian.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission 5 Day with an Assessment Reference Date (ARD) of 7/23/17. The Brief Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated that Resident #148 was not cognitively intact and incapable of daily decision making.</p> <p>The last Minimum Data Set (MDS) assessment was a Discharge with an Assessment Reference Date (ARD) of 8/8/17. Under Section A2000 Discharge Date Resident #148 was coded as 8/9/17. Under A2100 Discharge Status Resident #148 was coded as 1 (Community).</p> <p>ON 10/10/18 at 11:31 A.M. a phone interview was conducted with Resident #148's son (Responsible Party). Resident #148's son was made aware that surveyors were in the facility and his complaint investigation had begun. Resident #148's son stated, "The facility nurse called me on August 8, 2017 around 5 o'clock asking me if I was aware that my mother was being discharged today. I said "no" that no one had called me about a discharge because I needed to arrange for a private sitter to stay with</p>	F 582	<p>ability to be affected if not informed of services not covered under their payer source or for when any services will cease within proper time frame as deemed appropriate per Medicare guidelines</p> <p>3. Social services personnel will be in serviced on providing proper notice of Medicare non-coverage within proper time frame as deemed appropriate per Medicare guidelines to Medicare patients prior to discharge.</p> <p>4. The Social Services Director or designee will audit all Medicare/Commercial payer changes from the past 30 days and will conduct an audit of 5 payer changes weekly for two months. Results of these audits will be analyzed and discussed for further recommendations during the facilities monthly Quality Assurance process Results will be reported in QAPI committee and any variances addressed.</p>	

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F 582	<p>Continued From page 10</p> <p>her at nights at her assisted living for her safety. The nurse called me because her transport had not arrived yet so they canceled the discharge for that night but discharged her the next day. Resident #148's son was asked if he had received a Medicare Notice of Non-Coverage from the facility prior to discharge. Resident #148's son stated, "No, I wasn't given anything I did not even know she was being discharged."</p> <p>Resident #148's Facility Progress Notes were reviewed and are documented in part, as follows:</p> <p>8/4/17 at 8:51 A.M. Social Services Note=SSD (Social Services Director) spoke with (Name) at the Name (assisted living), is ready to accept resident back. Planned discharge Tuesday.</p> <p>8/8/17 at 10:45 A.M. Social Services Note=resident set to discharge to ALF (Assisted Living Facility).</p> <p>8/8/17 at 19:55 (7:55) P.M. Health Status Note=pt. (patient) was scheduled for discharge today. called and spoke with son and he stated that he was not aware of discharge today. discharge is canceled for today. In house supervisor made aware.</p> <p>8/8/17 at 22:58 (10:58) P.M. Health Status Note=Spoke with SW (Social Worker) today, son still working on the D/C (discharge) date.</p> <p>8/9/17 at 22:00 (10:00) P.M. Health Status Note= Patient discharged as planned. MD (Medical Doctor) aware.</p> <p>A Skilled Nursing Facility Protection Notification Review was completed on 10/10/18. Resident</p>	F 582			

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NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARRY BYRD HIGHWAY STERLING, VA 20164		
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F 582	<p>Continued From page 11</p> <p>#148's information was reviewed and documented in part, as follows:</p> <p>Medicare Part A Skilled Services Episode Start Date: 7/16/17 Last covered day of Part A Service: 8/9/17</p> <p>How was the Medicare Part A Service Termination/Discharge determined? The facility/provider initiated the discharge from Medicare Part A Services when benefit days were not exhausted.</p> <p>2. Was a Notice of Medicare Non-Coverage (NOMNC) provided to the resident? No-If no, explain why the form was not provided: 2. Other: Not found in the Medical Record and no way to validate if completed or not.</p> <p>On 10/10/18 at approximately 12:30 P.M. the Regional Director of Operations stated, "We cannot find a NOMNC for Name (Resident #148) that was issued, the Social Workers that were here then have all gone now."</p> <p>The MDS Billing Calendar provided by the facility billing department for Resident #148 was reviewed.. The MDS Billing Calendar for Resident #148 indicated that the resident had 76 Part A Skilled Medicare days left.</p> <p>On 10/11/18 at 2:00 P.M. a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Director of Operations were the above information was shared. Prior to exit no further information was provided.</p> <p>This is A COMPLAINT DEFICIENCY</p>	F 582		

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F 623 F 623 SS=D	Continued From page 12 Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is	F 623 F 623		11/23/18	

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F 623	Continued From page 13 required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623			

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F 623	<p>Continued From page 14</p> <p>§483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on resident record review, staff interviews and facility document review, the facility failed to notify the Office of the State Long-Term Care Ombudsman in writing of a hospital discharge for 1 of 40 residents (Resident #63) in the survey sample.</p> <p>1. The facility staff failed to notify the Office of the State Long-Term Care Ombudsman of Resident #63's transfer to the emergency room (ER) from dialysis on 07/18/18.</p> <p>The finding included:</p> <p>Resident #63 was re-admitted to the facility on 07/19/18. Diagnosis for Resident #63 included but not limited to *End Stage Renal Disease (ESRD).</p>	F 623	<p>1. Resident # 63 was transferred from Dialysis Center to the hospital. Resident 63 no longer resides at the facility. The facility sent a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for resident #63</p> <p>2. Any resident being discharged has the ability to be affected. if the center does not inform the office of the State Long Term Care Ombudsman in writing of a resident or patient that is transferring or discharging from the facility in any capacity as soon as practicable.</p> <p>3. Social Services personnel will be in serviced on providing the office of the State Long Term Care Ombudsman notice in writing of all residents or patient that transfer from facility at any capacity.</p>		

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F 623	<p>Continued From page 15</p> <p>The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated no cognitive impairment.</p> <p>The Discharge MDS assessments was dated for 07/18/18, discharge return anticipated, re-admitted to the facility on 07/19/18.</p> <p>On 07/18/18, according to the facility's documentation, Resident #63 called the facility from the dialysis center to inform the nurse she was being sent to the local ER for evaluation due to complaints of dizziness. Resident returned to the facility on 07/19/18.</p> <p>On 10/10/18 at approximately at 12:35 p.m., an interview was conducted with the Assistant Social Worker who stated, "I was unable to locate in the medical record where the Ombudsman was notified of Resident #63's discharge to the hospital on 07/18/18. The surveyor asked, "Should you have notified the ombudsman of Resident #63's discharge to the hospital" she replied, "Yes."</p> <p>The facility administration was informed of the finding during a briefing on 10/11/18 at approximately 2:00 p.m. The facility did not present any further information about the findings.</p> <p>The facility's policy titled Notification of Discharge. -Policy: The facility must provide advance notice to the resident/resident representative, and a copy to the state ombudsman for planned discharges for all facility initiated discharges at or around the time of discharge. Advance notice is</p>	F 623	<p>4. The Social Services Director or designee will audit the EMR to ensure notification is in compliance for all residents or patients that have transferred or discharged from the facility with weekly x 4 weeks then monthly x 2 months. Results will be reported in QAPI committee and any variances addressed.</p>		

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F 623	Continued From page 16 defined as 30 days or as soon as practicable depending on the reason for the discharge. -Discharges notice for emergent discharges will be provided to the patient/representative as soon as practicable. Copies of notices for emergency transfers must also be sent to the ombudsman, but they may be sent when practicable and may be provided in the form of a list of residents on a monthly basis. Definitions: *ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure).	F 623			
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and facility documentation review, the facility staff failed to ensure one (Resident #146) of 40 residents in the survey sample had an accurate Minimum Data Set (MDS) assessment. Resident #146's discharge MDS, dated 8/28/18, was coded that she was discharged to the hospital rather than discharged home. The findings included:	F 641	. Resident #146's, MDS dated 8/28/18 section A was modified to reflect discharge to home. 2. Any resident whose discharge status is not accurately coded in the MDS has the potential to be affected. A review of the current discharged residents will be conducted to ensure accurate coding of the MDS. 3. The interdisciplinary team responsible for coding the MDS will be educated	11/23/18	

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F 641	<p>Continued From page 17</p> <p>Resident #146 was a 87 year old admitted to the facility on 8/15/18 with diagnoses to include Chronic Kidney Disease and Congestive Heart Failure.</p> <p>The most recent MDS assessment was a Discharge with an Assessment Reference date of 8/28/18. Under Section A Type of Assessment Resident #146 was coded as 10/1 (Discharge assessment-return not anticipated), planned. Under A 2100 Discharge Status Resident #146 was coded as 03 (discharge to acute hospital).</p> <p>Resident #146's progress note dated 8/28/18 at 11:26 A.M. was reviewed and is documented in part, as follows:</p> <p>pt. (patient) left the facility at 11:00 to home accompanied by her daughter. pt. received education regarding medication administration, diet, and emergency situation. pt. received all her belongings including medication and personal. pt. denied any pain or discomfort at the time of exit.</p> <p>Resident #146's Physician Order dated 8/28/18 at 6:02 A.M. was reviewed and is documented in part, as follows:</p> <p>Pt. to DC (discharge) home on 8/28/18.</p> <p>The facility Discharge Summary for Resident #146 was reviewed and is documented in part, as follows:</p> <p>A. 1. Date of admission: 8/15/18 2. Date of discharge/transition: 8/28/18</p> <p>B. Discharge Disposition of Patient:</p>	F 641	<p>regarding accurate coding of the MDS.</p> <p>4. MDS coordinators or designee(s) will conduct an audit of 6 completed discharge assessments weekly for four weeks then monthly for two months for coding of discharge status. Results of these audits will be analyzed and discussed for further recommendations during the facility's monthly Quality Assurance process. Great except for date</p>	

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F 641	Continued From page 18 1. Discharge/Transition destination: a. Home with caregiver/family. b. Home with Home Health services. On 10/10/18 03:15 PM an interview was conducted with the MDS Director regarding Resident #146's Discharge MDS dated 8/28/18. After reviewing the resident's medical record the MDS Director stated, "It looks like the resident went home. Yes it is an inaccurate MDS because the resident went home and did not go to the hospital." The facility policy titled "MDS COORDINATION AND COMPLETION" dated 10/11/18 was reviewed and documented in part, as follows: Procedure: 1. The MDS Coordinator shall be designated the responsibility of coordinating each resident's assessment (MDS) according to the RAI(Resident Assessment Instrument) manual guidelines. 3. Each individual who completed a portion of the assessment (MDS) must attest to the accuracy of that portion of the assessment. On 10/11/18 at 2:00 P.M. a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Director of Operations were the above information was shared. Prior to exit no further information was provided.	F 641			
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		11/23/18	

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F 656	Continued From page 19 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656			

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F 656	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, record review, family interviews, staff interviews, and facility documentation review, the facility failed to develop a Comprehensive Care Plan to include discharge goals and interventions for 1 of 40 residents in the survey sample, Resident #148.</p> <p>The facility staff failed to develop a Comprehensive Care Plan to include discharge goals and interventions for Resident #148</p> <p>The findings included:</p> <p>Resident #148 was admitted to the facility on 7/16/17 with diagnoses to include Left Femur Fracture, Atrial Fibrillation and Dementia. On the facility Admission Record Resident #148's son was listed as her Responsibility Party and Guardian.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission 5 Day with an Assessment Reference Date (ARD) of 7/23/17. The Brief Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated that Resident #148 was not cognitively intact and incapable of daily decision making.</p> <p>The last Minimum Data Set (MDS) assessment was a Discharge with an Assessment Reference Date (ARD) of 8/8/17. Under Section A2000 Discharge Date Resident #148 was coded as 8/9/17. Under A2100 Discharge Status Resident #148 was coded as 1 (Community).</p> <p>ON 10/10/18 at 11:31 A.M. a phone interview was conducted with Resident #148's son</p>	F 656	<ol style="list-style-type: none"> 1. It is duly noted that Resident #148's care plan failed to include discharge goals and interventions. Resident # 148 no longer resides in center. 2. Any resident who resides in the facility has the potential to be affected if care plan does not include discharge goals and interventions. A review of the current residents will be conducted to ensure that the Care Plan includes discharge goals and interventions. 3. The interdisciplinary team responsible for care planning will be educated regarding accurate care planning per the RAI manual. 4. MDS coordinators or designee(s) will conduct an audit of 10 care plans weekly for four weeks then monthly for two months. Results of these audits will be analyzed and discussed for further recommendations during the facility's monthly Quality Assurance process. 		

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F 656	<p>Continued From page 21</p> <p>(Responsible Party). Resident #148's son was made aware that surveyors were in the facility and his complaint investigation had begun. Resident #148's son stated, "The facility nurse called me on August 8, 2017 around 5 o'clock asking me if I was aware that my mother was being discharged today. I said "no" that no one had called me about a discharge because I needed to arrange for a private sitter to stay with her at nights at her assisted living for her safety. The nurse called me because her transport had not arrived yet so they canceled the discharge for that night but discharged her the next day. Resident #148's son was asked if he had received a Medicare Notice of Non-Coverage from the facility prior to discharge. Resident #148's son stated, "No, I wasn't given anything I did not even know she was being discharged."</p> <p>Resident #148's Team Based Admission Assessment (TBAA) dated 7/18/17 was reviewed and is documented in part, as follows:</p> <p>3. Family Member participated via: 1. Present for meeting (Son)</p> <p>Summary of Discussion Goals: 1. Summarize goals for safe transition identified during the meeting=go back to memory care home. Able to ambulate with walker by self.</p> <p>Estimated Safe Transition: 3. Enter the estimated safe transition week based on today's status and discussions=30 days.</p> <p>Plan of Care: 1. Plan was reviewed during meeting.</p>	F 656		

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F 656	<p>Continued From page 22</p> <p>2. Was developed and input from patient/RP (responsible party)</p> <p>Resident #148's Comprehensive Care Plan dated 7/16/17-8/9/17 was reviewed. There was no focus, goal, or interventions regarding Resident #148's plan for discharge back to her assisted living noted in her comprehensive care plan.</p> <p>On 10/11/18 at 9:45 A.M. an interview was conducted with MDS Coordinator #1. MDS Coordinator #1 was asked if discharge planning is part of the comprehensive plan of care and should it have been included in Resident #148's comprehensive plan of care. MDS Coordinator #1 stated, "Yes we do include discharge planning in the care plan, and it should have been done for her as well."</p> <p>On 10/11/18 at 9:55 A.M. an interview was conducted with the Regional Director of Operations. The Regional Director of Operations was asked if discharge planning is part of the comprehensive plan of care and should it have been included in Resident #148's comprehensive plan of care. The Regional Director of Operations stated, "Yes, absolutely the discharge should be included in the comprehensive care plan. It was missed for this resident."</p> <p>Resident #148's Facility Progress Notes were reviewed and are documented in part, as follows:</p> <p>8/4/17 at 8:51 A.M. Social Services Note=SSD (Social Services Director) spoke with (Name) at the Name (assisted living), is ready to accept resident back. Planned discharge Tuesday.</p> <p>8/8/17 at 10:45 A.M. Social Services</p>	F 656			

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F 656	<p>Continued From page 23</p> <p>Note=resident set to discharge to ALF(Assisted Living Facility).</p> <p>8/8/17 at 19:55 (7:55) P.M. Health Status Note=pt. (patient) was scheduled for discharge today. called and spoke with son and he stated that he was not aware of discharge today. discharge is canceled for today. In house supervisor made aware.</p> <p>8/8/17 at 22:58 (10:58) P.M. Health Status Note=Spoke with SW (Social Worker) today, son still working on the D/C (discharge) date.</p> <p>8/9/17 at 22:00 (10:00)P.M. Health Status Note= Patient discharged as planned. MD (Medical Doctor) aware.</p> <p>The facility policy titled "Comprehensive Care Planning Process" dated 4/19/18 was reviewed and documented in part, as follows:</p> <p>Policy: The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. An interdisciplinary assessment team shall develop a comprehensive assessment and care plan for each resident based on outcomes of assessments and input from the resident, family and interdisciplinary team members.</p> <p>On 10/11/18 at 2:00 P.M. a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Director of Operations were the above information was shared. Prior to exit no further information was provided.</p>	F 656			

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F 656	Continued From page 24	F 656			
F 660 SS=D	<p>This is a COMPLAINT DEFICIENCY.</p> <p>Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix)</p> <p>§483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-</p> <p>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.</p> <p>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.</p> <p>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.</p> <p>(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.</p> <p>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.</p> <p>(vi) Address the resident's goals of care and treatment preferences.</p> <p>(vii) Document that a resident has been asked</p>	F 660		11/23/18	

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F 660	Continued From page 25 about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.	F 660			

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F 660	<p>Continued From page 26</p> <p>This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, record review, family interviews, staff interviews, and facility document review the facility failed to involve the resident and resident representative in the final discharge plan for 1 of 40 residents in the survey sample, Resident #148.</p> <p>The facility staff failed to ensure that Resident #148's son was involved in the final discharge plan scheduled on 8/8/17.</p> <p>The findings included:</p> <p>Resident #148 was admitted to the facility on 7/16/17 with diagnoses to include Left Femur Fracture, Atrial Fibrillation and Dementia. On the facility Admission Record Resident #148's son was listed as her Responsibility Party and Guardian.</p> <p>The most recent comprehensive Minimum Data Set (MDS) assessment was an Admission 5 Day with an Assessment Reference Date (ARD) of 7/23/17. The Brief Interview for Mental Status (BIMS) was a 3 out of a possible 15 which indicated that Resident #148 was no cognitively intact and incapable of daily decision making.</p> <p>The last Minimum Data Set (MDS) assessment was a Discharge with an Assessment Reference Date (ARD) of 8/8/17. Under Section A2000 Discharge Date Resident #148 was coded as 8/9/17. Under A2100 Discharge Status Resident #148 was coded as 1 (Community).</p> <p>ON 10/10/18 at 11:31 A.M. a phone interview was conducted with Resident #148's son</p>	F 660	<ol style="list-style-type: none"> 1. Resident #148 no longer resides in center. 2. Any resident who discharges from the facility has the potential to be impacted if they are discharging, the facility must develop and implement a discharge planning process that includes the resident, patient as well as their representative. 3. IDT team will be in-serviced on developing and implementing a discharge planning process that includes the resident or patient as well as their wanted representative. The IDT or designee will communicate all discharge plans with resident or patient as well as representative as wanted during the discharge planning process and notate these communications in resident or patient's EMR. 4. The Social Services Director or designee will audit the EMR five times a week for 2 months to ensure communication documentation is complete and includes all intended parties Results will be reported in QAPI committee and any variances addressed. 		

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F 660	<p>Continued From page 27</p> <p>(Responsible Party). Resident #148's son was made aware that surveyors were in the facility and his complaint investigation had begun. Resident #148's son stated, "The facility nurse called me on August 8, 2017 around 5 o'clock asking me if I was aware that my mother was being discharged today. I said "no" that no one had called me about a discharge because I needed to arrange for a private sitter to stay with her at nights at her assisted living for her safety. The nurse called me because her transport had not arrived yet so they canceled the discharge for that night but discharged her the next day. Resident #148's son was asked if he had received a Medicare Notice of Non-Coverage from the facility prior to discharge. Resident #148's son stated, "No, I wasn't given anything I did not even know she was being discharged."</p> <p>Resident #148's Comprehensive Care Plan dated 7/16/17-8/9/17 was reviewed. There was no focus, goal, or interventions regarding Resident #148's plan for discharge back to her assisted living noted in her comprehensive care plan.</p> <p>On 10/11/18 at 9:45 A.M. an interview was conducted with MDS Coordinator #1. MDS Coordinator #1 was asked if discharge planning is part of the comprehensive plan of care and should it have been included in Resident #148's comprehensive plan of care. MDS Coordinator #1 stated, "Yes we do include discharge planning in the care plan, and it should have been done for her as well."</p> <p>On 10/11/18 at 9:55 A.M. am interview was conducted with the Regional Director of Operations. The Regional Director of Operations</p>	F 660		

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F 660	<p>Continued From page 28</p> <p>was asked if discharge planning is part of the comprehensive plan of care and should it have been included in Resident #148's comprehensive plan of care. The Regional Director of Operations stated, "Yes, absolutely the discharge should be included in the comprehensive care plan. It was missed for this resident."</p> <p>Resident #148's Facility Progress Notes were reviewed and are documented in part, as follows:</p> <p>8/4/17 at 8:51 A.M. Social Services Note=SSD (Social Services Director) spoke with (Name) at the Name (assisted living), is ready to accept resident back. Planned discharge Tuesday.</p> <p>8/8/17 at 10:45 A.M. Social Services Note=resident set to discharge to ALF(Assisted Living Facility).</p> <p>8/8/17 at 19:55 (7:55) P.M. Health Status Note=pt. (patient) was scheduled for discharge today. called and spoke with son and he stated that he was not aware of discharge today. discharge is canceled for today. In house supervisor made aware.</p> <p>8/8/17 at 22:58 (10:58) P.M. Health Status Note=Spoke with SW (Social Worker) today, son still working on the D/C (discharge) date.</p> <p>8/9/17 at 22:00 (10:00) P.M. Health Status Note= Patient discharged as planned. MD (Medical Doctor) aware.</p> <p>The facility policy titled "Safe Transition Planning (Anticipated Discharge)" dated 6/1/18 was reviewed and is documented in part, as follows:</p>	F 660			

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F 660	Continued From page 29 Specific Procedures/Requirements: 1. The interdisciplinary team, with input and collaboration from the resident/resident representative will develop a safe transition plan for all residents. 3. The transition plan will: a. Involve the resident and resident representative in the development of the plan and inform the resident and resident representative of the final plan. 6. If a resident is transferred to another skilled nursing facility, or home health agency, or intensive rehabilitation facility or long term hospital, the nursing facility: f. The resident/representative will be notified and oriented to the orientation to the upcoming transition to ensure that the transition is as safe and orderly as possible. On 10/11/18 at 2:00 P.M. a pre-exit de-briefing was held with the Administrator, the Director of Nursing and the Director of Operations where the above information was shared. Prior to exit no further information was provided.	F 660			
F 677 SS=D	This is a COMPLAINT DEFICIENCY ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews	F 677	1. Resident #61 and 63 received a	11/23/18	

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F 677	<p>Continued From page 30</p> <p>and clinical record review the facility staff failed to provide personal care to include showers for two resident in the survey sample of 40 (Resident #61 and 63) who were unable to independently carry out activities of daily living (ADL's).</p> <ol style="list-style-type: none"> 1. The facility staff failed to ensure Resident #61 received showers according to resident plan and preference. 2. The facility staff failed to ensure Resident #63 received showers according to resident plan and preference. <p>The findings include:</p> <ol style="list-style-type: none"> 1. Resident #61 was originally re-admitted to the facility on 05/25/17. Diagnosis for Resident #61 included but not limited to *Anxiety disorder and *Cardiomyopathy. <p>Resident #61's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 08/24/18 coded Resident #61's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #61 total dependence of one with bathing, extensive assistance of two with bed mobility and transfer, extensive assistance of one with dressing and toilet use for Activities of Daily Living care. Resident #61 was also coded for frequently incontinent of bowel and bladder.</p> <p>The care plan dated 05/08/17 with a revision date of 04/30/18 identified Resident #61 comprehensive care plan with the need for ADL assistance. The goal set for the resident by the</p>	F 677	<p>shower on 10/1//2018 and the shower schedule was amended to reflect preference.</p> <ol style="list-style-type: none"> 2. Any resident who does not receive showers per their plan and preference has the potential to be impacted if not implemented. A review of current residents plan for showers will be conducted, and the plan will be updated. 3. Education will be conducted for Nurses and CNAs to review the facility's policy, and ensure that the staff understands that showers must be documented when provided, and provided as resident plan and preference. IT scheduling requirements for documentation will be reviewed with newly hired licensed and certified staff as well as Medical Records staff. 4. Unit Manager or Designee(s) will conduct an audit on five patients per unit weekly for four weeks and monthly for 2 Months to ensure showers are provided and documented on. Results of these audits will be discussed and reviewed in weekly clinical meeting to ensure compliance and it will also be discussed for further recommendations during the facility's monthly Quality Assurance process 		

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F 677	<p>Continued From page 31</p> <p>staff was that the resident will receive necessary level of ADL assistance through the next review . One of the interventions/approaches the staff would use to accomplish this goal included to provide assistance with bathing, dressing, grooming, toileting and eating as needed.</p> <p>On 10/09/18 at approximately 3:05 p.m., an interview was conducted with Resident #61 who stated, "I have not been receiving my showers lately; at least for the last 2 months." The resident proceeded to say, "I should have gotten a shower today but the Certified Nursing Assistant (CNA) did not give it to me."</p> <p>On 10/10/18, the surveyor reviewed the units shower schedule. Resident #61 was scheduled to have showers every Tuesday and Friday (7 a.m.-3 p.m. shift).</p> <p>Review of Resident #61's documentation report for bathing revealed the following: Showers were not given on the following shower days: June 2018 (06/29/18), July 2018 (7/3, 7/13 and 7/31/18), August 2018 (8/7, 8/21, and 8/24/18), September 2018 (9/4, 9/7, 9/11, 9/14, 9/18, 9/25 and 9/28/18) and October 2018 (10/2, 10/5 and 10/9/18).</p> <p>A phone call was placed to Certified Nursing Assistant (CNA) #2 on 10/11/18 at approximately 9:13 a.m. The CNA was assigned to Resident #61 on her shower days; a message was left, the CNA never called back.</p> <p>An interview was conducted with Director of Nursing (DON) on 10/11/18 at approximately 9:50 a.m. She said when unit (Name) went from 40 residents to 47 residents, we decided to try a</p>	F 677		

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F 677	<p>Continued From page 32</p> <p>shower/restorative aide. The DON said the shower/restorative aide only lasted about 3 days (this was done as a trial basis only). The DON said, each CNA is now responsible for giving their own showers and performing the residents restorative program. The surveyor asked, "What are your expectation for your CNA's for giving Resident's their scheduled showers" she replied, "I expect for the CNA's to given resident's their showers twice a week and if they refused; they are to notify the nurse so the refusal could be documented."</p> <p>2. Resident #63 was readmitted to the facility on 07/19/18. Diagnosis for Resident #63 included but not limited to *Leukemia.</p> <p>Resident #63's Minimum Data Set (MDS-an assessment protocol) was a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/18 coded Resident #63's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #63 total dependence of one with bathing, and supervision with limited assistance of one with bed mobility, transfer, dressing toilet use and personal hygiene for Activities of Daily Living care.</p> <p>The care plan dated 05/22/18 with a revision date of 07/19/18 identified Resident #63 person-centered comprehensive care plan with the need for ADL assistance with a diagnosis of Leukemia, and is currently on hemodialysis. The goal set for the resident by the staff was that the resident will receive necessary level of ADL assistance through the next review. One of the interventions/approaches the staff would use to</p>	F 677			

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F 677	<p>Continued From page 33</p> <p>accomplish this goal included to provide assistance with bathing and hygiene as needed.</p> <p>An interview was conducted with Resident #63 on 10/09/18 at approximately 3:37 p.m., who stated, "No one here is giving showers; I'm not getting my showers like I should." The resident said they use to be a shower aide but that position went away about 4 months ago and then the showers just stopped."</p> <p>On 10/10/18, the surveyor reviewed the units shower scheduled. Resident #63 was scheduled to have showers given every Tuesday and Friday (7 a.m.-3 p.m. shift).</p> <p>Review of Resident #63's documentation report for bathing revealed the following: Showers were not given on the following shower days: July 2018 (7/3, 7/6, 7/10, 7/13, 7/17, 7/20, 7/24, 7/27 and 7/31/18), August 2018 (8/3, 8/7, 8/10, 8/14, 8/17, 8/21, 8/24, 8/28 and 8/31/18), September 2018 (9/4, 9/7, 9/11, 9/14, 9/18, 9/25 and 9/28/18) and October 2018 (10/2, 10/5 and 10/9/18).</p> <p>A phone call was placed to CNA #2 on 10/11/18 at approximately 9:13 a.m. The CNA was assigned to Resident #63 on her shower days; a message was left, the CNA never called back.</p> <p>An interview was conducted with the Director of Nursing (DON) on 10/11/18 at approximately 9:50 a.m. She said when unit (Name) went from 40 residents to 47 residents, we decided to try a shower/restorative aide. The DON said the shower/restorative aide only lasted about 3 days (this was done as a trial basis only). The DON</p>	F 677			

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F 677	<p>Continued From page 34</p> <p>said, each CNA is now responsible for giving their own showers and performing the residents restorative program. The surveyor asked, "What are your expectation for your CNA's for giving Resident's their scheduled showers" she replied, "I expect for the CNA's to give the resident's their showers twice a week and if they refuse; they are to notify the nurse so the refusal can be documented."</p> <p>The facility administration was informed of the finding during a briefing on 10/11/18 at approximately 2:00 p.m. The facility did not present any further information about the findings.</p> <p>The facility's policy titled Bathing, Whirlpool Tub (Revised 3/12).</p> <p>-Policy: Residents are to receive whirlpool tub bath or shower at least twice weekly, unless otherwise ordered by the physician.</p> <p>Definitions:</p> <p>*Anxiety disorder is a mental condition in which you are frequently worried or anxious about many things. Even when there is no clear cause, you are still not able to control your anxiety (https://medlineplus.gov/ency/patientinstructions/000685.htm).</p> <p>*Cardiomyopathy, or heart muscle disease is a type of progressive heart disease in which the heart is abnormally enlarged, thickened, and/or stiffened. As a result, the heart muscle's ability to pump blood is less efficient, often causing heart failure and the backup of blood in the lungs or rest of the body (webmd.com).</p>	F 677		

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F 677	Continued From page 35 *Leukemia is a cancer of blood-forming tissues, hindering the body's ability to fight infection (Mayoclinic.com).	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		11/23/18

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F 690	<p>Continued From page 36</p> <p>restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, resident interview, staff interview, clinical record review, and review of the facility's policy the facility staff failed to receives the appropriate care and services to prevent potential indwelling catheter complications for 1 of 40 residents (Resident #48), in the survey sample.</p> <p>The facility staff failed to anchor Resident #48's indwelling urinary catheter to prevent tension on the catheter and avoid potential kinking of the tubing.</p> <p>The findings included:</p> <p>Resident #48 was originally admitted to the facility 8/9/18 and readmitted 9/27/18 after an acute care hospital stay. The current diagnoses included; urinary retention with bilateral hydronephrosis (kidney swelling due to urine failing to drain properly).</p> <p>The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/16/18 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #48's cognitive abilities for daily decision making were intact.</p> <p>In section "G" (Physical functioning) the resident was coded as requiring supervision of 1 person with eating and extensive assistance of 1 person with locomotion, dressing, and personal hygiene and bathing, extensive assistance of 2 people</p>	F 690	<p>Resident #48 indwelling Urinary Catheter was anchored as soon as notified to prevent tension on the catheter and avoid potential kinking of the tubing.</p> <p>2. Any Resident with a Foley Catheter has the potential to be impacted if their catheter is not being anchored properly with the potential for kinking the tubing.</p> <p>3. Education to be provided for licensed and certified staff as it relates to catheter care and placement by 10/31/2018. The center's Foley Catheter Policy will also be reviewed during the training. Newly hired licensed and certified staff will receive Indwelling Catheter Care policy information included in orientation.</p> <p>4. Unit Manager or Designee(s) will conduct an audit on all patients with Foley Catheters in the facility daily for a week, weekly for three weeks and monthly for 2 Months, to ensure that indwelling catheters are anchored properly. Results of these audits will be discussed and reviewed in clinical meeting weekly to ensure compliance and it will also be discussed for further recommendations during the facility's monthly Quality Assurance process with any variances addressed.</p>	

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F 690	<p>Continued From page 37</p> <p>with bed mobility, transfers, and toileting, and total care of 2 people with bathing In section "H" Bladder and Bowel, the resident was coded as frequently incontinent of her bladder and bowels.</p> <p>A Physician's order dated 10/1/18, read; Indwelling catheter 16 french, 10 milliliter balloon for hydronephrosis. Catheter care every shift.</p> <p>The current care plan dated 10/9/18 had a problem which read (name of resident) has a history of urinary tract infection (UTI) and is at risk for future infections related to urinary retention and presence of urinary catheter with a diagnosis of bilateral hydronephrosis. The care plan goal read (name of resident) will remain free of UTI's through 1/1/2019. The interventions included; Foley catheter as ordered with catheter care per facility protocol. Give antibiotic therapy as ordered. Observe/document for side effects and effectiveness. Obtain and monitor lab/diagnostic work as ordered. Report results to physician and follow-up as indicated</p> <p>Clinical record notes had a nurse's note dated 10/1/18 at 9:59 a.m., which read; "Resident is alert and oriented times 3. At 8:00 a.m., this morning, resident was noted with a distended bladder. Resident was encouraged to void but unable to urinate by herself. Physician in house and assessed the resident. A new order was given to insert a Foley catheter for urinary retention. A 16 french catheter was inserted times 1 attempt. Clear yellow urine 2,000, milliliters drained and connected to urinary bag. Resident stated I feel so relieved. Resident denied pain and distress. Resident is her self responsible party and agreed daughters (name of daughter) and (name of daughter) were called and made</p>	F 690			

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F 690	<p>Continued From page 38 aware. Will continue to monitor."</p> <p>On 10/10/18 at approximately 1:05 p.m., Resident #48 complained of discomfort in her private area and desired to remove her pant. The resident called for staff assistance and CNA #5 came in and assisted her to remove there pants. Resident #48 was observed with the indwelling catheter tubing under her legs and without an anchor or a clip to prevent dislodgement or a urethral tear.</p> <p>On 10/10/18 at approximately 1:30 p.m., an interview was conducted with Resident #48's physician. The physician stated the resident will continue to require the indwelling catheter until she is cleared by the urologist. The physician also stated a renal ultrasound must be performed first, then the urologist will determine if the hydronephrosis has resolved. The physician further stated she provide the primary care for the urinary retention and hydronephrosis but all to maintain the indwelling catheter (catheter care, positioning, anchoring, etc) are roles of the nursing staff.</p> <p>An interview was conducted with on 10/10/18 at approximately 1:40 p.m., Licensed Practical Nurse (LPN) #50, stated she was going to obtain the necessary equipment and anchor the resident's catheter. At approximately 4:05 p.m., Resident #48 stated LPN #50 had taped the tubing to her thigh.</p> <p>The facility's undated policy titled "Catheter Care" read; Purpose, to maintain a Foley catheter and help prevent UTI which can cause serious</p>	F 690			

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F 690	Continued From page 39 compromise to the resident's health. Procedure "G" read; Use soap and water to the catheter tubing from point of entry out for at least 4 inches using rotating outward movement. Do not pull on the catheter. Procedure "H" read; position catheter tubing and collection container so that tubing is no kinked or clamped off, tubing is not pulling, tubing is not touching the floor, and collection container is below the bladder level but not touching the floor. On 10/11/18, at approximately 2:30 p.m., the above findings were shared with the Administrator, Director of Nursing and corporate consultant. The Director of Nursing stated the facility's expectation is for the resident's indwelling catheter to be anchored, not making contact with the floor, for the drainage bag to remain below the bladder and to keep the tubing from becoming kinked.	F 690			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure 2 of 40 residents (Resident #53 and #63) received the care and services consistent with the standards of practice and comprehensive person-centered care plan.	F 698	1. Resident # 53 and 63 had bruit and thrill assessed as normal as soon as notification was received and Dialysis Company was contacted to receive communication	11/23/18	

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F 698	<p>Continued From page 40</p> <p>1. The facility staff failed to ensure hemodialysis care was provided for Resident #53 to include consistent and accurate assessments of *bruit and *thrill by the licensed nurses.</p> <p>2. The facility staff failed to ensure hemodialysis care was provided to Resident #63 to include consistent assessments of bruit and thrill, as well as communication between the facility and dialysis center.</p> <p>The findings included:</p> <p>1. Resident #53 was re-admitted to the nursing facility on 11/7/17 with a diagnosis that included end stage renal disease (ESRD) on hemodialysis.</p> <p>The most recent Minimum Data Set (MDS) assessment dated 8/21/18 was an annual and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 6 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making. The resident was coded to receive hemodialysis.</p> <p>The care plan dated as revised 9/10/18 identified Resident #53 was on dialysis related to ESRD Tuesday, Thursday and Saturday. The goal the staff set for the resident was that she would receive treatments as scheduled with monitoring of disease process through next review. One of the approaches to accomplish this goal included monitor thrill and bruit every shift per order and protocol.</p> <p>A physician's order dated 2/26/18 included the following: "Please listen to bruit and palpate for</p>	F 698	<p>2. Any resident receiving dialysis has the potential to be impacted if staff does not include consistent assessments of bruit and thrill as well as communication between the facility and the dialysis center. An education audit was conducted on licensed nurses' skills with on the spot retraining on bruit and thrill assessment conducted by the ADON on 10/11/2018 An audit of hemodialysis patients admitted for past 30 days was conducted to determine presence of communication to and from dialysis with scanned into EMR as appropriate.</p> <p>3. The Facility will conduct training for licensed Nurses including those newly hired on assessing and documentation of bruit and thrill, and ensuring that each dialysis patient takes along with them their dialysis Communication binder to dialysis on each dialysis day and returns with communication from dialysis.</p> <p>4. Unit Manager or Designee(s) will conduct an audit on hemodialysis patients to ensure presence of dialysis communication 3 times a week x 1 week, weekly for three weeks and monthly for 2 Months. Results of these audits will be discussed and reviewed in Risk meeting weekly to ensure compliance and it will also be discussed for further recommendations during the facility's monthly Quality Assurance process</p>		

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F 698	<p>Continued From page 41</p> <p>thrill to dialysis site on left arm on dialysis days, Tuesday, Thursday and Saturdays and every shift."</p> <p>On 10/10/18 at 9:30 a.m., Resident #53 was observed in her wheelchair. On 10/10/18 at 11:15 a.m., Licensed Practical Nurse (LPN) #3 was asked to demonstrate an assessment of the resident's Arterio-Venous shunt (AV) bruit and thrill as signed off per shift on the Medication Administration Record (MAR). The LPN retrieved a stethoscope and placed it over the AV shunt site on the residents left forearm and stated the bruit and thrill was the same; "You listen for the blood flow". Afterwards she stated she needed to look up the procedure to make sure, but indicated she had been signing off on the MAR she performed an assessment of the AV shunt. Another LPN #4 was asked to demonstrate an assessment of Resident #53 AV shunt bruit and thrill. The LPN retrieved a stethoscope and placed the diaphragm over the shunt site. LPN #4 said, "That's all you have to do; that is the procedure for bruit and thrill, you listen closely. Did I do it right?" She stated when she has the resident, she signs off on the MAR per her shift that she made assessment of the bruit and thrill.</p> <p>On 10/11/18 at 10:35 a.m., the Director of Nursing (DON) stated the LPN's did not perform the accurate assessment of bruit and thrill and was surprised because they each had recent inservicing by the infusionist from the dialysis center on 6/25/18, as well as a video on 6/17/18. Both LPNs had attended the aforementioned training as verified through review of the original education sign in sheets.</p> <p>On 10/11/18 at 1:50 p.m., the aforementioned</p>	F 698			

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F 698	<p>Continued From page 42</p> <p>issue was brought to the attention of the Administrator, Regional Director of Operations and Director of Nursing (DON). No further information was brought forward prior to survey exit.</p> <p>The facility policy and procedures titled "Dialysis Services" undated indicated the licensed nurse, on a regular basis, will palpate the AV (Arterio-Venous) hemodialysis shunt site that is usually in the arm, to feel the "thrill" and use the stethoscope to hear the "whoosh" or "bruit" of blood flow through the access to detect possible clots and obstruction of the shunt. Emergency guidelines are to be followed if it is determined blood flow is disrupted and the physician is to be called immediately. Observe for "steal" syndrome, caused by too little blood in the extremity distal to the fistula.</p> <p>3. Resident #63 was re-admitted to the facility on 07/19/18. Diagnosis for Resident #63 included but not limited to *End Stage Renal Disease (ESRD) (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week every Monday, Wednesday and Friday.</p> <p>The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS was coded under section O for receiving dialysis treatments.</p> <p>The comprehensive care plan dated 05/22/18 with a revision date of 09/17/18 identified</p>	F 698			

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F 698	<p>Continued From page 43</p> <p>Resident #63 requires hemodialysis related to ESRD. The goal set for the resident by the staff was that the resident would receive dialysis services as ordered with no avoidable negative effects. One of the intervention/approaches to manage goal include to assess dialysis access site as ordered and to check *bruit and *thrill as per order or protocol.</p> <p>Resident #63's physician orders contained the following order: Please listen for bruit and thrill to left arm dialysis shunt on dialysis days and report any dialysis shunt malfunctions to MD.</p> <p>An interview was conducted with License Practical Nurse (LPN) #5 on 10/10/18 at approximately 9:55 a.m. The surveyor asked the LPN, "How do you check for bruit and thrill." The LPN demonstrated the following on Resident #63; she placed her stethoscope on to the left arm (proximal of shunt site) then said, "You listen for bruit." The surveyor then asked, "How do you check for thrill," she replied, "The same way as the bruit; you use the stethoscope and listen for the thrill."</p> <p>An interview was conducted with Registered Nurse (RN) #1 on 10/11/18 at approximately 9:25 a.m. who stated, "I expect for all nurses to know how to check for bruit and thrill." The surveyor asked the UM, "How do you check bruit and thrill, she replied, "You use a *stethoscope to hear the bruit and you feel with your fingers for the thrill."</p> <p>The above information was shared with Administration staff during a pre-exit meeting on 10/11/18 at 2:00 p.m. No additional information was provided.</p>	F 698			

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F 698	<p>Continued From page 44</p> <p>The facility's policy titled Dialysis services included:</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Prior to admission of any resident requiring dialysis services, the Director of Nursing will ensure that nursing personnel will receive training in the special care and needs of dialysis residents. 2. Training will include the response of medial and non-medical emergencies and complications that typically are associated with dialysis residents, the development and implementation of special considerations in the dialysis resident's comprehensive care plan, and the exchange of information regarding the dialysis resident's care with the dialysis services provider and the resident's physician. 3. Training will also address the appropriate care of shunts and fistulas. <p>Definitions:</p> <p>*ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure).</p> <p>*Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week.</p>	F 698			

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F 698	Continued From page 45 *For dialysis, a catheter is inserted into a large vein in either the neck or chest. A catheter is usually a short-term option; however, in some cases a catheter is used as a permanent access. With most dialysis catheters, a cuff is placed under the skin to help hold the catheter in place. The blood flow rate from the catheter to the dialyzer may not be as fast as for an AV graft or AV fistula; therefore, the blood may not be cleaned as thoroughly as with an arteriovenous access (https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301). *Bruit is listening for adequate bruit with a stethoscope. A continuous low-pitched bruit should be present (www.laminatemedical.com/assessment-and-monitoring-of-av-fistulas-for-new-dialysis). *Thrill - Check the pulse in your access arm. You should feel blood rushing through that feels like a vibration. This vibration is called a "thrill." (Source: https://medlineplus.gov/ency/patientinstructions/000705.htm). *Stethoscope is an instrument used to detect and study sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a usually cup-shaped piece placed upon the area to be examined. (Source: http://c.merriam-webster.com/medlineplus/stethoscope).	F 698			
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c)	F 726		11/23/18	

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F 726	Continued From page 46 §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interviews and facility documentation, the facility staff failed to ensure the licensed nursing staff were competent with the appropriate skills to provide assessments of Arterio-Venous (AV) dialysis shunts for 2 of 40 residents (#53 and	F 726	1.The identified nurses received training on accurately assessing bruit and thrill. An education audit was conducted on licensed nurses' skills with on the spot retraining on bruit and thrill assessment conducted by the ADON on 10/11/2018.		

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F 726	<p>Continued From page 47 #63) in the survey sample.</p> <p>1. The facility staff failed to ensure the licensed nursing staff were competent in the provision of hemodialysis care for Resident #53 to include accurate assessments of *bruit and *thrill.</p> <p>2. The facility staff failed to ensure the licensed nursing staff were competent in the provision of hemodialysis care for Resident #63 to include accurate assessments of bruit and thrill.</p> <p>The findings included:</p> <p>1. Resident #53 was re-admitted to the nursing facility on 11/7/17 with a diagnosis that included end stage renal disease (ESRD) on hemodialysis.</p> <p>The most recent Minimum Data Set (MDS) assessment dated 8/21/18 was an annual and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 6 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making. The resident was coded to receive hemodialysis.</p> <p>The care plan dated as revised 9/10/18 identified Resident #53 was on dialysis related to ESRD Tuesday, Thursday and Saturday. The goal the staff set for the resident was that she would receive treatments as scheduled with monitoring of disease process through next review. One of the approaches to accomplish this goal included monitor thrill and bruit every shift per order and protocol.</p> <p>A physician's recent order dated 2/26/18 indicated the following: "Please listen to bruit and palpate</p>	F 726	<p>2. Any hemodialysis patient has the potential to be impacted if nurses do not accurately assess bruit and thrill.</p> <p>3. The Facility will conduct a training for all Nurses on assessing and documentation of bruit and thrill, to ensure competence. Newly hired nurses will receive training during orientation.</p> <p>4. ADON/Staff Educator will do checks on dialysis patients with their assigned nurses to demonstrate competent skills in assessing for bruit and thrill weekly for 4 weeks and monthly for 2 months. Results of these audits will be discussed and reviewed in Risk meeting weekly to ensure compliance and it will also be discussed for further recommendations during the facility's monthly Quality Assurance process</p>	

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F 726	<p>Continued From page 48</p> <p>for thrill to dialysis site on left arm on dialysis days, Tuesday, Thursday and Saturdays and every shift."</p> <p>On 10/10/18 at 9:30 a.m., Resident #53 was observed in her wheelchair. On 10/10/18 at 11:15 a.m., Licensed Practical Nurse (LPN) #3 was asked to demonstrate an assessment of the resident's Arterio-Venous shunt (AV) bruit and thrill as signed off per shift on the Medication Administration Record (MAR). The LPN retrieved a stethoscope and placed it over the AV shunt site on the residents left forearm and stated the bruit and thrill was the same; "You listen for the blood flow". Afterwards she stated she needed to look up the procedure to make sure, but indicated she had been signing off on the MAR she performed an assessment of the AV shunt. Another LPN(#4) was asked to demonstrate an assessment of Resident #53 AV shunt bruit and thrill. The LPN retrieved a stethoscope and placed the diaphragm over the shunt site. LPN #4 said, "That's all you have to do; that is the procedure for bruit and thrill, you listen closely. Did I do it right?" She stated when she has the resident, she signs off on the MAR per her shift that she made assessment of the bruit and thrill.</p> <p>On 10/11/18 at 10:35 a.m., the Director of Nursing (DON) stated the LPNs did not perform the accurate assessment of bruit and thrill and was surprised because they each had recent inservicing by the infusionist from the dialysis center on 6/25/18, as well as a video on 6/17/18. Both LPNs had attended the aforementioned training as verified through review of the original education sign in sheets.</p> <p>On 10/11/18 at 1:50 p.m., the aforementioned</p>	F 726		

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F 726	<p>Continued From page 49</p> <p>issue was brought to the attention of the Administrator, Regional Director of Operations and Director of Nursing (DON). No further information was brought forward prior to survey exit.</p> <p>The facility policy and procedures titled "Dialysis Services" undated indicated the licensed nurse, on a regular basis, will palpate the AV (Arterio-Venous) hemodialysis shunt site that is usually in the arm, to feel the "thrill" and use the stethoscope to hear the "whoosh" or "bruit" of blood flow through the access to detect possible clots and obstruction of the shunt. Emergency guidelines are to be followed if it is determined blood flow is disrupted and the physician is to be called immediately. Observe for "steal" syndrome, caused by too little blood in the extremity distal to the fistula.</p> <p>3. Resident #63 was re-admitted to the facility on 07/19/18. Diagnosis for Resident #63 included but not limited to *End Stage Renal Disease (ESRD) (Chronic irreversible kidney failure). The resident was receiving *hemodialysis treatments three times a week every Monday, Wednesday and Friday.</p> <p>The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 08/29/18 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS was coded under section O for receiving dialysis treatments.</p> <p>The comprehensive care plan dated 05/22/18 with a revision date of 09/17/18 identified</p>	F 726			

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F 726	<p>Continued From page 50</p> <p>Resident #63 requires hemodialysis related to ESRD. The goal set for the resident by the staff was that the resident would receive dialysis services as ordered with no avoidable negative effects. One of the intervention/approaches to manage goal include to assess dialysis access site as ordered and to check *bruit and *thrill as per order or protocol.</p> <p>Resident #63's physician orders contained the following: Please listen for bruit and thrill to left arm dialysis shunt on dialysis days and report any dialysis shunt malfunctions to MD every shift every Monday, Wednesday and Saturday.</p> <p>An interview was conducted with License Practical Nurse (LPN) #5 on 10/10/18 at approximately 9:55 a.m. The surveyor asked the LPN, "How do you check for bruit and thrill." The LPN demonstrated the following on Resident #63; she placed her stethoscope on to the left arm (proximal of shunt site) then said, "You listen for bruit." The surveyor then asked, "How do you check for thrill," she replied, "The same way as the bruit; you use the stethoscope and listen for the thrill."</p> <p>An interview was conducted with Registered Nurse (RN) #1 on 10/11/18 at approximately 9:25 a.m. who stated, "I expect for all nurses to know how to check for bruit and thrill." The surveyor asked the UM, "How do you check bruit and thrill, she replied, "You use a stethoscope to hear the bruit and you feel with your fingers for the thrill."</p> <p>On 10/11/18, at approximately 1:05 p.m., the surveyor was given an In-service attendance form dated 6/17/18. The facilities objective of session read in part; Topic - Manual Peritoneal</p>	F 726			

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F 726	<p>Continued From page 51</p> <p>Dialysis/Hemodialysis. The summary remarks, method of instructions read: Watch the video from You - Tube (see policy attached). The review of the attendance record revealed that LPN #5 did not watch the video.</p> <p>The review of LPN #5's licensed nurse/charge nurse performance checklist signed and dated 7/12/18 did not include the assessment of A-V fistula or A-V shunt for dialysis residents.</p> <p>An interview was conducted with the Chief Clinical Officer on 10/11/18 at approximately 1:15 p.m. Two surveyors were present doing the interview. The surveyor informed the Chief Clinical Officer that LPN #5 was unable to demonstrate how to check for bruit and thrill on a dialysis resident. The surveyor asked, "How do you ensure sure your nurses are competent when caring for a dialysis resident" she replied, "The Virginia Board of Nursing say they are competent." She then stated, "She (LPN #5) will know now."</p> <p>The facility's policy titled Dialysis services.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Prior to admission of any resident requiring dialysis services, the Director of Nursing will ensure that nursing personnel will receive training in the special care and needs of dialysis residents. 2. Training will include the response of medial and non-medical emergencies and complications that typically are associated with dialysis residents, the development and implementation of special considerations in the dialysis resident's 	F 726			

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F 726	<p>Continued From page 52</p> <p>comprehensive care plan, and the exchange of information regarding the dialysis resident's care with the dialysis services provider and the resident's physician.</p> <p>3. Training will also address the appropriate care of shunts and fistulas.</p> <p>The facility's policy titled Dialysis Services - Care of Shunt/Fistula/Device/Site -Policy: The access point (A-V fistula or A-V shunt) will be monitored per physician order by the RN/LPN.</p> <p>Procedure read in part: -Report signs of thrombosis formation - in a healthy fistula a bruit can be heard over the venous side and a thrill can be palpated as arterialized blood flows through the vein. Absence of these signs may indicate clot development.</p> <p>Definitions:</p> <p>*ESRD is the last stage of chronic kidney disease. When your kidneys fail, it means they have stopped working well enough for you to survive without dialysis or a kidney transplant (www.kidneyfund.org/kidney-disease/kidney-failure).</p> <p>*Hemodialysis-cleans blood by removing it from the body and passing it through a dialyzer, or artificial kidney. The process of removing blood from the body, filtering it and returning it takes time. Hemodialysis treatment usually takes three to five hours and is repeated three times a week.</p>	F 726		

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F 726	Continued From page 53 *For dialysis, a catheter is inserted into a large vein in either the neck or chest. A catheter is usually a short-term option; however, in some cases a catheter is used as a permanent access. With most dialysis catheters, a cuff is placed under the skin to help hold the catheter in place. The blood flow rate from the catheter to the dialyzer may not be as fast as for an AV graft or AV fistula; therefore, the blood may not be cleaned as thoroughly as with an arteriovenous access (https://www.davita.com/kidney-disease/dialysis/treatment/arteriovenous-av-fistula-%2597-the-gold-standard-hemodialysis-access/e/1301). *Bruit is listening for adequate bruit with a *stethoscope. A continuous low-pitched bruit should be present (www.laminatemedical.com/assessment-and-monitoring-of-av-fistulas-for-new-dialysis). *Thrill - Check the pulse in your access arm. You should feel blood rushing through that feels like a vibration. This vibration is called a "thrill." (Source: https://medlineplus.gov/ency/patientinstructions/000705.htm) *Stethoscope is an instrument used to detect and study sounds produced in the body that are conveyed to the ears of the listener through rubber tubing connected with a usually cup-shaped piece placed upon the area to be examined. (Source: http://c.merriam-webster.com/medlineplus/stethoscope).	F 726			
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		11/23/18	

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F 880	<p>Continued From page 54</p> <p>§483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.</p> <p>§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</p> <p>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:</p>	F 880		

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NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARRY BYRD HIGHWAY STERLING, VA 20164		
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F 880	<p>Continued From page 55</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(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</p> <p>(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, clinical record review and review of facility documentation, the facility staff failed to ensure hand washing after removal of gloves during accuchecks (a fingerstick for blood glucose testing) for 2 of 40 residents (Resident #53 and #13) in the survey sample.</p> <p>1. The facility staff failed to ensure hand washing after the removal of gloves during the accucheck procedure for Resident #53.</p>	F 880	<p>1. Handwashing after removal of gloves following accucheck procedure was reviewed with the nurses identified.</p> <p>2. Any resident has the potential to be impacted if staff fail to ensure hand washing after the removal of gloves during the accucheck procedure, the importance of handwashing was reviewed with the nurses identified.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/11/2018
NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARRY BYRD HIGHWAY STERLING, VA 20164		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	<p>Continued From page 56</p> <p>2. The facility staff failed to ensure hand washing after the removal of gloves during the accucheck procedure for Resident #13.</p> <p>The finding include:</p> <p>1. Resident #53 was re-admitted to the nursing facility on 11/7/17 with a diagnosis that included diabetes.</p> <p>The most recent Minimum Data Set (MDS) assessment dated 8/21/18 was an annual and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 6 out of a possible score of 15 which indicated the resident was severely impaired in the skills needed for daily decision making. The resident was coded to be an insulin dependent diabetic.</p> <p>The care plan dated as revised 9/10/18 identified Resident #53 was a diabetic that required finger stick accuchecks before meals and at bedtime.</p> <p>On 10/10/18 at 11:50 a.m., Licensed Practical Nurse (LPN) #3 performed a finger stick accucheck. The LPN failed to wash her hands after removal of her gloves and prior to exiting the resident's room.</p> <p>On 10/11/18 at 10:35 a.m., the Director of Nursing (DON) stated LPN #3 should have washed her hands after removal of her gloves per standard precautions protocol because it was a procedure that involved blood. She stated, "Hands are to be washed after removal of gloves period."</p> <p>On 10/11/18 at 1:50 p.m., the aforementioned</p>	F 880	<p>3. A return demonstration training session will be conducted for licensed and non-licensed staff at which time the importance of hand washing will be emphasized, as it relates to infection control, and prevention of the spread of bacteria and germs. The education will also include reminders to wash hands after glove removal. Licensed and non-licensed staff will perform a hand washing return demonstration to ensure that their hands are washed properly</p> <p>4. ADON/Unit Managers/Supervisors or Designee will do random checks and observation on nurses during Medication administration pass and associated with accuchecks and glove use, to ensure handwashing protocols are observed. Each designee will observe 2 nurses weekly for 2 months. Results of these audits/observations will be discussed and reviewed in clinical meeting weekly to ensure compliance and it will also be discussed for further recommendations during the facility's monthly Quality Assurance process</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/11/2018
NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARRY BYRD HIGHWAY STERLING, VA 20164		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 57</p> <p>issue was brought to the attention of the Administrator, Regional Director of Operations and reviewed with Director of Nursing (DON). No further information was brought forward prior to survey exit.</p> <p>The facility's policy and procedure titled Hand Hygiene undated indicated hands need to be washed using proper accepted standards of practice after the removal of gloves.</p> <p>The facility's policy and procedure titled Blood Glucose Monitoring, Finger Stick undated indicated after finger stick glucose testing and removal of gloves, wash hands.</p> <p>2. Resident #13 was admitted to the nursing facility on 7/16/17 with a diagnosis that included diabetes.</p> <p>The most recent Minimum Data Set (MDS) assessment dated 7/9/18 was an annual and coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 13 out of a possible score of 15 which indicated the resident was intact in the skills needed for daily decision making. The resident was coded to be an insulin dependent diabetic.</p> <p>The care plan dated as revised 7/26/18 identified Resident #13 was a diabetic that required finger stick accuchecks before meals and at bedtime.</p> <p>On 10/10/18 at 11:40 a.m., Licensed Practical Nurse (LPN) #4 performed a finger stick accucheck. The LPN failed to wash her hands after removal of her gloves and proceeded to administer insulin subcutaneous for coverage of an elevated blood sugar. Following</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/13/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495179	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/11/2018
NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARRY BYRD HIGHWAY STERLING, VA 20164		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 880	<p>Continued From page 58</p> <p>administration of the insulin, again after removal of gloves, she failed to wash her hands. LPN #4 proceeded to the nursing station to perform other duties.</p> <p>On 10/11/18 at 10:35 a.m., the Director of Nursing (DON) stated LPN #4 should have washed her hands after removal of her gloves per standard precautions protocol because both the accucheck and insulin administration were procedures that involved blood. She stated, "Hands are to be washed after removal of gloves period."</p> <p>On 10/11/18 at 1:50 p.m., the aforementioned issue was brought to the attention of the Administrator, Regional Director of Operations and reviewed with Director of Nursing (DON). No further information was brought forward prior to survey exit.</p>	F 880			

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0056	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/11/2018
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NAME OF PROVIDER OR SUPPLIER POTOMAC FALLS HEALTH & REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 46531 HARRY BYRD HIGHWAY STERLING, VA 20164
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(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	<p>Initial Comments</p> <p>An unannounced biennial State Licensure Inspection was conducted 10/9/18 through 10/11/18. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Eight (8) complaints were investigated during the survey.</p> <p>The census in this 150 licensed bed facility was 147 at the time of the survey. The survey sample consisted of 32 current Resident reviews and 8 closed record reviews.</p>	F 000		
F 001	<p>Non Compliance</p> <p>The facility was out of compliance with the following state licensure requirements:</p> <p>This RULE: is not met as evidenced by: The Nursing facility was not in compliance with the following Virginia Rules and Regulations for Nursing Facilities:</p> <p>12 VAC 5-371-150 B1. Resident Rights. Cross Reference to F558, F559, F582, F623.</p> <p>12 VAC 5-371-180 A. Infection Control. Cross Reference to F880.</p> <p>12 VAC 5-371-220 F. Nursing Services. Cross Reference to F677</p> <p>12VAC 5-371-220 C. Nursing Services. Cross Reference to F690 & F698</p> <p>12 VAC 5-371-250 C., A., G Resident Assessment. Cross Reference to F641, F656, F660.</p>	F 001	<p>12 Vac 5-371-150 Resident Rights Please cross reference the Plan of Correction for F558, F559, F582, F623</p> <p>12 VAC 5-371-180A. Infection Control. Please cross reference the Plan of Correction for F880.</p> <p>12 VAC 5-371-220 F. Nursing Services. Please cross reference the Plan of Correction for F677</p> <p>12VAC 5-371-220 C. Nursing Services. Please cross reference the Plan of Correction for F690 & F698</p> <p>12 VAC 5-371-250 C. A., G Resident Assessment. Please cross reference the Plan of Correction for F641, F656, F660.</p>	11/23/18

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

TITLE

(X6) DATE

Electronically Signed

11/01/18



Commonwealth of Virginia
Virginia Department of Health

Nursing Home License Number: **NH2776**

*In accordance with the provisions of Title 32.1, Chapter 5,
Article I, of the Code of Virginia 1950, as amended.*

CCSP NOVA LLC

is Authorized to Operate,

Potomac Falls Health & Rehab Center

(Name of Organization)

a Nursing Home, located at:

46531 Harry Byrd Highway, Sterling, Virginia 20164

Approved Capacity **150** Beds

Expiration 12/31/2017

Marissa J. Levine, MD MPH
State Health Commissioner

...

Erik O. Bodin, Director
Office of Licensure and Certification



Commonwealth of Virginia
Virginia Department of Health

Nursing Home License Number: **NH2776**

*In accordance with the provisions of Title 32.1, Chapter 5,
Article 1, of the Code of Virginia 1950, as amended*

CCSP NOVA LLC

is Authorized to Operate,

Potomac Falls Health & Rehab Center

(Name of Organization)

a Nursing Home, located at:

46531 Harry Byrd Highway, Sterling, Virginia 20164

Approved Capacity **150** Beds

Expiration **12/31/2018**

Marissa J. Eline, **MO MPH**
State Health Commissioner

Erik O. Bodin, Director
Office of Licensure and Certification



**Commonwealth of Virginia
Virginia Department of Health**

Nursing Home License Number: **NH2776**

*In accordance with the provisions of Title 32.1, Chapter 5, Article 1,
of the Code of Virginia 1950, as amended.*

CCSP NOVA, LLC

(Operator)

is Authorized to Operate,

Potomac Falls Health and Rehab Center

(Name of Organization)

a Nursing Home, located at:

46531 Harry Byrd Highway, Sterling, Virginia 20164

Approved Capacity **150** Beds

Expiration **12/31/2019**

M. H. Oliver, M.D. M.A.
State Health Commissioner

Robert A. K. Payne, JD
Director
Office of Licensure & Certification



**Commonwealth of Virginia
Virginia Department of Health**

Nursing Home License Number: **NH2776**

*In accordance with the provisions of Title 32.1, Chapter 5, Article 1,
of the Code of Virginia 1950, as amended.*

CCSP NOVA, LLC
(Operator)

is Authorized to Operate,

Potomac Falls Health and Rehab Center

(Name of Organization)

a Nursing Home, located at:

46531 Harry Byrd Highway, Sterling, Virginia 20164

Approved Capacity **150** Beds Expiration **12/31/2020**

Handwritten signature of M. Norman Oliver in black ink.

M. Norman Oliver, M.D. M.A.
State Health Commissioner

Handwritten signature of Robert A.K. Payne, J.D. in black ink.

Robert A.K. Payne, J.D. Director
Office of Licensure & Certification

Virginia Department of Health Application for Nursing Home License

In accordance with the provisions of Chapter 5, Article 1, Title 32.1, Code of Virginia of 1950, all non-federal medical and nursing facilities desiring license as a nursing home in Virginia must submit the following information to the Virginia Department of Health.

Any changes during the year, which would affect the accuracy of the following information, must be reported promptly in writing, to the Virginia Department of Health.

Application for: (check one)

- Annual Renewal for Calendar Year
 Initial License to Operate a Nursing Home
 Changes in Licensed Bed Capacity/Bed Change
 Changes in Ownership or Operator

Effective Date: 011.Q1L2018

RECEIVED
 OCT 20 2017
 VDH/OLC

Name of Facility (Doing Business As name): Potomac Falls Health & Rehab Center

Facility Physical Address: 46531 Harry Byrd Highway

(Additional space if needed) _

City Or Town: Sterling

State: Zip Code:

County: Loudoun

Telephone Number with Area Code: 703-834-580Q

Fax Number: 571-529-5010

Mailing Address: 46531 Harry Byrd Highway, Sterling, VA 20164

Facility E-Mail Address: zNIKOV@potomacfalls-rehab.com

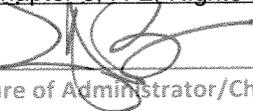
Facility Web Address: www.potomacfalls-rehab.com

Name of Administrator of Record: Zoie B. Nikov

If the facility is Medicare/Medicaid certified, has the facility registered for ePOC? YES NO NOT Certified

If "YES," enter date registered and name of ePOC user. 10/04/2016

I hereby certify that the above named facility is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 6, A 2, Rights and Responsibilities of Patients in Nursing Homes.



 (Signature of Administrator/Chief Officer)

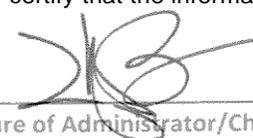
1/0100210/

 (Nursing Home Administrator's License Number)

Conditioned Certificate of Public Need for Indigent and Specialty Care: I hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 1, Section 32.1-102.C. The facility has reviewed its status regarding Certificates of Public Need issued to it, and has determined that:

1. Conditioned certificates for indigent or specialized care are applicable to the nursing facility. **DYES NO**
2. If conditioned certificates for indigent or specialized care are applicable to this nursing facility, does the nursing facility meet the requirements of the certificates? **DYES NO** (If "NO," attach a letter of explanation)

I hereby certify that the information contained in the Application for License Renewal is, to the best of my knowledge, accurate and true.



 (Signature of Administrator/Chief Officer)

10/3/2017

 (Date Completed)

Licensing Classification of Nursing Home Facilities and Bed Capacity by Service

Types of Beds by License Classification

Bed Capacity

Licensed Beds Requested

150

Total Bed Capacity (Specify Bed Types excluding Day Care)

Number of Beds Certified for Medicare Only
18)

Number of Beds Certified for Medicare/Medicaid
(Title 18/19)

Number of Beds Certified for Medicaid only
19)

Number of Non-certified beds
(Exclude Adult Residential beds)

FOR OFFICE USE
ONLY

Total Licensed Beds
Approved

1'Dad

Does the facility have a specialized unit?

YES NO

If yes, specify the type of specialized unit and number of beds (i.e. secured unit, ventilator unit, etc.)?

Type of Unit _____

Number of beds _____

Does the facility have a Nurse Aide training program on your premises?

YES NO

If yes, is it a certified Nursing Assistant Program approved by the Board of Nursing?

YES NO

- | | |
|--|---------------------------|
| A. Name of Director of Nursing Service: <u>Glendy</u> Reeves | Start Date: 07aJL2017 |
| B. Name of In-Service Training Director: Abdulai Koroma | Start Date: 09m.L_2017 |
| C. Name of Social Services Director: Alvoid Washington | Start Date: 10IQ.U2017 |
| D. Name of Activities Director: Elizabeth Pellegrino | Start Date: 08L.1.U2017 |
| E. Name of Food Services Supervisor: Adele Alexis | Start Date: 03.LQ\$L2017 |
| F. Name of Medical Director/Advisory Physician(s): Dr. Jeevindra S.Rana | Start Date: 04.LQU2012 |
| G. Name of Dietary Consultant: <u>Melissa Meyer</u> | Start Date: 01.Lili2014 |
| H. Name of Pharmacy Consultant: <u>Remedi Pharmacy</u> | Start Date: 03L'.illU2013 |
| I. Name of Physical Therapy Consultant: <u>Heritage</u> Healthcare | Start Date: 10.LQU2014 |
| J. Name of Dental Consultant: <u>Stay At Home Smiles</u> , Dr. Natalie Anne Vlasek | Start Date: 10ili2017 |

Survey of Long-Term Care Facilities

Facility Name (Doing Business As name): Potomac Falls Health & Rehab Center

Please make sure the Facility Name is spelled the same as on page 5)

Is any part of the facility licensed by another state agency? YES NO If yes, enter the number of beds: ____
 If yes, specify the type of beds (i.e. Adult Residential) ____

Does the facility have Adult Day Care facilities? YES NO If yes, enter the number of accommodations: ____
 Does the facility have Child Day Care facilities? YES NO If yes, enter the number of accommodations: ____
 If yes, are the day care facilities required to be licensed by the Department of Social Services? DYES D NO

Does the facility share resources with an Assisted Living Facility? YES NO If yes, complete the following section:

Assisted Living Facility Name: ____

Number Of Assisted Living Facility Beds: _

State licensure laws and regulation do not prohibit the integration or sharing of services/areas within nursing facility/assisted living arrangements. However, providers must demonstrate compliance with all relevant licensure regulations regarding full time staffing and facility environmental requirements. Providers are obligated to assure that staffing assignments and shared services are sufficient to meet the assessed needs of all residents and the applicable regulations for each type of facility license. Please complete the questions below addressing sharing of staff, services, and areas.

1. Are residents of the two facilities in: Same building, Separate buildings, same campus,
 Same wing Different wing, Other: ____

2. What services/areas are commonly shared?
 Direct care, Administrative, Housekeeping, Food service/dietary,
 Other: ____

3. What staff positions are shared and what is the frequency of duties shared?

Duties	No. of Staff	No. of Shared Staff	Frequency Daily or Weekly	Duties	No. of Staff	No. of Shared Staff	Frequency Daily or Weekly
Direct Care Staff				Housekeeping			
Administrative Staff				Food/service Dietary			
Other:							

4. How are the Administrator duties conducted? Separate for each facility? D YES D NO . If no, there must be an Assistant Administrator. Describe how the duties are delegated and how the Administrator is kept informed.

Enter duties delegated

Enter how Administrator is informed

Is the facility part of a CCRC? YES NO If yes, complete the following section:

A. How many beds are in the CCRC? _

B. How many Life Care Contract holders are in NON nursing home beds? _

Ownership and Operation of Nursing Home

Is the facility operated by the owner of the building?
 Is the facility owned by the owner of the building?

Type of Ownership and Control

If the facility owner-operated, select ONE from Column A.

If the facility IS NOT operated by the owner, select ONE from Column A and ONE from Column B.

(A) OWNER (of facility)	(B) OPERATOR (of facility)
-------------------------------	----------------------------------

State or Local Government:

- | | | |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | State |
| <input type="checkbox"/> | <input type="checkbox"/> | County |
| <input type="checkbox"/> | <input type="checkbox"/> | City(ies) |
| <input type="checkbox"/> | <input type="checkbox"/> | Multijurisdictional |
| <input type="checkbox"/> | <input type="checkbox"/> | Hospital District/Authority |

Non-Profit:

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Church Related
Non-Profit Corporation |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Non-Profit |

Proprietary:

- | | | |
|--------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Single Proprietary |
| <input type="checkbox"/> | <input type="checkbox"/> | Partnership |
| <input type="checkbox"/> | <input type="checkbox"/> | Corporation |
| <input type="checkbox"/> | <input type="checkbox"/> | Limited Liability Corporation |

Is there any person other than those listed on this form (owner, operator, administrator of record) who is authorized to make administrative management decisions regarding the facility? YES **D** NO

If yes, please identify the person and their relationship to the facility

Person's name and relationship to facility Deborah Petrine, CEO; David W Tucker, President; Charles Rehnberg, Director of Operations - Commonwealth Care of Roanoke, Inc.

Information Required on the Operator/Manager of the Facility

Please enter the names and Physical addresses of the governing body. If the position is vacant, please put "vacant." If more space is needed, please attach additional pages to the back of the application

Name of President/Chair: Deborah I. Petrine
 Physical Address: 5372 Fallowater Lane, Suite 200, Roanoke, VA 24018

Name of Vice President:
 Physical Address:

Name of Secretary:
 Physical Address:

Name of Treasurer: Brady L. Sheffer
 Physical Address: 5372 Fallowater Lane, Suite 200, Roanoke, VA 24018

If any officer, director, trustee or any member of the governing body or any other individual, partnership, association, trust, corporation, or other legal or commercial entity owns, holds or has a financial interest of five (5) percent or more in the operating/management entity, list the name and percentages of ownership below:

<u>NAME</u>	<u>OWNERSHIP PERCENTAGE</u>
<u>NOVA CARE LLC</u>	<u>50%</u>
<u>SP NOVA LLC</u>	<u>50%</u>

Are all remaining financial interests less than 5 percent?

If the operator/manager has a lease or management agreement with the legal entity or individual who owns the physical plant/buildings, list the name and the address of the building owner.

Name of Building Owner: NVHI II, LLC
 Physical Address of Owner: 4423 Pheasant Ridge Road #301, Roanoke, VA 24014

If the operator/manager has a lease or management agreement with a legal entity or individual who is not the owner of the physical plant/buildings, list the name and address of the lessor.

Name of Lessor: Commonwealth Care of Roanoke, Inc. (management agreement)
 Physical Address of Lessor: 5372 Fallowater Lane, Suite 200, Roanoke, VA 24018

If the operator/manager has a lease or management agreement with an owner or a lesser, does the owner or the lesser have a five (5) percent or more ownership interest in the legal entity that operates/manages the facility? DYES **NO**

Virginia Department of Health Application for Nursing Home License

In accordance with the provisions of Chapter 5, Article 1, Title 32.1, Code of Virginia of 1950, a non-federal medical and nursing facility desiring a license as a nursing home in Virginia must submit the following information to the Virginia Department of Health.



Application for: (check one)

- Annual Renewal for calendar Year
- Initial License to Operate a Nursing Home
- Changes in Licensed Bed Capacity/Bed Change
- Changes in Ownership or Operator

FOR OLC USE ONLY			
Check #:	021204	Check Amt:	225.00
Rec. Date:	10/12/18	Check Date:	10/11/18
Deposit Date:	10/15/18	Ticket #:	70563374

Effective Date: 01-01-2019

Name of Facility (Doing Business As name): Potomac Falls Health & Rehab Center

Facility Physical Address: 46531 Harry Byrd Highway

(Additional space if needed) _____

City or Town: Sterling

State:

Zip Code:

County:

Jet. phone Number with Area Code: 703-834-5800

Fax Number: Z.-SU-5010

Mail Address: 46531 Harry Byrd Highway

Facility Web Address: www.Potomacfalls-rehab.com

RECEIVED
OCT 12 2018
VDH/OLC

Name of Administrator of Record: John Mitchell

Administrator Email Address: JMITCHELL4PPotomac@Hs-rhab.com

If the facility is Medicare/Medicaid certified, has the facility registered for ePOC? YES NO NOT CERTIFIED
If "YES," enter:

Date Registered: 10/04/2016

Name of Registered User: John Mitchell@potomacfalls-rehab.com

I hereby certify that the above named facility is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 2, Rights and Responsibilities of Patients in Nursing Homes.

(Signature of Administrator/Chief Officer)

J.ZP100ff

(Nursing Home Administrator's License Number)

Conditioned Certificate of Public Need for Indigent and Specialty Care: I hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 1, Section 32.1-102.C. The facility has reviewed its status regarding Certificates of Public Need issued to it, and has determined that:

1. Conditioned certificates for indigent or specialized care are applicable to the nursing facility. YES NO
2. If conditioned certificates for indigent or specialized care are applicable to this nursing facility, does the nursing facility meet the requirements of the certificates? Yes NO (If "No," attach a letter of explanation)

I hereby certify that the information contained in the Application for License Renewals, to the best of my knowledge, accurate and true.

(Signature of Administrator/Chief Officer)

10-8-2018
(Date Completed)

Licensing Classification of Nursing Home Facilities and Bed Capacity by Service

Types of Beds by License Classification Bed capacity

Licensed Beds Requested **150**

Total Bed capacity (Specify Bed Types excluding Day care) **150**

Number of Beds Certified for Medicare Only (Title 18)

Number of Beds Certified for Medicare/Medicaid (Title 18/19)

Number of Beds Certified for Medicaid only (Title 19)

Number of Non-certified beds (Exclude Adult Residential beds)

FOR OFFICE USE ONLY

Total Licensed Beds Approved **(150)**

10/12/18
Date



Does the facility have a specialized unit? YES NO

If YES, specify the type of specialized unit and number of beds (i.e. secured unit, ventilator unit, etc.)?

Type of Unit _____ Number of beds _____

Does the facility have a Nurse Aide training program on your premises? YES NO

If yes, Is it a certified Nurse Aide Assistant Program approved by the Board of Nurses? YES NO

A. Name of Director of Nursing Service: Gwendy Reeves Start Date: 7-31-2017

a. Name of In-Service Training Director: Abdullah Koroma Start Date: 9-27-2017

C. Name of Social Services Director: Mary McNabb Start Date: 7-24-2018

D. Name of Activities Director: Elizabeth Pellmar Start Date: 8-13-2018

E. Name of Food Services supervisor: Unda Hepler Start Date: 03-06-2017

F. Name of Medical Director/Advisory Physician(s): PB Jeeyndras Rana Start Date: Qf::

01-2012

G. Name of Dietary Consultant: Jennifer Hoan Start Date: 01-28-2014

H. Name of Pharmacy Consultant: Remed J Pharmacy Start Date:

ml

I. Name of Physical Therapy Consultant: Heritage Healthcare Start Date: AQ:

.Q1: UH

J. Name of Dental Consultant: Sttv at Home Smlluor Natalte Anne Viase.k.

Start Date 10-03-2017

Survey of Long-Term Care Facilities

Facility Name (Doing Business As name): Potomac Falls Health & Rehab Center
 (Please make sure the Facility Name is spelled the same as on page 5)

Is any part of the facility licensed by another state agency? YES NO 181 If yes, enter the number of beds:
 If you specify the type of beds (i.e. Adult Residential)

Does the facility have Adult Day care facilities? YES NO 181 If YES, enter the number of accommodations:
 Does the facility have Child Day care facilities? YES NO 181 If yes, enter the number of accommodations:
 If yes, are the day care facilities required to be licensed by the Department of Social Services? YES NO

Does the facility share resources with an Assisted Living Facility? YES NO 181 If yes, complete the following section:
 Assisted Living Facility Name:
 Number of Assisted Living Facility Beds:

State licensure laws and regulations do not prohibit the integration or sharing of services (aws within a facility) / services / amenities. However, providers must demonstrate compliance with all relevant licensure regulations regarding full-time staff and environmental requirements. Providers are obligated to assure that staffing assignments and shared services are sufficient to meet the needs of all residents and to comply with applicable regulations for each type of facility. Please complete the questions below addressing staff, services, and areas.

1. Are residents of the two facilities in: Same building, separate buildings, same campus,
 Same wing Different wing, Other:

2. What services/areas are commonly shared?
 Direct care, Administrative, Housekeeping, Food service/dietary,
 Other:

3. What staff positions are shared and what is the frequency of duties shared?

Duties	No. of Staff	No. of Shared Staff	Frequency Daily or Weekly	Duties	No. of Staff	No. of Shared Staff	Frequency Daily or Weekly
Direct care Staff				Housekeeping			
Administrative Staff				Food/service Dietary			
Other: <u> </u>							

4. How are the Administrator duties conducted? Separate for each facility? YES NO. If no, there must be an Assistant Administrator. Describe how the duties are delegated and how the Administrator is kept informed.

EQ/tr dut Ja dtlfted

Enttc how Administrator Is Informed

Is the facility part of a CCRC? YES 181 NO If yes, complete the following section:

- A. How many beds are in the CCRC?
- B. How many Uficare Contract holders are in it? If nursing home beds?

Ownership and Operation of Nursing Home

Facility Name (Doing Business As name): Potomac Falls Health & Rehab Center

{Please make sure the Facility Name is spelled the same as on **page S**}

Legal name of the Operator of the facility: CCSPNOVALLC

Operator's physical **address:** 46S31 Harry Byrd Highway

(Additional space if needed) _

City or Town: Sterling

State: VA.

Zip Code: 20164

Operator Telephone Number with Area Code: 703-834-5800

Fax with area code: 571-529-5010

Legal/Doing Business As name of the Owner of the nursing home business: CCSPNOVALLC d/b/a Potomac Falls Health & Rehab enter

Owner's physical address: 46531 Harry Byrd Highway

(Additional space if needed) _

City or Town: Sterling

State: YA

Zip Code: 24018

Is the facility operated by the owner of the building? **0** YES **!Z** NO

Is the facility owned by the owner of the building? **D** YES **!Z** NO

Type of Ownership and Control

If the facility is **owner-operated**, select ONE from Column A,

If the facility is **NOT operated by** the owner, select **ONE** from Column **A** and **ONE** from Column B.

(A)
OWNER
(of facility)

(B)
OPERATOR
(of facility)

State or Local Government:

State
County
City(ies)
Multijurisdictional

Hospital District/Authority

Non-Profit:

Church **Related**

Non-Profit Corporation

Other **Non-Profit**

Proprietary:

Single **Proprietary**

Partnership

Corporation

Limited Liability Corporation

Is there any person other than those listed on this form (owner, operator, administrator of record) who is authorized to make administrative management decisions regarding the facility? **!Z** YES **D** NO

If yes, please identify the person and their relationship to the facility

Person's name and relationship to facility Deborah, CEO; David W Tucker, President; Wendy Walter Regional Director of Operations

Information Required on the Operator/Manager of the Facility

Please enter the names and Physical addresses of the aovernln1 body. If the position Isvacant, please put"vacant." If more space Isneeded, pleaseattach addltional pagesto the back of theapplication

Name of President/Chair: Debor1h LPetrino
 Phvslr:al Address: 5372FaUowater Lane.suite200. Roanoke ya 24911

Name of Vice President:
 Physical Address:

Name of Secretary:
 Physical Address:

Name of Treasurer: Brady LSheffer
 Physical Address: 5372 FaUqwattr Lana.Suite 200, Roanoke va 24018

If any officer, director, trustee or any member of the governing body or any other Indlvldual, partnership, association, trust, corporation, or other lelal or commercial entity owns, holds or has a financial Interest of five (S) percent of more In the operatln&/management entity, list the name and percentages of ownership below:

<u>fiaMi</u>	<u>OWNERSHIP PERCENTAGE</u>
<u>NOVAtareLLC</u>	
<u>sp Noyauc</u>	

Are all remaining flnandal Interests less than 5 percent? 18iYES ONO

If the operator/manaaer has a lease or mana1 lment agreement with the lqal entity or Indlvlduat who owns the physical pl1nt/buUdl1s, list the name and the **address** of the bulldng owner.

Name of Bulldln, Owner: NYHIL UC
 Physical Address of Owner: 4423 Pheasant BJDlf Roade # 301. Roanoke. Va24014

If the operator/manager"-s a lease or manaaament agreement with a lepl entity or Indlvldual who Is not the owner of the physical pl1nt/bulldlns, list the name and address of the lessor.

Name of Lessor: Commonwlth care of Roanoke Inc(mananment uceern•nl1
 Physical Address of Lessor: 5372 Fallowater Lant.SUit• 200.Roanoke Ya14018

If the operator/manapr has a **lease** or man11ement •lnment with an ownar or a leJser, doesthe owner or the lessor have a five (SJ percent or more ownership Interest In the leaalentity that operates/manages thefacillty? 0 YES 181 NO

Virginia Department of Health Application for Nursing Home License

In accordance with the provisions of Chapter 5, Article 1, Title 32.1, Code of Virginia of 1950, all non-federal medical and nursing facilities desiring license as a nursing home in Virginia must submit the following information to the Virginia Department of Health.

Any changes during the year, which would affect the accuracy of the following information, must be reported promptly, in writing, to the Virginia Department of Health.

Application for: (check one)

- Annual Renewal for Calendar Year
- Initial License to Operate a Nursing Home
- Changes in Licensed Bed Capacity/Bed Change
- Changes in Ownership or Operator

Effective Date: Q1LQU2017

Name of Facility (Doing Business As name): Potomac Falls Health & Rehab Center

Facility Physical Address: 46531 Harry Byrd Highway

(Additional space if needed) _____

City Or Town: Sterling

State: VA Zip Code: 20164

County: Loudoun

Telephone Number with Area Code: 703-834-5800

Fax Number: 571-529-5010

Mailing Address: 46531 Harry Byrd Highway, Sterling, VA 20164

Facility E-Mail Address: znikov@potomacfalls-rehab.com

Facility Web Address: www.potomacfalls-rehab.com

Name of Administrator of Record: Zoie B Nikov

If the facility is Medicare/Medicaid certified, has the facility registered for ePOC? YES NO D NOT Certified D

If "YES," enter date registered and name of ePOC user. 10/04/2016

Zoie ;

rnmoohjja-rehab.com 6'-0" (t, 0, L) NIKOV

I hereby certify that the above named facility is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, c::hapter 5, Article 2, Rights and Jtesponsibilities of Patients in Nursing Homes.



(Signature of Administrator/Chief Officer)

1/01002107

(Nursing Home Administrator's License Number)

Conditioned Certificate of Public Need for Indigent and Specialty Care: I hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 1, Section 32.1-102.C. The facility has reviewed its status regarding Certificates of Public Need issued to it, and has determined that:

1. Conditioned certificates for indigent or specialized care are applicable to the nursing facility. DYES NO
2. If conditioned certificates for indigent or specialized care are applicable to this nursing facility, does the nursing facility meet the requirements of the certificates? DYES D NO (If "NO," attach a letter of explanation)

I hereby certify that the information contained in the Application for License Renewal is, to the best of my knowledge, accurate and true.



(Signature of Administrator/Chief Officer)

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10/10/2016
(Date Completed)

007 13 2016

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Licensing Classification of Nursing Home Facilities and Bed Capacity by Service

Types of Beds by License Classification	Bed Capacity
Licensed Beds Requested	<u>150</u>
Total Bed Capacity (Specify Bed Types excluding Day Care)	<u>150</u>
Number of Beds Certified for Medicare Only (Title 18)	
Number of Beds Certified for Medicare/Medicaid (Title 18/19)	<u>150</u>
Number of Beds Certified for Medicaid only (Title 19)	
Number of Non-certified beds (Exclude Adult Residential beds)	

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Total Licensed Beds Approved

Does the facility have a specialized unit? LJYES IXINO
 If yes, specify the type of specialized unit and number of beds (i.e. secured unit, ventilator unit, etc.)?
 Type of Unit _____ Number of beds _____

Does the facility have a Nurse Aide training program on your premises? YES NO
 If yes, is it a certified Nursing Assistant Program approved by the Board of Nursing? YES No

- | | |
|--|--------------------------|
| A. Name of Director of Nursing Service: <u>Phyllis Harris</u> , RN | Start Date: 12f121_2014 |
| B. Name of In-Service Training Director: <u>Johanna Espinales</u> , RN | Start Date: 10.LQli2011 |
| C. Name of Social Services Director: Chandis <u>Par</u> BSW | Start Date: 10LQU.2010 |
| D. Name of Activities Director: Barbara Eastman | Start Date: 10L1..ZL2014 |
| E. Name of Food Services Supervisor: Michelle Board | Start Date: 09a.QI2014 |
| F. Name of Medical Director/Advisory Physician(s): Dr. <u>Jeevindr S . B ana</u> | Start Date: 04LQU_2012 |
| G. Name of Dietary Consultant: <u>Melissa Meyer</u> , RD | Start Date: 01f1il2014 |
| H. Name of Pharmacy Consultant: <u>Remedi Pharmacy</u> | Start Date: 03LillU_2013 |
| I. Name of Physical Therapy Consultant: <u>Heritage</u> Healthcare | Start Date: 10LQU.2014 |
| J. Name of Dental Consultant: <u>D enMed Solution</u> . LLC | Start Date: 10f121_2014 |

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Survey of Long-Term Care Facilities

Facility Name (Doing Business As name): Potomac Falls Health & Rehab Center

(Please make sure the Facility Name is spelled the same as on page 5)

Is any part of the facility licensed by another state agency? YES NO If yes, enter the number of beds: _____
 If yes, specify the type of beds (i.e. Adult Residential) _____

Does the facility have Adult Day Care facilities? YES NO If yes, enter the number of accommodations: _____

Does the facility have Child Day Care facilities? YES NO If yes, enter the number of accommodations: _____

If yes, are the day care facilities required to be licensed by the Department of Social Services? DYES D NO

Does the facility share resources with an Assisted Living Facility? YES NO If yes, complete the following section:

Assisted Living Facility Name: _____

Number Of Assisted Living Facility Beds: _____

State licensure laws and regulation do not prohibit the integration or sharing of services/areas within nursing facility/assisted living arrangements. However, providers must demonstrate compliance with all relevant licensure regulations regarding full time staffing and facility environmental requirements. Providers are obligated to assure that staffing assignments and shared services are sufficient to meet the assessed needs of all residents and the applicable regulations for each type of facility license. Please complete the questions below addressing sharing of staff, services, and areas.

1. Are residents of the two facilities in: Same building, Separate buildings, same campus,
 Same wing Different wing, Other: _____

2. What services/areas are commonly shared?

Direct care, Administrative, Housekeeping, Food service/dietary,
 Other: _____

3. What staff positions are shared and what is the frequency of duties shared?

Duties	No. of Staff	No. of Shared Staff	Frequency Daily or Weekly	Duties	No. of Staff	No. of Shared Staff	Frequency Daily or Weekly
Direct Care Staff				Housekeeping			
Administrative Staff				Food/service Dietary			
Other:							

4. How are the Administrator duties conducted? Separate for each facility? D YES D NO . If no, there must be an Assistant Administrator. Describe how the duties are delegated and how the Administrator is kept informed.

Enter duties delegated

Enter how Administrator is informed

Is the facility part of a CCRC? YES NO If yes, complete the following section:

A. How many beds are in the CCRC? _____

B. How many Life Care Contract holders are in NON nursing home beds?

Ownership and Operation of Nursing Home

Facility Name (Doing Business As name): Potomac Falls Health & Rehab Center

Please make sure the Facility Name is spelled the same as on page 5)

Legal name of the Operator of the facility: CCSP NOVA LLC

Operator's physical address: 46531 Harry Byrd Highway

[Additional space if needed] _____

City or Town: Sterling

State: VA,

Zip Code: 20164

Operator Telephone Number with Area Code: 703-834-5800

Fax with area code: 571-529-5010

Legal/Doing Business As name of the Owner of the nursing home business: CCSP NOVA LLC

Owner's physical address: 46531 Harry Byrd Highway

[Additional space if needed] _____

City or Town: Sterling

State: VA,

Zip Code: 20164

Is the facility operated by the owner of the building?

Is the facility owned by the owner of the building?

Type of Ownership and Control

If the facility IS owner-operated, select ONE from Column A.

If the facility IS NOT operated by the owner, select ONE from Column A and ONE from Column B.

(A)
OWNER
(of facility)

(B)
OPERATOR
(of facility)

State or Local Government:

(A) (B)

- State
- County
- City(ies)
- Multijurisdictional
- Hospital District/Authority

(A) (B)

Non-Profit:

(A) (B)

- Church Related
- Non-Profit Corporation
- Other Non-Profit

(A) (B)

Proprietary:

- Single Proprietary
- Partnership
- Corporation
- Limited Liability Corporation

Is there any person other than those listed on this form (owner, operator, administrator of record) who is authorized to make administrative management decisions regarding the facility? YES **D** NO

If yes, please identify the person and their relationship to the facility

Person's name and relationship to facility Deborah Petrine, CEO; David W Tucker, President; Charles Rehnborg, Director of Operations - Commonwealth Care of Roanoke, Inc.

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OCT 13 2016

VDH/OLC

Information Required on the Operator/Manager of the Facility

Please enter the names and Physical addresses of the governing body. If the position is vacant, please put "vacant." If more space is needed, please attach additional pages to the back of the application

Name of President/Chair: Deborah L. Petrine
Physical Address: 5372 Fallowater Lane, Suite 200, Roanoke, VA 24018

Name of Vice President:
Physical Address:

Name of Secretary:
Physical Address:

Name of Treasurer: Brady L. Sheffer
Physical Address: 5372 Fallowater Lane, Suite 200, Roanoke, VA 24018

If any officer, director, trustee or any member of the governing body or any other individual, partnership, association, trust, corporation, or other legal or commercial entity owns, holds or has a financial interest of five (5) percent or more in the operating/management entity, list the name and percentages of ownership below:

<u>NAME</u>	<u>OWNERSHIP PERCENTAGE</u>
NOVA CARE LL	<u>50%</u>

SPNOVALLC	<u>50%</u>
-----------	------------

Are all remaining financial interests less than 5 percent?

If the operator/manager has a lease or management agreement with the legal entity or individual who owns the physical plant/buildings, list the name and the address of the building owner.

Name of Building Owner: NVHI II, LLC
Physical Address of Owner: 4423 Pheasant Ridge Road, #301, Roanoke, VA 24014

If the operator/manager has a lease or management agreement with a legal entity or individual who is not the owner of the physical plant/buildings, list the name and address of the lessor.

Name of Lessor: Commonwealth Care of Roanoke, Inc. (management agreement)
Physical Address of Lessor: 5372 Fallowater Lane, Suite 200, Roanoke, VA 24018

If the operator/manager has a lease or management agreement with an owner or a lesser, does the owner or the lessor have a five (5) percent or more ownership interest in the legal entity that operates/manages the facility? YES NO

Virginia Department of Health Application for Nursing Home License

In accordance with the provisions of Chapter 5, Article 1, Title 32.1, Code of Virginia of 1950, all non-federal medical and nursing facilities desiring to operate as a nursing home in Virginia must submit the following information to the Virginia Department of Health,

Any changes during the year which would affect the accuracy of the following information, must be reported promptly, in writing, to the Virginia Department of Health.

Application for: (check one)

- Annual Renewal for Calendar Year
- Initial License to Operate a Nursing Home
- Change in Licensed Bed Capacity/Bed Change
- Change in Ownership or Operator

FOR OLC USE ONLY	
Check#:	1701002045
Facility Name:	Potomac Falls Health & Rehab Center
Effective Date:	10/01/2016

Effective Date: 10/01/2016

Name of Facility (Doing Business As name): Potomac Falls Health & Rehab Center

Facility Physical Address: 46531 Harry Byrd Highway

(Additional space if needed) _

City or Town: Sterling State: VA Zip Code: 20164

County: London

Telephone Number with Area Code: 703-834-5800 Fax Number: 571-529-5010

Mail Address: 46531 Harry Byrd Highway

Facility Web Address: 1011111-PotomacFalls-rehab.com

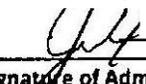
Name of Administrator of Record: John Mitchell

Administrator Email Address: lrator@PotomacFalls-rehab.com

If the facility is Medicare/Medicaid certified, has the facility registered for ePOC? YES NO NOT Certified If "YES," enter:

Date Registered: 10/01/2016
 Name of Registered User: Joh. Mitchell

I hereby certify that the above named facility is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 2, Rights and Responsibilities of Patients in Nursing Homes.



 (Signature of Administrator/Chief Officer)

1701002045

(Nursing Home Administrator's License Number)

Conditioned Certificate of Public Need for Indigent and Specialty Care: I hereby certify that the facility named on this application is in compliance with the provisions of the Code of Virginia, 1950, as amended, Title 32.1, Chapter 5, Article 1, Section 32.1-102.C. The facility has reviewed its status regarding Certificates of Public Need Issued to it, and has determined that:

- 1. Conditioned certificates for indigent or specialized care are applicable to the nursing facility. YES NO
- 2. If conditioned certificates for indigent or specialized care are applicable to this nursing facility, does the nursing facility meet the requirements of the certificates? YES NO (If "NO," attach a letter of explanation)

I hereby certify that the information contained in the Application for License Renewal is, to the best of my knowledge, accurate and true.



 (Signature of Administrator/Chief Officer)

10/2/2019
 (Date Completed)

RECD: 10/2/2019
 OCT 1 2019
 VDK/OLC

Licensing Classification of Nursing Home Facilities and Bed Capacity by Service

Types of Beds by License Classification	Bed Capacity
Licensed Beds Requested	150
Total Bed Capacity (Specify Bed Types excluding Day care)	150
Number of Beds Certified for Medicare Only (Title 18)	
Number of Beds Certified for Medicare/Medicaid (Title 18/19)	150
Number of Beds Certified for Medicaid only (Title 19)	
Number of Non-certified beds (Exclude Adult Residential beds)	

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Total Licensed Beds Approved

150

11/18/2019
Date

****PLEASE INCLUDE FLOORPLAN OF FACILITY****

Does the facility have a specialized unit? D YES | NO

If yes, specify the type of specialized unit and number of beds (i.e. secured unit, ventilator unit, etc.)?

Type of Unit _____ Number of beds _____

Does the facility have a Nurse Aide training program on your premises? YES | NO

If yes, is it a certified Nursing Assistant Program approved by the Board of Nursing? YES | NO

- | | |
|---|-------------------------------|
| A. Name of Director of Nursing Service: <u>Abdul Koroma</u> | Start Date: <u>9-22-19</u> |
| B. Name of In-Service Training Director: <u>_</u> | Start Date: _____ |
| C. Name of social Services Director: <u>Samantha Askroff</u> | Start Date: <u>8/11/2019</u> |
| O. Name of Activities Director: <u>Elizabeth Pellegrino</u> | Start Date: <u>8-13-2018</u> |
| E. Name of Food Services Supervisor: <u>Linda Hepler</u> | Start Date: <u>2017</u> |
| F. Name of Medical Director/Advisory Physician(s): <u>Dr Jeevindra S Rana</u> | Start Date: <u>04/01/2012</u> |
| G. Name of Dietary Consultant: <u>Jennifer Hogan</u> | Start Date: <u>01/28/2014</u> |
| H. Name of Pharmacy Consultant: <u>Remedi Pharmacy</u> | Start Date: <u>03/08/2013</u> |
| I. Name of Physical Therapy Consultant: <u>Heritage Healthcare</u> | Start Date: <u>2014</u> |
| J. Name of Dental Consultant: <u>Stay at Home Smiles Dr Natalie Anne Viasek</u> | Start Date: <u>10/03/2017</u> |

REF: VEO
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ownership and Operation of NursInc Home

Facility Name (Do not include name): **ac** **Fllt Health & Rehab Centet**
(Please make sure the Facility Name is spelled the **same as** on page 5)

Legal name of the Operator at the facility: **CCSPNOVALIC**

Operator's address: **48631** Harry It;inf HG
(Additional space if needed)

City/State/Zip: **NU, VA, 20164**
Operator Telephone: **NU, with Area Code: 734-6800** **EMWltbire code: 571-629-6010**

Legal name of the Owner at the nursing home business: **CCSPNOVAU.C d/b/a Potomac Falli Health & Rehab Center**
Owner's physical address: **46531** Harry Byra Highway
(Additional space if needed)

City/State/Zip: **ilmi 164**

Is the facility opened by the owner of the building? **D** YES NO
Is the facility **owned** by the owner of the building? **0** YES NO

IYP of OwnersHIP and Control

If the facility is **owner-operated**, select ONE from Column A.
If the facility is **NOT** operated by the owner, select mg from Column A and QML from Column 8.

(A) OWNER (of facility)	(B) OPERATOR (of facility)	
<input type="checkbox"/>	<input type="checkbox"/>	<u>State or Local Government:</u> State
<input type="checkbox"/>	<input checked="" type="checkbox"/>	County
<input type="checkbox"/>	<input type="checkbox"/>	City/Town
<input type="checkbox"/>	<input type="checkbox"/>	Multijurisdictional
<input type="checkbox"/>	<input type="checkbox"/>	Hospital District/Authority
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>Non-Profit:</u>
<input type="checkbox"/>	<input type="checkbox"/>	Church Related
<input type="checkbox"/>	<input type="checkbox"/>	<u>Non-Profit</u> Corporation
<input type="checkbox"/>	<input type="checkbox"/>	Other Non-Profit
<input type="checkbox"/>	<input type="checkbox"/>	<u>Proprietary:</u>
<input type="checkbox"/>	<input type="checkbox"/>	Single Proprietary
<input type="checkbox"/>	<input type="checkbox"/>	Partnership
<input type="checkbox"/>	<input type="checkbox"/>	Corporation
<input checked="" type="checkbox"/>	<input type="checkbox"/>	limited liability Corporation

Is there any individual other than those listed on this form (owner, operator, administrator of record) who is authorized to manage administrative decisions in the facility? YES NO

If yes, please identify the person's relationship to the facility
Person's name and relationship to facility: Peune, CEO; David W Tucker, President; Wrlody Wlbr,

Regional Director of Operations

RECEIVED
OCT 11 2019
VDHJOLC

Information Required on the Operator/Manager of the Facility

Please enter the names and Physical addresses of the governing body. If the position is vacant, please put "vacant." If more space is needed, please attach additional pages to the back of the application

Name of President/Chair:

Physical Address: Deborah L Petrine
5372 Fallowater Lane, Suite 200, Roanoke Va 24018

Name of Vice President:

Vacant

Physical Address:

Name of Secretary:

Vacant

Physical Address:

Name of Treasurer:

Brady L Sheffer

Physical Address: 5372 Fallowater Lane, Suite 200, Roanoke Va 24018

If any officer, director, trustee or any member of the governing body or any other Individual, partnership, association, trust, corporation, or other legal or commercial entity owns, holds or has a financial interest of five (5) percent or more in the operating/management entity, list the name and percentages of ownership below:

<u>NAME</u>	<u>OWNERSHIP PERCENTAGE</u>
<u>NOVA</u> Care LLC	50%
<u>va</u> LLC	50%

Are all remaining financial interests less than 5 percent? YES NO

If the operator/manager has a lease or management agreement with the legal entity or individual who owns the physical plant/buildings, list the name and the address of the building owner.

NVHI II, LLC

Name of Building Owner:

Physical Address of Owner: 4423 Pheasant Ridge Road # 301, Roanoke, Va 24014

If the operator/manager has a lease or management agreement with a legal entity or Individual who is not the owner of the physical plant/buildings, list the name and address of the lessor.

Name of Lessor: Commonwealth Care of Roanoke Inc (Management agreement)

Physical Address of Lessor: Fallowater Lane, Suite 200, Roanoke Va 24018

If the operator/manager has a lease or management agreement with an owner or a lessor, does the owner or the lessor have a five (5) percent or more ownership interest in the legal entity that operates/manages the facility? YES NO

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(Tags: Trial attorney, Covid-19, Coronavirus, nursing home lawyer, nursing home attorney, overmedication, medication error, pressure sores, bed sores, sepsis, wrongful death, wounds, falls, attorney handling medication errors, nursing home abuse attorney, assisted living attorney, assisted living accidents, dehydration, malnutrition, Northern Virginia Elder abuse attorney, attorney, nursing home injury, skilled rehab injury, skilled rehab attorney, drugs, pharmaceutical drugs, antipsychotic drugs, negligence attorney, nursing home abuse attorney, adult protective service lawyer, overdose, legal liability for overdose, nursing home abuse lawyer, , nursing home chains, statistics on nursing home abuse, Virginia Nursing abuse attorney, Sterling nursing home attorney, wrongful death, pressure sores, Potomac Falls Health and Rehabilitation Center)