STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495374	A. Building B. Wing	04/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norton Community Hospital Snf Unit	100 15th St NW Norton, VA 24273

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 03115 Based on record review and staff interviews the facility failed to ensure Resident (R)23's assessment accurately reflected gradual dose reduction attempts for an antipsychotic. This failure affected one of five residents reviewed for unnecessary medications. Findings include: Review of the diagnosis tab in the electronic medical record (EMR) revealed Resident (R) 23's diagnosis included Alzheimer's Disease, Unspecified Dementia with behavioral disturbance, anxiety disorder due to know physiological condition, restlessness and agitation, and repeated falls. Review of physician's orders under the orders tab in the EMR revealed R23 had an order for Seroquel Tablet 25 MG (an Antipsychotic) give 0.5 tablet by mouth in the morning related to unspecified dementia with behavioral disturbance and an order for Seroquel tablet 25 MG give 1 tablet by mouth at bedtime related to unspecified dementia with behavioral disturbance. Both orders had a start date of 04/22/19. Review of R23's Minimum Data set (MDS) assessments for the past year revealed each of the assessments was inaccurately coded at Section N0450 Antipsychotic Medication Review to indicate a gradual dose reduction had been attempted during that quarter and included an inaccurate GDR date. Review of the MDS assessments revealed the following: The Quarterly MDS Assessment with an assessment reference date of 12/10/20 was marked that a Gradual Dose Reduction (GDR) of Seroquel was attempted on 02/25/20. The EMR was reviewed in its entirety and was silent for a dose reduction on the date listed. The Quarterly MDS Assessment with an assessment reference date of 12/10/20 was marked that a GDR of Seroquel was attempted on 02/25/20. The EMR was reviewed in its entirety and was silent for a dose reduction on the date listed. The Annual MDS assessment with an assessment reference date of 06/11/20 was marked that a GDR of the Seroquel was attempted on 02/18/20. The EMR was reviewed in its entirety and was silent for a dose reduction on the date listed. (continued on next page)

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.

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/29/21 at 11:02 AM the above MDS assessments were reviewed with the MDS Coordinator. On 04/29/21 at 1:26 PM the MDS Coordinator stated she completed a thorough review of R23's record and the only GDR she could find was on 04/22/19. She verified the MDS assessments were inaccurate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on interview, record review and facility policy/procedure review the facility failed to ensure a resident's Port-A-Cath (also known as an intravenous vascular access port -IVAP) was flushed with heparin by a Registered Nurse (RN) and not by a Licensed Practical Nurse (LPN). Per accepted standards of practice, these flushes are outside an LPN's scope of practice. The deficient practice affected one sampled resident (R)21 and one unsampled resident R22; and had the potential for poor quality of care for all residents, if staff operated outside their accepted scope of practice. Findings include: Review of the facility procedure titled Implanted Venous Access Port: Flushing, dated February 9, 2018, revealed RNs, physicians, nurse practitioners and physician assistants can flush IVAPs. RNs are generally responsible for monitoring the effects of injected medications or fluids for administering appropriate treatment for adverse effects. Tasks related to the use and maintenance of an IVAP cannot be delegated to assistive healthcare staff. 1.) Review of the Face Sheet in the Electronic Medical Record (EMR) revealed R21 was admitted to the facility on [DATE] and readmitted on [DATE]. The resident had diagnoses that included Alzheimer's disease and chronic kidney disease - stage 4. Review of the Orders tab in the EMR for R21 revealed a physician order dated 10/23/20 : Heparin Lock Flush Solution 100 Unit/milliliter (ml). Use 5 ml intravenously every night shift starting on the 23rd and ending on the 23rd every month for management of a Port-A-Cath access port a cath and flush with 10 ml of normal saline flush and then flush with 5 ml of heparin. Review of the Medication Administration Record (MAR) from July 2020 to April 2021 revealed the flushing of the Port-A-Cath was performed by a LPN, seven times, on 07/22/20, 8/22/20, 11/23/20, 12/23/20, 2/23/21 3/23/21, and 4/23/21. Review of the Progress Notes tab in the EMR dated 07/22/20, revealed LPN4 documented a comment in the Progress Notes on the e-MAR Administration Note addressing the heparin flush: flushed per charge nurse. LPN4 was the charge nurse. 2.) Review of the Face Sheet in the EMR revealed R22 was admitted to the facility on [DATE] and readmitted on [DATE]. The resident's diagnoses included Hodgkin's lymphoma. Review of the Orders tab in the EMR for R21 revealed a physician order dated 08/20/18: Heparin Lock Flush Solution 100 Unit/ml. Use 5 ml intravenously every night shift starting on the 15th and ending on the 15th every month for management of a Port-A-Cath access port a cath and flush with 10 ml of normal saline flush and then flush with 5 ml of heparin. Review of the MAR from July 2020 to April 2021 revealed the flushing of the Port-A-Cath was performed by a LPN, nine times, on 07/15/20, 8/15/20, 9/15/20, 10/15/20, 11/15/20, 12/15/20, 2/15/21 3/15/21, and 4/15/21. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes tab in the EMR dated 04/15/21, revealed LPN4 documented a comment in the Progress Notes for the e-MAR Administration Note for the heparin flush no RN avail at this time. On 04/28/21 at 12:30 PM, the Director of Nursing (DON) verbalized only RNs can do flushing of Port-a-Cath. LPNs are not to flush the ports. The DON verbalized she was aware LPNs were doing the flush of the Port-a-Cath and it was not an acceptable practice and only RNs are to perform the heparin flush for R#21 and R#22. On 04/29/21 at 12:20 PM, LPN3 confirmed only RNs should do the heparin flush.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the correct physician's order was followed for wound care for one of 12 sampled residents (Resident (R)11). The failure to follow current physician's orders for wound care could impede healing of the sacral pressure ulcer being treated, and increase the health risks associated with a wound, such as infection and sepsis. Findings include: Review of the Face Sheet in the Electronic Medical Record (EMR) revealed R11 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Alzheimer's Disease and chronic kidney disease, stage four. Review of the Orders tab in the EMR for R11, a new physician's order dated 04/18/21 revealed Wound Care-Sacrum: Clean with normal saline (NS), pat dry, cover with Allevyn daily and as needed (PRN). On 04/28/21 at 6:22 AM, in R11's room, the pressure ulcer dressing was changed by Licensed Practical Nurse (LPN)1. The resident was positioned on her side and the previous dressing of Allevyn and Aquacel AG was removed. Skin and wound were cleaned with normal saline and gauze. The Aquacel AG dressing needed to be cut to the size of the opening of the pressure ulcer. Once the Aquacel AG dressing was in place the Allevyn dressing was applied over the wound. Review of the Medication Administration Record (MAR) dated April 2021 for R11, revealed dressing changes were performed from 04/18/21 to 04/27/21 (10 days) with initials in the boxes for the order reading clean sacral wound with NS, pat dry, and cover with Allevyn daily and PRN. Review of the Assessments tab in the EMR the documents titled My Wound Flowsheet-V2 revealed the description of the wound order of the dressing changes for R11 from 04/18/21 to 04/27/21 was clean sacral wound with NS, pat dry, apply Aquacel AG and cover with Allevyn daily and PRN. The application of the Aquacel AG was not included on the MAR order but was documented as applied on the My Wound Flowsheet-V2. On 04/28/21 at 6:45 AM, LPN1 stated she did not review the physician's order before performing the dressing change and did not realize the Aquacel AG dressing was not ordered for the wound care for R11. On 04/28/21 at 8:36 AM, the Charge Nurse confirmed the physician's order was changed on 04/18/21 and Aquacel AG was no longer being applied to the wound during the dressing change. The Charge Nurse confirmed her expectation that staff would review the physician's orders prior to doing a dressing change and to follow the current physician's orders. Review of the facility policy titled Wound Cleansing, Dressing and Irrigation - LTC - Ballad Health, revised 09/25/21, revealed Residents will receive appropriate wound care and dressing changes per providers orders.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 03115 Based on record review and staff interview the facility failed to ensure residents who received antipsychotic medications had a gradual dose reduction attempt at least annually. This failure affected 1 resident (R)esident 23) of 5 residents reviewed for unnecessary medications. Findings include: The diagnosis tab in the electronic medical record (EMR) revealed Resident (R) 23's diagnosis included Alzheimer's Disease, Unspecified Dementia with behavioral disturbance, restlessness and agitation, and repeated falls. Review of physician's orders under the orders tab in the EMR revealed R23 had an order for Seroquel Tablet 25 MG give 0.5 tablet by mouth in the morning related to unspecified dementia with behavioral disturbance and an order for Seroquel tablet 25 MG give 1 tablet by mouth at bedtime related to unspecified dementia with behavioral disturbance. Both orders had a start date of 04/22/19. Seroquel is an antipsychotic medication. Antipsychotics are a class of psychotropic medications primarily used to manage psychosis (including delusions hallucinations, or disordered thought), particularly in schizophrenia and bipolar disorder. Review of R23's care plan revealed she had a care plan focus area stating she receives psychotropic medications due to behavior management (agitation), general anxiety disorder, Depression and Disease process (dementia) and appetite stimulation. The care plan had a revision date of 03/15/21. The interventions included to consult with the pharmacy, MD to consider dosage reduction when clinically appropriate but at least quarterly. There were no documented behaviors present in the record review for R23. The drug regimen reviews printed on forms titled MV Pharmacy Drug Regimen Review were reviewed. The pharmacist documented no recommendations or irregularities were noted on the drug regimen review forms dated 04/14/20, 06/15/20, 07/14/20, 08/18/20, 10/23/20, 11/16/20, 12/21/20, 1/19/21, 02/16/21, 03/16/21, and 04/20/21. On 04/28/21 at 1:00 PM an interview was conducted with the Director of Nursing (DON) related to dose reduction attempts for the Seroquel. She provided two Medication Regimen Review forms titled Professional Networks Services dated 04/15/19 and 11/18/19. Review of the Medication Review forms revealed the following: On 04/15/19 the pharmacist wrote R23 was receiving Seroquel 25mg two times a day since 10/21/18 and requested the physician consider reducing Seroquel to 25mg once a day. On the bottom of the form the physician wrote to reduce the Seroquel to 12.5mg in the morning and 25mg in the evening. He signed and dated the form 04/22/19. Review of the physician's orders under the orders tab in the EMR revealed the order was changed on 04/22/19. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/22/19 the pharmacist recommended reducing the Seroquel to 12.5mg twice a day. On the bottom of the form the physician checked the Do not change box and wrote, Pt failed GDR repeatedly in the past. He did not include any additional information or include the dates Gradual Dose Reductions (GDR) had been attempted and failed. The paper chart and EMR were reviewed in its entirety and were silent to any notes related to attempted dose reductions other than the reduction on 04/22/19. Review of the physician progress notes under the miscellaneous tab of the EMR revealed the physician wrote progress notes on 10/16/20, 12/04/20, 02/26/21, and 04/13/21 and each of the notes was silent to the use of the Seroquel for the resident. The facility policy titled Medication Reconciliation/Drug Review with a last reviewed date of 12/18/21 stated, Gradual dose reductions will be completed at a minimum frequency of annually for any resident receiving psychotropic medications. On 04/29/21 at 11:02 AM the Director of Nursing and the MDS Coordinator were interviewed. The DON and the MDS Coordinator verified the physician failed to attempt gradual dose reductions quarterly and failed to document the attempted dose reductions. On 04/29/21 at 1:26 PM the MDS Coordinator stated she looked through all of R23's medical record in attempt to find physician documentation related to the reason for using the Seroquel and any gradual dose reduction attempts. She stated she could not find any progress notes addressing gradual dose reductions and the only notes she found related to why R23 was on Seroquel were dated 11/18/16 and 12/13/16. There were no more recent behaviors documented for R23.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 39540 Based on observation, interview and facility policy review the facility failed to ensure expired medications were removed from the medication cart and the medication storage room. This deficient practice occurred in one of one med rooms and two of two med carts; and could potentially lead to administering ineffective, outdated medications to the residents. Findings include: On 04/29/21 at 12:12 PM, in the medication cart for resident rooms 4-11 and 29-32, two individual Tylenol 325 milligram (mg) packets were found with an expiration date of 03/04/21. On 04/29/21 at 12:12 PM, Licensed Practical Nurse (LPN)3 verified the Tylenol packets were outdated and confirmed the medication should have been removed from the cart and not available for administration. On 04/29/21 at 12:43 PM, three 10 cubic centimeters (cc) heparin flush syringes were found in the medication storage room with an expiration date of 2/2021. On 04/29/21 at 12:43 PM, LPN2 verified the heparin syringes were outdated and confirmed the syringes should be sent back to the pharmacy and not available for resident use. On 04/29/21 at 12:46 PM, the Charge Nurse confirmed the syringes were outdated and should have been discarded. The Charge Nurse verified the pharmacy sent 30 cc and since there were three 10 cc syringes in the bag, concluded none of the expired heparin syringes were used for resident port flushes. Review of the facility policy titled Storage of Medication - LTC - Ballad Health, dated 09/25/20, revealed, No discontinued, outdated or deteriorated medications are available for use in the facility. All such medications are destroyed. Any unused, expired, damaged, returned, and/or contaminated medications are removed from medication cart.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 03115 Based on observation, menu review, and staff interview the facility failed to follow the menu selected for the residents. This affected three (Resident (R) 2, R20, R23) of 25 residents in the facility. Findings include: The lunch meal was observed in the kitchenette on the nursing unit on 04/28/21 continuously from 11:54 AM through 12:40 PM. At 12:36 PM the [NAME] ran out of spaghetti (pasta). As a result, Resident (R) 2, R22, and R23 did not receive any pasta. The pasta was served as a side dish with chicken parmesan and the last three residents served were not offered or provided a substitiute of equal nutritive value when there was not enough spaghetti prepared. Review of the orders tab in each of the resident's electronic medical records revealed R2 had an order for a regular, dysphagia mechanically altered texture; R20 had an order for a Regular diet; and R23 an order for a Regular, dysphagia mechanically altered, regular consistency diet. Review of the menu revealed R20 was supposed to receive pasta and R2 and R23 mechanically altered diets were supposed to receive chopped pasta. Following the observations on 04/28/21 at 12:43 PM the [NAME] was interviewed. He stated he was the person who cooked the meal. He stated he did not cook enough pasta and he verified he did not give the last three residents he served pasta or a substitute for the pasta. The System Chef was present in the dining room on the nursing unit when the cook ran out of pasta. At 1:00 PM he confirmed the cook ran out of the pasta and should have cooked enough for all the residents.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 03115 Based on observation, staff interview, and policy review the facility failed to ensure the sanitizing solution was maintained at an acceptable level to sanitize food contact surfaces; and failed to perform hand hygiene after contaminating their gloves and before touching resident food. This had the potential to affect 25 of 25 residents residing in the facility. Findings include: 1.On 04/26/21 at 11:07 AM one of two red containers of sanitizing solution used to sanitize food preparation surfaces and to hold wiping cloths measured at zero parts per million (ppm). The wiping container was located by the three-compartment sink. The Dietary Supervisor and the System Chef both verified the solution was not at the proper sanitizer level to sanitize the food contact surfaces. The Dietary Supervisor stated she made the solution about 8:00 AM that morning. The System Executive Chef tested the sanitizing solution with a test strip and verified it measured zero ppm. The facility policy titled Sanitizing Food Contact Surfaces with a revised date of 01/19 stated the J-512 sanitizer must be between 200 ppm and 400 ppm. The policy stated the sanitizer in the red buckets should be replaced every two hours or more frequently, if visibly dirty. The manufacture's information titled Diversey Final Step J-512 stated the solution should be between 200 ppm and 400 ppm to sanitize food contact surfaces and equipment. 2. On 04/28/21 the noon meal service was observed continuously from 11:54 AM through 12:40 PM. At 11:56 AM a plastic bag containing hot dog buns dropped on the floor from the cart. The [NAME] picked the bag up with his gloved hands and placed it on a tray with clean soup bowls. Without first washing his hands or changing his gloves he removed bread from a bread bag and made a turkey and cheese sandwich and held the sandwich with the same gloved hands to cut it in half. He served two additional trays touching the handles of the serving utensils with the contaminated gloves and at 12:03 PM, with the same gloves on, he obtained a bowl off the tray and poured potato soup into it. He touched the handle of the ladle with the same gloves on. At 12:04 PM he removed his gloves, washed his hands, and put on clean gloves. During the same continuous observation of the cook on 04/28/21 at 12:25 PM he pushed his eyeglasses up with his gloved hands. At 12:27 PM he stuck his hands in a quart size bag of parmesan cheese and obtained the cheese with his gloved hands without first changing his gloves. The Executive Chef was present in the kitchenette area and verbally prompted him to use a spoon to serve the parmesan cheese. At 12:29 PM the cook picked up the bag containing the hot dog buns that had been dropped on the floor touching the portion of the bag (bottom) that had landed on the floor. He removed two hot dog buns with the same gloves on. He put the hot dogs on the bun using tongues. At 12:32 PM he again obtained bread from the bread bag with the same gloves on. At that time, the Executive Chef was made aware of the situation and he prompted the cook to change his gloves and wash his hands and stated he was going to replace the resident's hot dogs. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 12:43 PM the [NAME] was interviewed. He verified that he did pick the bread up and verified he had not changed his gloves or washed his hands after picking it up off the floor and confirmed he touched the bag and served the hot dog buns that were in the bag. The facility policy titled Hand Hygiene with a revised date of 01/19 stated hands should be washed with soap and water after any activity that may contaminate the hands. The facility policy titled Food Handling Guidelines with a revised date of 01/19 stated gloves should be changed between task and hands should be washed after removing gloves.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39540 Based on observation, interview, record review, and facility policy review the facility failed to ensure the scissors, used by the nurse, to cut dressings for a pressure ulcer were cleaned prior to use on the dressing for one of 12 sampled residents (Resident (R) 11). The failure to follow accepted standards of practice related to infection control with wound care could potentially introduce bacteria into the wound causing an infection. Findings include: Review of the Face Sheet in the Electronic Medical Record (EMR) revealed R11 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Alzheimer's Disease and chronic kidney disease, stage four. Review of the Orders tab in the EMR for R11, a physician's order dated 04/18/21 revealed Wound Care-Sacrum: Clean with normal saline (NS), pat dry, cover with Allevyn daily and as needed (PRN). On 04/28/21 at 6:22 AM, in R11's room, the pressure ulcer dressing was changed by Licensed Practical Nurse (LPN)1. The resident was positioned on her side, and the previous dressings were removed. R11's skin and wound were cleaned with normal saline and gauze. The dressing needed to be cut to the size of the opening of the pressure ulcer. LPN1 removed her scissors from the pocket of her uniform and, without cleaning the blades of the scissors, cut the dressing to the size of the opening of the pressure ulcer. Once the dressing was in place the Allevyn dressing was applied over the wound. On 04/28/21 at 6:45 AM, LPN1 acknowledged she knew to clean the scissors prior to cutting the dressing to the size of the pressure ulcer opening. She admitted that she did not bringing alcohol pads with her into the room for the dressing change, and so she did not clean the blades of the scissors prior to using them to cut the dressing. LPN1 explained by not cleaning the blades of the scissors, bacteria could potentially be introduced into the pressure ulcer creating an infection. Additionally, LPN1 stated she did not review the physician's order before performing the dressing change and did not realize the wound care order had changed for R11's dressings. On 04/28/21 at 8:46 AM, the Charge Nurse confirmed the importance of following infection control practices for dressing changes and the use of aseptic technique; and by not cleaning the scissor blades prior to cutting the dressing created an increased potential for infection in the pressure ulcer for R11. Review of the facility policy titled Infection Control Program-Long Term Care-Ballad Health, revised January 21. 2021, revealed There is consistent use of aseptic technique for dressing changes.