STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 08/27/19 through 08/29/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Four complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/27/19 through 8/29/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four complaints were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 112 certified bed facility was 95 at the time of the survey. The survey sample consisted of nineteen current resident reviews and four closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(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,	F 580		9/17/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 09/10/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 580	Continued From page 1 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 resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to notify the physician of a change in condition for one of 23	F 580	1. Resident #95 no longer resides in the facility as of 10/4/2018. 2. Residents who reside in the facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 580

Continued From page 2

residents in the survey sample. There was no notification to the physician when Resident #95 was assessed with edema and diminished lung sounds/wheezing.

The findings include:

Resident #95 was admitted to the facility on 10/3/18 and died in the facility on 10/4/19. Diagnoses for Resident #95 included cerebral infarction, dysphagia with gastrostomy, high blood pressure and abdominal aneurysm. The nursing admission assessment dated 10/3/18 assessed Resident #95 with short and long-term memory problems and moderately impaired cognitive skills.

Resident #95's clinical record documented the resident was assessed upon admission on 10/3/19 at 4:00 p.m. with diminished breath sounds in the lower lungs and wheezing in the upper right lung. A nursing note dated 10/3/18 at 4:00 p.m. documented, "...L [left] side diminished wheezing on the Right will have Dr. [doctor] see him tomorrow..." A nursing note dated 10/4/18 at 7:00 a.m. documented the resident was assessed with edema in the left foot and left hand in addition to a cough and wheezing. This note documented, "...has non pitting edema in L [left] foot + L foot elevated...has non pitting edema in L hand...has a productive cough wheezing in lower R [right] lobe and upper R and upper + lower L [left] lobe diminished. Will continue to monitor..."

The clinical record documented no notification to the physician regarding the diminished lung sounds, left foot/hand edema and cough.

A nursing note dated 10/4/19 at 9:30 a.m.

F 580

have the potential to be affected. Quality review of residents admitted within the past 2 weeks will be completed by the DON or designee to ensure that any changes in condition after admission have been communicated to the Physician. Follow up to be conducted based on findings.

3. Licensed nursing staff will be re-educated on MD notification of significant changes in condition by DON/SDC/designee. New admissions will be reviewed in the daily clinical meeting by the DON and the clinical interdisciplinary team to capture any changes in condition and ensure there was notification to the physician. The DON and the clinical interdisciplinary team will review the 24 hour report during the daily clinical meeting to ensure that any changes in condition have been reported to the physician. This will continue weekly for 8 weeks.

4. The results of the quality monitoring will be presented to QAPI committee monthly for review, analysis and further recommendations. Quality monitoring schedule modified based on findings.

5. Date of Compliance: 9/17/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 580	Continued From page 3	F 580		

documented the resident was found without pulse and respirations. The physician's assistant (PA) note dated 10/4/19 documented he pronounced Resident # 95 dead on 10/4/19 at 9:06 a.m.

On 8/29/19 at 8:30 a.m., the licensed practical nurse (LPN #5) that cared for Resident #95 was interviewed about any notification to the physician concerning the diminished lung sounds, coughing and edema. LPN #5 stated she cared for Resident #95 on 10/3/19 until 7:00 p.m. and then again on 10/4/19 starting at 7:00 a.m. LPN #5 stated the night shift nurse reported to her at shift change on 10/4/19 at 7:00 a.m. that the resident had edema, wheezing and a cough. LPN #5 stated usually the physician or PA assessed residents on the next day after admission. LPN #5 stated she was not sure whether she reported the resident's condition to the PA or physician. LPN #5 stated she had not assessed Resident #95 on the morning of 10/4/19 until a certified nurses' aide called her to the room and the resident was found without pulse or respirations. LPN #5 stated she was not aware of any prior call or notification to the physician about the edema or diminished lung sounds.

On 8/29/19 at 9:12 a.m., the facility's PA was interviewed about Resident #95. The PA stated he had no report from nursing about the resident's wheezing, diminished lung sounds or left-sided edema. The PA stated when he arrived on 10/4/19 around 9:00 a.m., nursing immediately reported the resident had no pulse or respirations. The PA stated I assessed the resident immediately and found that he had been deceased "for quite some time."

On 8/29/19 at 9:55 a.m., the director of nursing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 580	Continued From page 4 (DON) was interviewed about notification regarding Resident #95 condition. The DON stated she was not familiar with Resident #95 and the unit manager, night shift nurse and DON at the time of Resident #95's stay no longer worked in the facility. The DON stated nurses were expected to notify the physician or on-call provider of changes in the condition. The facility's policy titled Notification of Change in Condition (effective 11/30/14) documented it was the policy of the facility "...to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition..." The policy listed under notification procedure, "The nurse to notify the attending physician and Resident Representative when there is a...Significant change in the patient/resident's physical, mental, or psychosocial status...Need to alter treatment significantly...New treatment...Discontinuation of a current treatment due to but not limited to: Adverse consequences...Acute condition...Exacerbation of a chronic condition...Document notification in the medication record..." (Sic) This finding was reviewed with the administrator and director of nursing during a meeting on 8/29/19 at 2:00 p.m. This was a complaint deficiency.	F 580		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		9/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 684 Continued From page 5 — F 684

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.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to apply physician ordered Ace wraps for one of 23 residents in the survey sample (Resident #151).

The findings include:

Resident #151 was admitted to the facility on 8/17/19 with diagnoses that included osteomyelitis, cellulitis of lower limb, pneumonia, anxiety, hypokalemia, depression, osteoarthritis, hypertension, asthma and hyperlipidemia. The nursing admission assessment dated 8/17/19 assessed Resident #151 as cognitively intact.

Resident #151's clinical record documented the resident had surgical wounds on the top of her left knee and outer lower leg/ankle. The resident's clinical record documented a physician's order dated 8/20/19 for dressing changes to the left knee and lower leg wounds with an Ace wrap applied over the gauze pads on each wound.

On 8/27/19 at 12:50 p.m., Resident #151 was observed in her room. The resident had a gauze dressing applied to her left knee and left foot/ankle. The dressings were dated 8/27/19. The resident had no Ace wrap on the left knee or left foot.

Provider's Plan of Correction:

1. Resident #151 is receiving treatment application and dressing changes as ordered by the physician.

2. Residents identified as having treatment orders be will reviewed by the DON or designee to ensure that treatments are being completed as written by the physician. Follow up to be conducted based on findings.

3. The DON/SDC/designee will educate licensed nursing staff on following physician orders to include treatment application and dressing changes in accordance with professional standards of practice. The DON or designee will perform 5 random observations of dressing changes and treatment applications weekly for 8 weeks to ensure the orders are followed as written.

4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations. Quality monitoring schedule modified based on findings.

5. Date of Compliance: 9/17/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 684	Continued From page 6 On 8/28/19 at 10:20 a.m., accompanied by licensed practical nurse (LPN #4), Resident #151 was observed in her room. The resident had no Ace wrap on the left knee or foot. LPN #4 asked the resident at this time about the Ace wrap on the left leg. Resident #151 stated she did not know why the Ace wrap was not in place. LPN #4 searched the room and found two Ace wraps on the top of the resident's bedside table. On 8/28/19 at 10:21 a.m., Resident #151 was interviewed again about the Ace wrap. Resident #151 stated she thought the nurse did not put the Ace wrap on the leg when the dressings were changed on 8/27/19. Resident #151 stated she did not remove the wraps. Resident #151 stated she had the Ace wraps on at one time but did not recall why it was not in place today (8/28/19). On 8/28/19 at 10:40 a.m., LPN #4 was interviewed about the Ace wraps. LPN #4 stated the Ace wraps were supposed to be applied over the gauze dressings on the left knee and foot. LPN #4 stated she did not know why the wraps were not applied as ordered. On 8/28/19 at 3:50 p.m., the unit manager (LPN #1) was interviewed about the Ace wraps for Resident #151. LPN #1 stated the Ace wraps were part of the physician's order for wound care and should have been in use. This finding was reviewed with the administrator and director of nursing during a meeting on 8/28/19 at 5:00 p.m.	F 684		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4)	F 700		9/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 700	Continued From page 7 §483.25(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. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed to properly assess one of 23 residents in the survey sample for the use of bed rails: Resident # 41. Findings include: Resident # 41 was admitted to the facility 9/26/17 with a readmission date of 6/29/18. Diagnoses for Resident # 41 included, but were not limited to: heart failure, high blood pressure, and GERD. The most recent MDS (minimum data set) was a quarterly assessment dated 712/19. Resident #	F 700	1. Resident #41 no longer has side rails as of May 17, 2019. 2. Residents who reside in the facility have the potential to be affected. Residents in the facility currently using side rails will be re-evaluated by a licensed nurse to ensure assessments are accurate and complete. Follow up to be completed based on findings. 3. The Regional Director of Nursing will educate the licensed nursing staff on regulations around side rail usage and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 700

Continued From page 8

41 was assessed as having severe cognitive impairment with a total summary score of 04 out of 15.

An Adult Protective Services (APS) report received by the State Agency 5/28/19 documented: "(name of resident) did have a skin injury caused by sticking her arm through the bed rail and scraping the skin. The unit manager contacted the physician and the skin tear was treated. The unit manager also instituted an immediate intervention by having a body pillow placed between (name of resident) and the bed rail and will add sheepskin as an added safety measure. Because staff acted appropriately in getting medical treatment and instituted immediate measures to ensure safety, report deemed 'unfounded'." The incident occurred 5/16/19.

On 8/27/19 at 10:45 a.m. during the initial tour of the facility, Resident # 41 was observed in bed. There were no side rails affixed to the bed, and fall mats were placed on each side of the bed. Interventions as documented in the APS report were observed in place, except for the bed rails. No skin tears were observed on the resident's arms. An interview was attempted with the resident, but due to her cognitive status was limited to the resident stating she was "fine today" and breakfast had been good.

On 8/28/19 at 10 :30 a.m. the clinical record was reviewed. The nursing note for the bed rail incident, dated 5/16/19 was reviewed, and documented the same information per the APS report regarding the skin tear injury and interventions put in place. The side rail evaluations were then reviewed prior to the injury.

F 700

how to accurately complete the assessments. The DON will make random quality monitoring observations weekly for 6 weeks of residents using side rails to ensure the side rails are being utilized appropriately and should remain in place.

4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations. Quality Monitoring schedule modified based on findings.

5. Date of Compliance: 9/17/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE** **FISHERSVILLE, VA 22939**

(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 700	Continued From page 9 A side rail evaluation dated 2/25/19 was located in the clinical record. The evaluation included areas to be completed prior to the use of side rails. The area "Side Rail Alternatives Attempted (list)" was blank. Under the documentation area, "Resident request side rails" was checked. Under Recommendations" was checked "Side Rails Recommended." There was no further documentation on the form. A quarterly data collection assessment dated 4/12/19 was then reviewed. Under "Fall Risk" the assessment was marked "yes" that the resident was using side rails. The directions for that section documented "If yes, complete additional Side Rails Evaluation." The evaluation was not located in the clinical record. On 8/28/19 at 3:15 p.m. the DON (director of nursing) was interviewed about the side rail evaluations. The DON acknowledged there was not a side rail evaluation for 4/12/19, and should have been completed. The evaluation dated 2/25/19 was also confirmed by the DON as incomplete. The DON added "[name of resident] did use the side rails to turn and reposition at that time; she has chronic back pain, and at that time was getting up more often." The DON was then asked how APS became involved with the incident. The DON stated "An APS worker is listed as a contact for the resident as there is no family support." After the incident of the resident incurring a skin tear from the sticking her arm through the side rail, the DON stated the side rails were discontinued as the resident was not as alert as before, and it was determined the side rails were no longer useful, but something that was just in the resident's way. On 8/28/19 during an end of day meeting with	F 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 700	Continued From page 10 facility staff beginning at 5:00 p.m. the administrator, DON, and corporate nurse consultant were informed of the above findings. No further information was presented prior to the exit conference.	F 700		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure	F 761	1) A) Medications carts are being locked to properly secure medications. B) Insulin	9/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 761

Continued From page 11

medications were locked in the medication cart during a medication pass and pour observation; failed to properly store insulin in one of three medication carts inspected, and also failed to label and date opened tuberculin solution and Lorazepam (an anti-anxiety medication) in one of three medication rooms inspected.

Findings include:

1. On 8/28/19 beginning at 8:10 a.m. a medication pass and pour observation was conducted with LPN (licensed practical nurse) # 6. After preparing medications for Resident # 61, LPN # 6 left the medications laying on the top of the cart and went in the resident's room to administer the medications. After administering the medications, LPN # 6 was asked about the medications left out on the top of the cart. LPN # 6 stated "I just forgot to put them up before going in the resident's room."

On 8/28/19 at 9:30 a.m. the DON (director of nursing) was asked for a policy on medication storage. The policy "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles" at 3.3 documented "Facility should ensure that all medications and biologicals...are securely stored in a locked cabinent/cart...inaccessible to residents and visitors."

On 8/28/19 at 5:00 p.m. during a meeting with the administrator and DON the above findings were discussed.

No further information was presented prior to the exit conference.

F 761

that is in usage is stored properly. C) The tuberculin and Lorazepam were discarded during survey.

2. Residents who reside in the facility have the potential to be affected. Quality review of medication carts will be completed by the Unit Managers to ensure medications were properly secured. Quality review of Insulin in use will be completed to ensure appropriate labeling with open and discard dates. Quality review of Tuberculin and Lorazepam will be completed to ensure they are labeled with open and discard dates by the Unit Managers. Follow up based on findings.

3. Licensed nurses will be re-educated by DON/SDC/designee on following proper storage and securement of medications as well as following manufacturing guidelines for insulin, tuberculin and lorazepam storage in regards to labeling and honoring expiration dates. Quality review of medication carts on each unit will be completed weekly for eight weeks by the DON or designee to ensure medication carts are locked when not in use and insulin is properly stored and labeled. Quality review of medication storage rooms will be completed weekly for 8 weeks by the DON or designee to ensure Tuberculin and Lorazepam are labeled and dated appropriately in accordance with manufacturers recommendation.

4. The results of the quality monitoring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 761	Continued From page 12 2. On 8/28/19 at 9:00 a.m. the medication cart on the 2 back hall was inspected with RN (registered nurse) # 1. Two insulin kwick pens were located unopened in the medication cart, and labeled "Refrigerate until open." RN # 1 confirmed the pens should be in the refrigerator until opened. RN # 1 then went to put the pens back in the refrigerator. RN #1 was asked if it was known how long the pens had been in the cart. RN # 1 stated "Oh, that's a good point..." At that time, the nurse consultant and DON (director of nursing) came to the cart. The DON stated "I think those insulin pens were delivered last night." The nurse consultant stated "Are those residents scheduled to get that insulin today?" RN # 1 checked to see when the insulins were to be given; she named a resident name, then stated "She is not on this unit..." The DON stated "she is on the front hall...that insulin isn't in the right cart..." On 8/28/19 at 9:30 a.m. the DON (director of nursing) was asked for a policy on medication storage. The policy "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles" at item 7. documented "Facility should store all medicaqtions and biologicals...for stability in accordance with manufacturer/supplier specifications." On 8/28/19 at 5:00 p.m. during a meeting with the administrator and DON the above findings were discussed. The DON stated she had called the pharmacy, and as long as the insulin was used by the evening of 8/28/19, and discarded in 28 days it would be acceptable. No further information was presented prior to the exit conference.	F 761	will be reported to the quality assurance committee team monthly for review, analysis and further recommendations. 5. Date of Compliance: 9/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 761	Continued From page 13	F 761		

3. The medication room on Unit 2 was inspected on 08/28/2019 at approximately 8:30 a.m. Observed in the refrigerator was an opened box of multi-dose Aplisol. Inside the box was an opened vial of Aplisol. Neither the box nor the vial were dated. LPN (licensed practical nurse)# 2 and LPN #3 were in the medication room and were asked about the Aplisol. Both stated, "The box and the vial should be dated...we will throw that away."

Also observed in the locked compartment of the refrigerator was a multi-dose vial of Lorazepam. The Lorazepam had a dropper in the top of the bottle. The bottle was contained inside of a brown medication bottle. A tamper resistant tape/seal across the top of medication bottle was disrupted. LPN # 2 was asked if the bottle had been opened and used. She stated, "The seal is broken so I would say, yes. Sometimes they come from the pharmacy with the dropper already in the bottle, and it has a seal around the top, sometimes the dropper and the bottle are separate inside of the medication bottle...I don't know which way this one came...but since the tamper resistant tape has been torn I would say it has been opened." LPN #3 stated, "It isn't labeled so we will discard it."

The facility policy on medication storage was requested and received. Per the policy, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles", contained the following: "...Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the primary medication container (vial, bottle, inhaler)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 761	Continued From page 14 when the medication has a shortened expiration date once opened...If a multi-dose vial has been opened or accessed (e.g. needle-punctured), the vial should be dated and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial," The above information was discussed with the DON (director of nursing) and the administrator during an end of the day meeting on 08/28/2019. No further information was obtained prior to the exit conference on 08/29/2019.	F 761		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization	F 801		9/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 801	Continued From page 15 recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 801	Continued From page 16 management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, the facility staff failed to provide scheduled oversight/consultation to the dietary manager regarding the facility's food/meal service to residents by the registered dietitian. The findings include: During the current survey, the survey team observed and identified issues with improper food storage, lack of proper dating/labeling of food in the kitchen refrigerator, inaccurate meal tickets for residents, failure to honor resident food preferences and unnecessary use of plastic utensils with residents. On 8/27/19 at 2:51 p.m., the facility's registered dietitian (RD) was interviewed about out of date and undated meat items stored in the walk-in refrigerator. The RD stated there was supposed to be a tracking system in the kitchen to ensure proper food storage. The RD stated there should have been a date on the meat products when they were removed from the freezer. The RD stated the dietary manager was responsible for food receipt and storage. On 8/28/19 at 11:15 a.m., the dietary manager	F 801	1. The facility has a qualified registered dietician in place to provide consultation to the dietary manager. 2. No residents were affected by this deficient practice. 3. The Registered Dietician will be re-educated on her role in the facility to include providing consultation to the dietary manager. Facility will ensure adequate oversight is provided to the dietary manager that is employed going forward. The RD will make weekly visits for 8 weeks to perform kitchen inspections and provide consultation as needed. 4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations. 5. Date of compliance: 9/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 801	Continued From page 17	F 801		

was asked about his credentials for managing the kitchen. The dietary manager stated he had worked at the facility for seven months, had taken a food safety class but was not a certified dietary manager. The dietary manager stated he was "working on" signing up for the certification class.

On 8/28/19 at 11:30 a.m., the administrator was interviewed about the identified issues in the kitchen with food storage and resident issues concerning food preferences, inaccurate meal tickets and plastic utensils. The administrator stated the food service workers in the facility were contract employees. The administrator stated the RD was not full-time but was in the facility on Tuesday of each week. The administrator presented records indicating the dietary manager was hired on 2/25/19 and did not yet have certification or higher education regarding food service management.

On 8/28/19 at 4:50 p.m., the RD was interviewed about lack of assessment and provision of food preferences for Resident #152. The RD stated she did not provide oversight over the facility kitchen or the kitchen processes. The RD stated she thought there should be oversight in the kitchen but it was not in her job description to monitor the kitchen activities. The RD stated the dietary manager was responsible for assessing/providing food preferences for residents. The RD stated she had worked other places where the RD provided oversight/consultation for the kitchen and food services but it was not in her job description at this facility.

On 8/29/19 at 9:30 a.m., the RD was interviewed again about her oversight of the facility's kitchen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 801	Continued From page 18 and food service. The RD stated she wanted to clarify what she stated the previous day (8/28/19) about her oversight of the kitchen. The RD stated she was in the facility at least one day per week and she "checked in" with the dietary manager. The RD stated the dietary manager had not asked her any questions or requested help from her about any concerns. The RD stated she was "in and out" of the kitchen during the day she was here with orders. The RD stated she did not currently perform audits concerning sanitary food storage/service and was not aware of issues with improper food storage or lack of honoring food preferences. The RD stated if she saw someone in the kitchen without a hairnet, she would question that. The RD stated the dietary manager had her phone number but he had never called or asked her for "anything." The RD described the situation as "terrible" in the kitchen and stated the company needed to clarify job descriptions. The RD's job description was requested and provided to the survey team. This job description documented in the position summary, "...Works effectively with others to ensure that quality nutritional services are being provided on a daily basis, and acts as a resource to the Director of Dining Services [dietary manager] so that the dining services department is maintained in a clean, safe, and sanitary manner..." Under essential functions of the job, the description documented, "...Provides oversight and guidance to the Dining Services Director regarding dining services and operations...Inspects food storage room...Monitors dining service personnel to ensure that they are following established safety precautions in the use of equipment and supplies...Provides consultation to the Director of	F 801		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 801	Continued From page 19 Dining Services...on federal, state, and local regulation pertaining to dining service operations..." This finding was reviewed with the administrator and director of nursing during a meeting on 8/28/19 at 5:00 p.m.	F 801		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident review and clinical record review, the facility staff failed to honor the food preferences for two of 23 residents, Resident #37 and Resident #152. Findings include: 1. Resident #37 was admitted to the facility on 04/12/2019 with the following diagnoses but not limited to: COPD (chronic obstructive pulmonary disease), heart failure, atrial fibrillation, GI (gastrointestinal) hemorrhage, hypothyroidism and hypertension. The most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment	F 806	1. Resident #37 and #152 have been re-evaluated for there food preferences as of 9/6/2019. Both residents are having their food preferences honored. 2. Residents who reside in the facility have the potential to be affected. The dietary manager will ensure that residents in the facility have a completed food preference assessment. 3. The dietary manager will be educated by the regional dietary manager on completion of food preference assessments and ensuring that meals are prepared accordingly. The Executive	9/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 806	Continued From page 20 reference date) of 07/01/2019, assessed Resident # 37 as cognitively intact with a summary score of "15". On 08/27/19 at 11:00 a.m., Resident #37 was interviewed regarding life at the facility. She was asked about the food served. She stated, "The food is terrible...they bring you what they want to bring you. I've told them over and over I don't like fish, I don't want it. What do they send? Fish! I'm not eating it, I don't care how they cook it. I want coffee for breakfast, I've told them that too, over and over. What do they send? Tea. I don't like pasta and I don't want any pork...they send that all the time too. My food is never right." At approximately 12:20 p.m., dining observations were conducted. Resident #37 was observed sitting in her room, two staff members were in the room with her. Resident #37's lunch tray had been removed from her bedside table. Observed on the tray was a chicken patty, mashed potatoes, chicken noodle soup, cut up lettuce, butter bread and yellow squash. There was no tray card on the tray. OS (other staff) # 6 stated, "The unit manager has the tray ticket." The tray ticket was brought back to the room by the unit manager, LPN (licensed practical nurse) #4. The tray ticket dated 8/29/2019 (the date was 8/27/2019) contained the following information: "Chicken noodle soup, coffee, peanut butter and jelly sandwich, assorted ice cream. Dislikes: Fish group, pasta, pork." Observed on Resident #37's bedside table in front of her was a bowl of tomato soup, a turkey and cheese sandwich, chocolate ice cream and cake. Resident #37 was asked if she wanted a peanut butter and jelly sandwich and chicken noodle soup as per her request on the tray ticket. Resident #37 stated,	F 806	Director or designee will complete weekly tray line observations to ensure meal tickets are printed to include preferences and that the meal is prepared accordingly for 8 weeks. 4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations. Quality monitoring schedule modified based on findings. 5. Date of Compliance: 9/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 806	Continued From page 21	F 806		

"I'm okay with what I have...that chicken noodle they sent is not any good, it's all broth, and they brought me some ice cream...I'll eat this." The unit manager was asked why the food on Resident #37's tray was not what she had requested. She stated, "I don't know."

During an end of the day meeting on 08/28/2019 at approximately 5:00 p.m., the DON (director of nursing), the administrator, corporate staff and the district food manager were notified of the above information. The district food manager asked for the tray ticket. She stated, "I'll look into it."

On 08/29/2019 at approximately 8:15 a.m., Resident #37 was observed sitting in her room. Her breakfast tray was beside her. She had eaten everything on her tray but the ground sausage that was covered in gravy. An empty carton of 2% milk was on the tray. Resident #37 was asked if she preferred 2 % milk. She stated, "No, I prefer whole milk, but I just pour it over my cereal so I guess that's ok...but I don't want any pork. They don't listen." The unit manager, LPN #4 was called to the room. She was was asked about the sausage on Resident #37's tray. She stated, "I don't know. I'll find out." At approximately 09:00 a.m. LPN #4 came to the conference room and stated, "I don't know what happened. I am redoing her diet slip to send to the kitchen with her preference for no pork."

On 08/29/2019 at approximately 12:15 p.m., the district food manager was handing out lunch trays on Resident #37's hallway. She was asked what she had found out about Resident #37 not receiving her requested/preferred food items. She stated, "I met with her today. She changes her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 806	Continued From page 22	F 806		

mind a lot and that's okay. I told her that we are going to meet with her everyday to see what she wants. I think she's happy with what she has today." The district food manager was asked why her preferences had not been honored before. She stated, "I don't know...I train, and train...I've still got some training to do."

Resident #37 was observed eating her lunch tray. She stated, "Thank you! This is them best meal I've had here...I have sloppy joe, macaroni and cheese, ice cream cake, green beans, and two cups of coffee. Thank you for your help."

The above information was discussed during an end of the day meeting on 08/29/2019 with the DON (director of nursing) and the administrator.

No further information was obtained prior to the exit conference on 08/29/2019.
2. Resident #152 was admitted to the facility on 8/17/19 with diagnoses that included fractured left ankle, right toe wound, bipolar disorder, hypothyroidism, anxiety, osteoporosis and mood disorder. The admission nursing assessment dated 8/17/19 assessed Resident #152 as cognitively intact.

On 8/27/19 at 3:48 p.m., Resident #152 was interviewed about quality of life and care in the facility. When asked about food, Resident #152 stated no one had asked her about food preferences and she had been served several disliked items since she had been admitted. Resident #152 stated she was routinely served eggs, white breads, pasta and meats. Resident #152 stated she did not like eggs and did not eat them when served. Resident #152 stated she preferred wheat bread and not white bread,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 806	Continued From page 23	F 806		

preferred extra vegetables and ate very little meat. When asked if any dietary staff had discussed her food preferences since her admission, Resident #142 stated, "No." Resident #152 stated her meal ticket stated she was on a regular diet with no likes and/or dislikes listed. Resident #152 stated she had a friend bring in her own cereals/grains to eat for breakfast because she was not going to eat eggs.

Resident #152's clinical record documented a diet order and communication slip dated 8/17/19 listing the resident was ordered a regular diet with thin liquids upon admission. The diet slip documented no preferences or special requests. The clinical record documented no assessment of the resident's likes and/or dislikes regarding food, snacks and/or drinks.

On 8/28/19 at 2:54 p.m., the registered dietitian (RD) was interviewed about any assessment of Resident #152's food preferences. The RD stated the dietary manager was responsible for assessing food preferences for residents.

On 8/28/19 at 3:00 p.m., the dietary manager was interviewed about Resident #152's food preferences. The dietary manager stated he was supposed to meet with new residents within 72 hours after admission to discuss food preferences. The dietary manager stated once preferences were assessed, they were entered into the meal ticket system and printed on each meal ticket for use during plating of food. Concerning Resident #152, the dietary manager stated, "I haven't gotten to her yet." The dietary manager stated he had several other new admissions to do ahead of Resident #152. The dietary manager stated sometimes nursing listed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 806	Continued From page 24 allergies and preferences on the meal order ticket. The dietary manager pulled Resident #152's diet ticket dated 8/17/19 and stated no preferences were listed. The dietary manager had no explanation why Resident #152 had been in the facility for over a week without an assessment for food preferences. When asked if he was behind on assessing food preferences, the dietary manager stated it was hard to get to all the "rehab" residents because they came in and left the facility quickly. This finding was reviewed with the administrator and director of nursing during a meeting on 8/28/19 at 5:00 p.m.	F 806		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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 from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		9/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 812	Continued From page 25 by: Based on observation, staff interview and facility document review, the facility staff failed to store and serve food in a sanitary manner. An opened package of refrigerated sandwich meat was stored and available for use beyond the discard date. Ten thawed packages sandwich meat, without designated expiration and/or discard dates, were stored in the refrigerator. Three packages of the turkey, identified during the survey with an undetermined storage status, were served during the lunch meal. The findings include: On 8/27/19 at 11:21 a.m., accompanied by the dietary manager, the main kitchen and food storage areas were inspected. Stored in the walk-in refrigerator was an opened package of ham sandwich meat with a discard date of 8/26/19. Five unopened packages of turkey sandwich meat were stored in a cardboard box. Another box was stored that contained five packages of salami sandwich meat. There were no dates of any type, including expiration or use by dates printed on the meat packages from the manufacturer. Printed labels on the ends of the boxes were partially torn with no expiration or use by dates visible. There were no handwritten dates indicating receipt, use by dates or expiration dates. On 8/27/19 at 11:25 a.m., the dietary manager was interviewed about the expired sandwich meat and the ten packages of sandwich meat with unknown storage status. The dietary manager stated the opened package of ham should have been discarded yesterday (8/26/19). The dietary manager stated the ten packages of	F 812	1. The facility staff is preparing and serving food in a sanitary manner. 2. The Executive Director will complete a quality review observation during meal delivery to ensure the food is prepared and served in a sanitary manner. Follow up based on findings. 3. The Dietary Manager will be educated by Regional Dietary Manger on preparing, storing and serving food in a sanitary manner. The Executive Director/RD or designee will complete quality reviews of the kitchen and dining rooms weekly for 8 weeks to validate that foods are being stored, prepared and served in a sanitary manner. 4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations. Quality monitoring schedule modified based on findings. 5. Date of Compliance: 9/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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 812	Continued From page 26 turkey/salami had been previously frozen and then thawed in the refrigerator. The dietary manager inspected the packages and boxes and stated he did not see a manufacturer's expiration date or date indicating when items were removed from freezer. On 8/27/19 at 2:30 p.m., the dietary manager was interviewed again about the ten meat packages with questionable storage status. The boxes were pulled from the refrigerator for further inspection. Three of the turkey packages were missing leaving five packages of salami and two packages of turkey. The dietary manager stated three packages of the turkey were served during lunch. The dietary manager stated he did not find an expiration date on any of the packages and he did not know the date the sandwich meat was removed from the freezer and thawed. The dietary manager stated there were codes printed on the packages from the manufacturer but he did not know what the codes were and they included no dates. The dietary manager stated normally kitchen staff labeled food with the date received, date removed from the freezer, date opened and the discard date. The dietary manager had no explanation of why three of the packages of turkey meat were served during lunch when the storage status of the meat was questionable. On 8/27/19 at 2:51 p.m., the facility's registered dietitian (RD) was interviewed about the out of date and undated meat items found in the walk-in refrigerator. The RD stated there was supposed to be a tracking system in the kitchen to ensure proper food storage. The RD stated there should have been a date on the meat products when they were removed from the freezer. The RD	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 812	Continued From page 27 stated the dietary manager was responsible for food receipt and storage. On 8/27/19 at 4:45 p.m., the dietary manager stated he called his food supplier about the sandwich meats with no dates. The dietary manager stated the printed label on the boxes had a 7/31/19 order date but he did not locate an expiration date. The dietary manager stated he knew the meat was pulled from the freezer on 8/16/19. When asked how he knew that, the dietary manager stated, "I just know." The dietary manager had no documentation of received dates, expiration dates or dates the meat was removed from the freezer to the refrigerator. On 8/28/19 at 12:00 p.m., the district food manager (other staff #4) was interviewed about the undated meat stored/used from the refrigerator. The district food manager stated the kitchen staff should date food when removed from the freezer for thawing. The district food manager was not sure when how long the meat had been thawed. The facility's policy titled Receiving (May 2014) documented, "It is the center policy that safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items...All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation...All food items will be stored in a manner that insures appropriate and timely utilization based on the principles of 'first in - first out'..." Concerning cold food storage this policy documented, "It is the center policy to insure all Time/Temperature Control for Safety (TCS), frozen and refrigerated food items, will be	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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 812	Continued From page 28 appropriately stored in accordance with guidelines of the USDA Food Code..." The U.S. Food Code 2017 on page 98 documents that ready-to-eat time/temperature control for safety foods shall be discarded if in a container or package that does not bear a date or day. Chart 4-C in the Food Code states opened containers of ready-to-eat time/temperature control for safety food items should be discarded within 7 days if opened or within 7 days after removed from freezer. (1) This finding was reviewed with the administrator and director of nursing during a meeting on 8/28/19 at 5:00 p.m. (1) Food Code 2017. U.S. Public Health Service. U.S. Food &Drug Administration. U.S. Department of Health and Human Services. College Park, MD. 2017.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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. §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:	F 880		9/17/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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	Continued From page 29 §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; §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: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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	Continued From page 30	F 880		

identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§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 observation, staff interview, facility document review and clinical record review, the facility staff failed to follow infection control practices during a dressing change for one of 23 residents in the survey sample (Resident #151).

The findings include:

Resident #151 was admitted to the facility on 8/17/19 with diagnoses that included osteomyelitis, cellulitis of lower limb, pneumonia, anxiety, hypokalemia, depression, osteoarthritis, hypertension, asthma and hyperlipidemia. The nursing admission assessment dated 8/17/19 assessed Resident #151 as cognitively intact.

Resident #151's clinical record documented the resident had surgical wounds on the top of her left knee and outer lower leg/ankle. The resident's clinical record documented a physician's order dated 8/20/19 for daily dressing changes to the left knee wound and ankle wound with wound cleanser, an ABD pad covered with an Ace wrap. A physician's order dated 8/20/19 documented daily dressing changes to the left outer ankle wound with cleanser, Xeroform

1. LPN #4 was educated by the DON on proper infection control practices regarding hand hygiene during dressing changes on 8/30/2019.

2. Residents have the potential to be affected. The DON/designee will conduct quality monitors to ensure hand hygiene is done properly and there are no infection control violations. Follow up based on findings.

3. The DON/SDC/designee will educate licensed nursing staff on proper infection control practices to include proper hand hygiene during dressing changes. DON/designee will conduct weekly quality review of dressing changes to ensure hand hygiene is being performed in accordance with proper infection control practices for 8 weeks.

4. The results of the quality monitoring will be reported to the quality assurance committee team monthly for review, analysis and further recommendations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	83 CROSSROADS LANE FISHERSVILLE, VA 22939

(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	Continued From page 31 dressing and an ABD pad covered with an Ace wrap. On 8/28/19 at 10:20 a.m., dressing changes to Resident #151's left knee wound and left outer leg/ankle wounds were observed performed by licensed practical nurse (LPN) #4. After collecting supplies, washing hands and putting on gloves, LPN #4 cut the soiled gauze dressings from Resident #151's left knee and left outer leg wounds. Without performing hand hygiene or changing gloves, LPN #4 sprayed wound cleanser onto new gauze pads, opened clean dressing packages and placed cleaned gauze pads onto the prepared tabletop pad. LPN #4 also opened the Xeroform dressing and placed it onto the clean field. LPN #4 then picked up the soiled gauze/dressings and discarded them into the waste bag, then removed the gloves, washed hands and put on a new pair of gloves. LPN #4 proceeded to cleanse the ankle, outer leg and knee wound with cleanser soaked gauze. Without performing hand hygiene or changing gloves, LPN #4 applied the Xeroform to the outer ankle wound, then ABD pads to the left ankle, left outer leg and left knee. LPN #4 then applied Ace wraps to the left leg/ankle, discarded supplies and washed her hands. On 8/28/19 at 10:45 a.m., LPN #4 was interviewed about not changing gloves and performing hand hygiene after removing the soiled dressings or prior to applying clean dressings. LPN #4 stated hand hygiene was supposed to be done between handling dirty dressings and prior to handling clean supplies. The facility's policy titled Dressing Change (effective 11/30/14) documented, "A clean	F 880	5. Date of Compliance: 9/17/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. BUILDING ______ B. WING ______	C 08/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTA NURSING & REHAB CENTER	**83 CROSSROADS LANE FISHERSVILLE, VA 22939**

(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	Continued From page 32 dressing will [be] applied by a nurse to a wound as ordered to promote healing..." Steps in the procedure included, "Place supplies on prepped work surface...Perform Hand Hygiene...Apply gloves...Remove and dispose of soiled dressing...Remove gloves...Perform hand hygiene...Apply gloves...Cleanse wound as ordered, dispose of gauze...Remove gloves and perform hand hygiene...Apply treatment as order and clean dressing...Discard gloves and perform hand hygiene..."(Sic) This finding was reviewed with the administrator and director of nursing during a meeting on 8/28/19 at 5:00 p.m.	F 880		