STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET PO BOX 1087 DUBLIN, VA 24084

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/12/20 through 2/14/20. Three complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 132 certified bed facility was 120 at the time of the survey. The survey sample consisted of 24 current Resident reviews and 2 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		3/20/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/12/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 578	Continued From page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the right to formulate an advanced directive as evidence by the advanced directive in the resident record not completed accurately for one of 26 residents, Resident #89. The findings: The facility staff failed to accurately complete Resident #89's Durable Do Not Resuscitate (DDNR) Order. Both Section 1 and Section 2 of the DDNR were left blank. Resident #89's clinical record was reviewed on 2/13/2020. The admission record listed the resident's diagnoses to include but not limited to, orthopedic aftercare following surgical amputation, type 2 diabetes mellitus, depressive episodes, prosthetic heart valve, cardiac	F 578	F578 Corrective Action(s): DDNR for Resident #89 was corrected on 2/14/2020. Other Potential: 100% review of Resident charts for DDNR was completed 2/14/2020 and corrections made where indicated. System Change: Education provided by Director of Nursing or Designee to licensed Nurses, Admissions and Medical Records on correct completion of DDNR form. Monitoring: 5 resident charts will be audited weekly x 6 weeks, then monthly x 3 months. Variances will be investigated and corrections made as appropriate.	

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F 578	Continued From page 2 pacemaker, peripheral vascular disease, and methicillin resistant staphylococcus aureaus. Section C of the resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/23/2020 included a BIMS (brief interview for mental status) summary score of 13 out of 15 points. Resident #89's clinical record contained a physician order for a "dnr" (do not resuscitate) dated 01/20/2020. The clinical record also included a scanned form; a Durable Do Not Resuscitate (DDNR) Order from Virginia Department of Health dated 01/17/2020. The DDNR had two sections (section 1 and section 2) that required a check beside which option was selected. Section 1 read, in part, "I further certify (must check 1 or 2)." The second section read, in part, "If you checked 2 above, check A, B, or C below:" Both sections 1 and 2 were left blank; no checks noted. Without a choice marked within Section 1, it would be impossible to determine whether Section 2 should have a choice marked. The facility's administrator was informed of the above concern on 02/13/2020 at approximately 5:30 p.m. On 02/14/2020 at 10:40 a.m., the facility administrator provided the surveyor with a printed copy of Resident #89's DDNR. The administrator acknowledged the form was not filled out properly. On 02/14/2020 at 1:37 p.m., the administrative team to include the administrator, regional clinical services director, the acting director of nursing, and the assistant director of nursing were informed of the DDNR concern.	F 578	Findings will be presented and monitored at QA meeting monthly x 3 months. Date of Compliance 3/20/2020	

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F 578	Continued From page 3 No further information was provided to the survey team prior to exit.	F 578		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview and during the course of a complaint investigation, the facility staff failed to review and	F 657	F657 Corrective Action: Resident #4s	3/23/20

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F 657	Continued From page 4 revise the comprehensive care plan for one of 26 residents in the survey sample as evidenced by failing to update and follow the plan of care for Resident # 4 following a fall. The findings included: The facility staff failed to update and follow the plan of care after Resident #4 had a fall which occurred on 12/20/2018. Resident #4 was admitted to the facility with the following diagnoses of, but not limited to high blood pressure, end stage renal disease, stroke, dementia, anxiety and depression. On the MDS (Minimum Data Sheet) that was completed before the resident fell on 12/20/2018, the resident was coded as being totally dependent on 2 staff members for transfers. Resident #4 was also coded as requiring extensive assistance of 2 staff members for toilet use and personal hygiene. The Office of Licensure and Certification received a complaint on 6/24/2019 in which the complainant questioned why the resident was being transferred by one CNA (certified nursing assistant) when the resident was in such a weakened state. The surveyor reviewed Resident #4's clinical record on 2/13/2020 through 2/14/2020. During this review the surveyor noted that the MDS that was documented on prior to the fall coded the resident as totally dependent on 2 or persons for transfers. The surveyor reviewed the nursing notes dated for 12/20/2018 and noted the following documentation: " ...12/20/2018 21:03 (9:03 PM) Resident admitted to _____ (name of hospital) ..." The comprehensive resident centered care plan	F 657	Comprehensive Care Plan has been reviewed and revised to reflect the residents current needs. Other Potential Residents: Director of Nursing and or designee will review all falls for the last three months to assure appropriate updates and interventions were reflected on the Care Plan. All residents will have an evaluation for criteria and care plan for safe resident handling and movement performed. Residents Plan of Care will be updated accordingly. System Change: Education provided by Director of Nursing or Designee to all licensed Nursing Staff on properly performing the assessment of "evaluation for criteria and care plan for safe resident handling and movement" and updating a Plan of Care. Falls will be reviewed daily and care plans revised accordingly. Falls will also be reviewed weekly in the Risk meeting and findings reviewed at monthly QA meeting. Monitoring: The QA Coordinator / designee will audit 3 records weekly x 6 weeks of residents who have experienced falls to ensure that the resident's plan of care had been revised to accurately reflect the care and assistance required by the resident. Variances will be investigated and corrective actions taken as appropriate. A summary of the weekly findings will be provided to the Administrator and an analysis of the weekly audits will be monitored through	

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F 657	Continued From page 5 was also reviewed at this time. Resident #4 was deemed as having risks of injury related to falls. The interventions were as follow: " ..."Assist _____ (name of resident) with transfers and mobility ... " Encourage as much independence with ADL (activities of daily living as to ____ (name of resident) abilities ... " Encourage the resident to participate to the fullest extent possible with each interaction ..." The surveyor notified the interim DON (director of nursing) of the above documented findings on 2/13/2020 at approximately 2 PM. The interim DON stated that this fall was investigated and the findings were that a CNA had transferred the resident from the bed to the wheelchair without further assistance of another staff member. The interim DON also stated, "During the investigation the resident was being assisted from the bed to the wheelchair by one CNA only. The CNA did not get a second person to assist her in this transfer." The interim DON reviewed the resident's care plan with the surveyor. The interim DON stated, "We have interventions in place for the resident being a high fall risk but I cannot find where the care plan states that the resident is a 2 person assist with transfers." The administrator and director of nursing was notified of the above documented findings on 2/14/2020 at approximately 11 am. No further information was provided to the surveyor prior to the exit conference on 2/14/2020.	F 657	the QAPI Committee. Date of Compliance 3/23/2020	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		3/23/20

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F 689	Continued From page 6 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, facility document review and during the course of a complaint investigation, the facility staff failed to ensure that two of 26 residents in the survey sample received adequate supervision and assisted devices to prevent accidents. (Resident #4, and Resident #10) The findings included: 1. Resident #4 was transferred from the bed to the wheelchair by one CNA which resulted in the resident falling and received fractures of both legs from this incident on 12/20/2018. Resident #4 was admitted to the facility with the following diagnoses of, but not limited to high blood pressure, end stage renal disease, stroke, dementia, anxiety and depression. On the MDS (Minimum Data Sheet) that was completed before the resident fell on 12/20/2018, the resident was coded as being totally dependent on 2 staff members for transfers. Resident #4 was also coded as requiring extensive assistance of 2 staff members for toilet use and personal hygiene. A complaint was received in the Office of Licensure and Certification on 6/24/2019 in which	F 689	F689 Corrective Action: Resident #4s Plan of Care was reviewed for accuracy, no changes indicated. Ensured staff can easily identify residents transfer status. Resident #10 had a new Hot Liquid Assessment completed and Plan of Care reviewed with no changes indicated. Resident #10 burns have healed; her plan of care was updated to minimize recurrence and the resident has had no further incidents with hot liquids. Other Potential Residents: Audit to be completed for current residents to ensure all Morse fall risk assessments are completed; that red dots are accurately placed on door frames for residents at risk and that the care plan accurately reflects the amount of assistance needed by the residents. Audit of current residents will be completed to ensure that hot liquid assessments have been completed and that risks and interventions to minimize injury from spillage is addressed in the resident's plan of care.	

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F 689	Continued From page 7 the complainant questioned why this resident was being transferred by one CNA when the resident was in such a weakened state. During the course of a complaint investigation, the surveyor reviewed the clinical record of Resident #4 on 2/13 and 2/14/2020. On 12/20/2018 at 21:03 (9:03 PM) the following was documented in the nurses notes' which read, " ...Resident admitted to _____ (name of hospital) ..." The surveyor reviewed the comprehensive care plan and noted the following interventions: " ..."Assist _____ (name of resident) with transfers and mobility ... " Red dot fall system: red dot on door to identify resident as a fall risk to staff ... " Assist resident w/ADLs (with activities of daily living) as needed (CNA) (certified nursing assistant) ... " Encourage the resident to participate to the fullest extent possible with each interaction ..." The surveyor interviewed the interim DON (director of nursing) on 2/13/2020 at 2 PM in the conference room. The surveyor asked the interim DON what the findings were from investigation of Resident #4's fall on 12/20/2018. The interim DON stated "Let me go pull that investigation on this fall. I wasn't the DON at the time this occurred." The interim DON returned to the conference room with the investigation tool that the facility used to investigate this fall. On this tool, the surveyor noted the following documentation: " " ...Resident should have been a 2-person transfer-but was being transferred by one CNA ... " Traumatic injury from fall..." " Admission Diagnoses to the hospital was "	F 689	System Change: The number of staff required to assist the resident will be included in the resident's plan of care and linked to Point of Care for easy access by staff. Licensed nurses and CNAs to be in-serviced on use of the red dot system, review of the care plan and Point of Care and on transfers. Licensed nurses will be in-serviced on how to properly complete transfer assessment. Coffee pots removed from all nursing units. They will be stored only in the kitchen. The kitchen will temp all coffee prior to it leaving the kitchen and the temp will not exceed policy. Kitchen staff have been educated on taking hot liquid temperatures and a temperature log will be maintained for each meal. Monitoring: The QA Coordinator or designee will conduct 6 observations weekly x 6 weeks and monthly x 3 months of residents being transferred. This audit will include review of the resident's care plan for assistance, visualization of the red dot system, and safe transfer by the staff. Variances will be investigated and corrective action taken as appropriate. Findings of the weekly observations will be given to the DON or designee for analysis and analysis of the findings will be provided to the QAPI Committee for additional guidance. The QA Coordinator or designee will review the kitchen hot liquid temperature log 3x/week x 6 weeks and will observe 6 meal observations per week x 6 weeks and then monthly x 3 months for appropriate temperature of hot beverages	

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F 689	Continued From page 8 ...Bilateral Distal femur Prosthetic fractures r/t (related to) fall ... The surveyor could not interview the CNA that transferred Resident #4 because she was no longer working at the facility. The interim DON also stated "We started a QAPI plan on this fall." The surveyor requested to review this plan. The interim DON provided the surveyor with a copy of this plan on 2/14/2020 at 1 PM. The surveyor noted the following documentation on this quality improvement plan which was dated for 1/4/2019: " ..."Resident had a fall on 12/20/2018 while being transferred from the bed to the wheelchair resulting in bilateral femur fractures ...One CNA was transferring the resident at the time of the fall. Resident was assessed as a high fall risk but did not have a red dot on the door to signify ..." The surveyor requested copies of any education and evidence to show that this plan was completed. The interim DON stated, "This is all I have. I have only been in this position for 2 days and I cannot find what you are asking for." The surveyor notified the administrator, interim DON, ADON (assistant director of nursing) and the regional nurse consultant on 2/14/2020 at 2 PM. The administrative team was provided time to give any further information to the survey team prior to the exit conference. The administrator stated, "We don't have any further information to provide." 2. The facility staff failed to follow the comprehensive plan of care for Resident # 10, which resulted in Resident # 10 spilling coffee and sustaining second-degree burns to inner thighs. This is harm.	F 689	and that interventions care planned to minimize injury from spillage of hot liquids are carried out. Variances will be immediately investigated and corrected as appropriate. Findings from the weekly observations will be provided to the Administrator weekly and an analysis of the findings will be provided to the QAPI Committee for additional oversight. Date of Compliance 3/23/2020	

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F 689	Continued From page 9 Resident # 10 had diagnoses that included but were not limited to dementia, Alzheimer's disease, and Parkinson's disease. The most recent MDS (minimum data set) assessment for Resident # 10 was a significant change assessment with an ARD (assessment reference date) of 11/21/19. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 10 had a BIMS (brief interview for mental status) score of 04 out of 15, which indicated that Resident # 10's cognitive status was severely impaired. Section G of the MDS assesses functional status. In Section G0110, the facility staff documented that Resident # 10 required set up assistance and supervision with eating. The comprehensive plan of care for Resident # 10 was reviewed and revised on 2/10/20. The facility staff documented a focus area for Resident # 10 as, "Resident # 10 is at risk for injury/burns due to spilling hot liquids related to dementia/cognitive loss, Parkinson's disease." Interventions included but were not limited to, "Serve hot beverages in mug with sip lid," and "Provide supervision with meals." Resident # 10 had orders that included but were not limited to, "Santyl Ointment 259 unit/GM (gram) Apply to right medial thigh topically every day shift for wound healing Irrigate area with wound cleanse or sterile water, do not scrub, or wipe area, pat dry, apply thin layer of Santyl to yellow/necrotic tissue only, Apply Gentamicin oint (ointment) to pink/granulation tissue and surrounding skin, and wrap with roll gauze and apply to right medial thigh topically as needed for soiled or dislodged dressing," which was initiated	F 689		

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F 689	Continued From page 10 by the physician on 1/17/20. Resident # 10 also had orders for Santyl Ointment 259 unit/GM (gram) Apply to left medial thigh topically every day shift for wound healing Irrigate area with wound cleanse or sterile water, do not scrub, or wipe area, pat dry, apply thin layer of Santyl to yellow/necrotic tissue only, Apply Gentamicin oint to pink/granulation tissue and surrounding skin," which was initiated by the physician on 1/17/20. On 2/13/20 at 1:45 pm, the surveyor observed a nurse's note in Resident # 10's clinical record that has been documented on 1/7/2020 at 5:20 pm. The nurse's note was documented as, "While in dining room resident poured half a cup of hot coffee into her lap due to shaking in hands. Rsd (resident) has blistering bilaterally on inner thighs, she also has redness on her right breast. Sent to (Hospital name withheld) ER (emergency room) with appropriate transfer documentation in place, Rp (responsible party) notified." The surveyor observed a progress note from the facility nurse practitioner that reflected the date of service was 1/8/2020. The nurse practitioner's progress note contained documentation that included but was not limited to, ..."History of Present Illness: Pt (patient) is seen today after reportedly spilling a cup of hot coffee on her lap yesterday at dinner. Staff report that skin to inner thighs started to blister almost immediately. Verbal orders were given to send pt to ER for evaluation. Dx (diagnosis) with second degree burns and discharged back to the facility with new orders for Neomycin ointment. Pt does not endorse pain today, states, "I have been through it." Pt is a very poor historian at baseline 2/2 (secondary to) advanced dementia. Currently has no	F 689		

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F 689	Continued From page 11 medications ordered for pain." ... The surveyor reviewed the clinical record for Resident # 10 and observed that the most recent "Hot Liquid/Risk Assessment" prior to the incident on 1/7/20 had been conducted on 4/10/19. The Hot Liquid/Risk Assessment for Resident # 10 contained documentation that included but was not limited to, ..."A. Decision Making/Behavior 1. Resident has moderate/severe cognitive loss a. Yes B. Functionality/Sensation/Vision 1. Resident has tremors in upper extremities that create risk for spillage a. Yes 3 Resident has weakness in upper extremities that create risk for spillage a. Yes 8. Resident requires supervision for eating a. Yes" ... The facility policy for "Hot Liquid Assessment" contained documentation that included but was not limited to, ..."Specific Procedures/Requirements: 1) On admission/readmission, quarterly and with significant change, the resident will be assessed for risk of use of hot liquids [i.e. beverages, soups, etc.] by a licensed nurse or therapist. 2) If the resident is determined to be at risk of spillage and/or injury from hot liquids, the interdisciplinary team will make recommendations to minimize the resident's risk. Recommendation to the physician for referral to therapy for screening/and or evaluation for improved skills or assessment of appropriate equipment/devices to promote resident safety will be made as appropriate." ...	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	02/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 12 On 2/13/20 at 3:30 pm, the surveyor spoke with the acting director of nursing and the administrator. The surveyor asked the acting director of nursing for any investigative information the facility had regarding Resident # 10 spilling coffee on 1/7/2020. On 2/13/20 at 4:02 PM, the acting director of nursing provided the surveyor with a copy of the facility investigation and a copy of a "Record of Verbal Warning" form for a CNA (certified nursing assistant). The record of verbal warning contained documentation that included but was not limited to, ..."Description of Education Provided: Be careful when administering hot liquids to residents. Place several ice cubes in liquid to ensure safe temperature. Ensure lid is in place. Monitor residents for safety while consuming hot liquids." ... The acting director of nursing stated, "The CNA did not follow the plan of care in this situation, and was counseled." Along with the facility investigation, the acting director of nursing provided a "QAPI (quality assurance performance improvement) ACTION PLAN." The QAPI action plan contained documentation that included but was not limited to, ..."Correction: 3. Staff education on hot liquid policy."... The acting director of nursing presented the surveyor two in-service logs dated 1/8/2020 with a subject "Hot Liquid Safety." The surveyor observed that the one in-service log contained 12	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 13 CNA signatures, and the other in-service log contained 11 CNA signatures. The surveyor asked the acting director of nursing if CNAs were the only staff members that supervised or assisted residents with meals. The acting director of nursing stated, "No, our nurses assist with feeding as well." The surveyor explained that the QAPI plan did not have sufficient evidence that reflected that the necessary staff had been educated. The acting director of nursing voiced understanding in the presence of the administrator and the survey team. On 2/14/20 at 1:10 PM, the surveyor interviewed CNA # 1 via telephone. The surveyor asked CNA # 1 if he/she was responsible for providing care to Resident # 10 on 1/7/20. CNA # 1 stated that he/she had been responsible for providing care to Resident # 10 on 1/7/20. CNA # 1 stated that Resident # 10 had requested more coffee. CNA # 1 stated that he/she had poured a half cup of coffee and added milk to the coffee for Resident # 10. CNA # 1 stated that when he/she turned around, Resident # 10 grabbed the cup of coffee and the coffee spilled on Resident # 10. The surveyor asked CNA # 1 if the coffee cup that had been prepared for Resident # 10 had a lid on it. CNA # 1 stated, "No it did not." On 2/14/20 at 1:40 PM, the administrator, acting director of nursing, assistant director of nursing, and regional director of clinical services were made aware of the findings as stated above. No further information regarding these issues was presented to the survey team prior to the exit conference on 2/14/20.	F 689		