STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(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 3/9/21 through 3/12/21. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	Wayland Nursing and Rehabilitation center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and provisions of quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Wayland Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Wayland Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
E 037 SS=D	EP Training Program CFR(s): 483.73(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles	E 037	F 037 • New Hires since June 2020 will receive training on Emergency preparedness by 3/29/21, the training will be completed by the Staff Development Coordinator. • New hires have been identified and will receive training by 3/29/21 by the Staff Development Coordinator. • The SDC will in-service all new hires from June 2020 on the Emergency Preparedness Plan as outlined in the Emergency Preparedness policy and procedure manual. All new hires will receive in-service training on Emergency Preparedness upon hire and annually thereafter.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/29/21

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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E 037	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:	E 037	Continued from page 1 • Facility Administrator will review the new hire orientation process weekly x 4 weeks to assure EP training is performed & documented appropriately per the orientation checklist as outlined by the EP policy and procedure manual. • All orientation new hire checklists will be reviewed in monthly QAPI meetings x 1 month.	04/12/21

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E 037	Continued From page 2 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 3 policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to have a complete emergency preparedness plan. The facility staff failed to provide documented evuidence that 20 new facility hires since June 2020, have received annual emergency preparedness training.	E 037		

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E 037	Continued From page 4 The findings include: On 3/11/21 at 11:50 a.m., a review of the facility's emergency preparedness plan was conducted. This review of the facility's emergency preparedness plan failed to evidence documentation that the 20 new facility hires since June 2020, have received initial emergency preparedness training. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #1 stated that the staff development coordinator is responsible for new hire training in emergency preparedness. He stated the staff development coordinator has been out on extended leave, and he could not verify that any new hires had been trained in emergency preparedness since she left. ASM #1 stated, "We can't see that it has been done since June of 2020." No further information was provided prior to exit.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/9/21 through 3/12/21. 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 90 certified bed facility was 50 at the time of the survey. The survey sample	F 000		

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F 000	Continued From page 5 consisted of 35 Resident reviews.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review it was determined that the facility failed to protect one of 35 residents in the survey sample from resident-to-resident abuse. On 2/28/21, Resident #37 and Resident #4 argued in their room which escalated to Resident #37 pushing his wheelchair into Resident #4's table causing a laceration to Resident #4's right lower leg that required treatment in a local emergency room and closure with 9 staples, resulting in harm. The findings include: Resident #4 was admitted to the facility with diagnoses including but not limited to chronic	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 6 obstructive pulmonary disease (1), congestive heart failure (2) and major depressive disorder (3). Resident #4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/1/21 coded Resident #4 as scoring a 15 on the BIMS (brief interview for mental status), 15- being cognitively intact for making daily decisions. On 3/9/21 at approximately 3:10 p.m., an interview was conducted with Resident #4. Resident #4 was observed to have a gauze wrap dressing dated 3/9/21 on his right lower leg. When asked about the dressing on his right lower leg, Resident #4 stated that he was assaulted by their previous roommate, Resident #37 and had to go to the emergency room to get staples in his leg to close an injury. Resident #4 stated that Resident #37 was no longer in the facility because "they got rid of him after that happened." Resident #4 stated that he had argued with Resident #37 over the television and that Resident #37 pushed his empty wheelchair through the privacy curtain into him causing the over bed table to cut his right lower leg. Resident #4 stated that the nurse had to apply pressure to the area and he had to go to the emergency room to get staples to the area. The progress notes for Resident #4 documented in part the following: - "2/17/2021 10:26 (10:26 a.m.) Note Text: Writer met with resident and advised that he would be getting a roommate today." - "2/28/2021 16:25 (4:25 p.m.) Note Text: resident had been arguing with his roommate over the TV, his room mate was yelling & they were calling	F 600		

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F 600	Continued From page 7 each other names, resident states he cannot stand the way his room mate talks to him & the way he "[curse] on himself". Writer explained to resident that he can not help being incontinent (without control of) however, he should not yell at his roommate & curse at him. They should try to compromise with what to watch on the TV." - "2/28/2021 16:40 (4:40 p.m.) Note Text: called to room Resident noted to be bleeding from a 8.5 cm (centimeter) laceration on the right lateral lower leg. Resident holding tissues on wound, large puddle of blood noted on the floor & in trash can. Resident had his leg propped on the trash can, blood dripping into it. Resident stated that his roommate pushed the w/c (wheelchair) on the other side of the curtain into his overbed table, which hit his leg. Roommates w/c [wheelchair] removed from the room, pressure applied to wound for several minutes to slow bleeding, wrapped with gauze. Explained to resident that he needed to go to the ER (emergency room) due to excessive bleeding, & for a tetanus shot. Resident still arguing, cursing & threatening with the room mate intermittently, yelling that he wanted to have "the cops called on that piece of [curse]" because "he assaulted me" Administrator made aware & stated that resident needed to go to a room on C-wing upon return from ER & he would straighten it out in the morning with both residents." - "2/28/2021 17:01 (5:01 p.m.) Note Text: Resident sustained right lower extremity trauma (8.5 cm laceration) by contact with wheelchair. RN [registered nurse] supervisor applied pressure dressing. Received verbal order from [name of nurse practitioner] to send resident to ER. Report called. Bed hold policy sent with resident.	F 600		

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F 600	Continued From page 8 Resident is own RR [responsible representative]." - "2/28/2021 20:40 (8:40 a.m.) Note Text: Returned to facility after receiving 9 staples and new orders for Keflex (antibiotic) 500 mg (milligrams) q (every) 12 hours x 10 days. Resident is own RR and is aware." - "3/1/2021 13:02 (1:02 p.m.) Note Text: Resident stated that he wanted to file assault charges against roommate for injuring him causing 9 staples in lower leg. This writer notified [County Name] Sheriff Dept. Spoke with investigator several times. Also notified [Name of ombudsman] LTC (long term care) Ombudsman and [Name of staff] with APS (adult protective services). Awaiting return call from investigator with [County Name]." - "3/1/2021 17:31 (5:31 p.m.) Note Text: Investigator and deputy in to speak with resident." The "ED (emergency department) Note Physician" for Resident #4 from [Name of Hospital] dated 2/28/2021, documented in part, "...Chief complaint from [Name of facility] - verbal argument with roommate; knocked wheelchairs into each other; laceration to right lower leg; dressing on with controlled bleeding...This is a [age and sex of Resident #4] that presents to the emergency department with a laceration to the right lower extremity. He was cut to the lower leg with a metal part of the wheelchair. The wound was thoroughly irrigated, cleansed with Betadine, and closed with staple gun. Patient will be placed on oral antibiotics. His tetanus shot was updated. Patient will be discharged back to the facility..." Resident #37 was admitted to the facility with	F 600		

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F 600	Continued From page 9	F 600		

diagnoses including but not limited to Parkinson's disease (4), major depressive disorder and anxiety disorder (5). Resident #37's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/8/21 coded Resident #37 as scoring a 15 on the BIMS (brief interview for mental status), 15- being cognitively intact for making daily decisions. Section E documented Resident #37 failed to evidence documentation of any behavioral symptoms during the observation period.

Resident #37 no longer resided at the facility and could not be observed during the survey dates. The record was reviewed as a closed record.

The comprehensive care plan for Resident #37 dated 12/28/2020 documented in part, "Problematic manner in which resident acts characterized by ineffective coping; verbal/ physical Aggression or Agitated, Combativeness related to: Anger, cursing, yelling at staff, threatening to hurt staff. Date Initiated: 12/22/2020, Created on: 12/22/2020, Revision on: 03/08/2021." The care plan further documented, "Negative feelings regarding self and social relationships characterized by; low self esteem, anxiety, mistrust, conflict/anger, ineffective coping related to: displays of inappropriate social behavior exposing self to staff, inappropriate communication with staff through letters & email. Date Initiated: 01/04/2021, Created on: 01/04/2021, Revision on 03/08/2021."

The progress notes for Resident #37 documented in part the following:

- "12/20/2020 14:52 (2:52 p.m.) Note Text: CNA

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F 600	Continued From page 10 (certified nursing assistant) came to writer and stated that resident was cursing her. She stated that she set up a bed bath, she asked [Resident #37] to go ahead and get started washing his face to his waist. She then informed him that she will be right back because she had 2 call lights going off. About 10 mins (minutes) had passed and he put his call light on. When she went in the room and apologized for taking longer to het [sic] back to him he started cursing at her. She said he threatened to "Kick my [curse words]". Then he stated he hopes that she become paralyzed. He also threatened to call the state and he has done it before. He also stated that he would refuse to feed himself so that CNAs would have to feed him because he pays good money to be here and he want his moneys worth. Housekeeper and another CNA heard him cursing and yelling." - "12/21/2020 08:37 (8:37 a.m.) Note Text: This writer and Clinical Care Coordinator went in to speak with resident. Staff reported that resident this weekend was cursing them, calling staff MF and F you. Also threatening staff. This writer and Clinical Care Coordinator explained to resident this behavior was unacceptable and if continued we would have to discharge. Explained that there are other ways of communicating with staff other than threatening and cursing staff. Resident replied, "I will call state and report yall for abuse. I know how it works. Stated I will just walk to the door and fall and sue yall." Resident stated that he would also call the LTC (long-term care) Ombudsman. This writer provided resident with the cell number to [Name of Ombudsman] LTC Ombudsman. Resident got out of bed and pushed bedside table toward door as walking." - "12/21/2020 08:57 (8:57 a.m.) Note Text: After	F 600		

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F 600	Continued From page 11 speaking with social worker and clinical care coordinator resident became angry and got up out of the bed pushed his bedside table into the hallway. Very unsteady gate." - "12/23/2020 12:06 (12:06 p.m.) Note Text: This writer and AR in to speak with resident regarding DSS (Department of Social Services) stating that his insurance will not cover his LTC (long term care) stay. Resident stated that he would call his father. Resident's sister called and stated that resident can not return to live with her or the father. Stated that the property manager also stated that he is not allowed on property. Sister stated something to do with indecent exposure." - "12/23/2020 13:21 (1:21 p.m.) Note Text: Was given note from CNA [Name of CNA] that resident gave her. Note entails resident's personal phone number and email note reads I missed you, signed by resident. CNA states resident asked her why she didn't call him, CNA responded to resident stating that would be inappropriate and was illegal. Resident wasn't happy with her comment. No further gestures at this time, CNA was informed that 2 staff members should be present when caring for resident." - "12/23/2020 14:19 (2:19 p.m.) Note Text: Received call from LTC Ombudsman regarding that she received a voicemail from resident stating that he is not allowed to have friends here. Explained to [Name of Ombudsman] (LTC Ombudsman) that resident was sending note to a CNA with his personal information on it such as email address, cell phone number and that CNA advised Clinical Care Coordinator. CNA stated to resident that this action was not acceptable."	F 600		

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F 600	Continued From page 12 - 12/30/2020 10:31 (10:31 a.m.) Note Text: Received fax from Harrisonburg DSS [department of social services] for resident to apply for Medicaid. Resident stated that the bank account and vehicle are in both his name and wife's name. This writer called [Name of staff] at Harrisonburg DSS at [Phone number] and left message to inquire how to obtain this information since the wife has a protective order against resident." - "12/30/2020 12:18 (12:18 p.m.) Note Text: CNA asked this writer to speak with resident because resident wanted CNA to wash him. Resident is capable of washing himself. Resident writes notes and texts on his cell phone. CNA stated that resident makes a effort to expose himself to them. Resident also will put his hands behind his head while they are giving care. This writer spoke with resident and advised that he is capable of washing himself. When this writer left room resident was starting to bathe himself." - "12/31/2020 09:54 (9:54 a.m.) Note Text: heard resident yelling at CNA. entered room, resident trying to make CNA leave room before she had finished cleaning him from a BM. he was talking about some shirts that had went to laundry and had not came back yet. told CNA to "go buy me some more shirts." explained to resident that we would see about his shirts being found. he went on to say that therapy was not helping him, and that he would find somewhere else to go. this nurse explained that he could do some things for himself, that we were here to help him do what he was unable to do, he stated he was not going to wear a gown, resident has issues with exposing himself and attempting to have staff provide care	F 600		

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F 600	Continued From page 13 In genital area when he is capable of doing this himself. When staff is entering room, resident will place both hands behind his head. Resident stated that we get paid to wait on him. Resident stated that he is going to stay naked, that would get somebody's attention. Stating that he has not been able to see his psychiatrist, states he is going to call the advocate. Was very rude and disrespectful with CNA and this nurse. Notified Social Worker of same." - "12/31/2020 10:54 (10:54 a.m.) Note Text: Resident no longer on precautions so will be moved to [Room number on C hall]. Resident is aware and is own RR (resident representative)." - "1/12/2021 16:50 (4:50 p.m.) Note Text: CNA came to get this writer to listen to resident yell. CNA and this writer were at resident's door. Resident found on floor laying on right side. CNA stated that resident continues to make statements about throwing himself on the floor when he is mad. This writer called [Name of Physician] who gave verbal order to sent to ER (emergency room) for eval (evaluation) of fall and psych (psychiatric) eval. 911 called. This writer also spoke with LTC Ombudsman regarding resident. LTC Ombudsman stated that resident calls several times on multiple occasion." - "1/13/2021 07:05 (7:05 a.m.) Note Text: resident returned from ER at this time. No new orders received." - "1/13/2021 10:41 (10:41 a.m.) Note Text: Law enforcement officer in to serve protective order on resident from his wife." - "1/13/2021 14:57 (2:57 p.m.) Note Text: This	F 600		

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F 600	Continued From page 14 writer and DON (director of nursing) in to talk with resident. This writer advised resident that his behaviors were unacceptable. Explained to resident that as of now he also has no payer source, that his Medicaid has not been approved for LTC (long-term care). Advised that this writer has sent his information to several facilities due to resident wanted to transfer but because of his behavior, the other facilities refused to take resident due to his behaviors." - "1/20/2021 07:55 (7:55 a.m.) Note Text: CNA reported that when she went to pick up resident's dinner tray, he had thrown it in the floor." - "1/23/2021 14:14 (2:14 p.m.) Note Text: resident rang call bell for tray to be picked up. told him that CNA would be picking all trays up in a few minutes. Because she did not go in room right away he got angry and threw tray and urinal full of urine in floor in room. Told resident that was uncalled for. He stated he has a mental problem and he demands service right now. Stated that is what we are getting paid for. Stated he would call social services. Mad because he cannot go to bank and dmv. Explained to him that there was nothing that myself or CNA could do about that but that he did not have to act in the manner that he did." - "1/27/2021 11:05 (11:05 a.m.) Note Text: CNA in to see this writer. Resident throwing tray in floor for CNA to clean up. Resident continues to have behavior issues. This writer received message to call [Name of Deputy] at sheriff's office due to resident needs to be served papers." - "1/27/2021 15:11 (3:11 p.m.) Note Text: LPN (licensed practical nurse) requested this writer to	F 600		

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F 600	Continued From page 15 come in to resident room as he had a conversation with him to address appropriate ways to address complaints. per staff on unit resident has been threatening to throw himself on the floor because the staff are not coming in rt (right) when he wants them to. This writer observed meal tray and trash all over the floor as the resident had thrown it. Resident was advised that as we have responsiblities toward him he also has responsibilities as a resident to behave appropriately. resident verbalized understanding." - "1/29/2021 15:30 (3:30 p.m.) Note Text: Resident stated to staff that she did not want to change him. CNA had been in residents room most of day. CNA stated that she has changed him 6 time. Resident had soiled his brief and as soon as he did, he removed brief and threw soiled brief in floor. CNA stated that she was giving care to another resident at the time he soiled brief but resident did not give CNA time to get to his room. CNA on next shift was making rounds with CNA from 1st shift, resident started cursing 2nd shift CNA for no reason as she had just came in room to do reporting rounds." - "2/9/2021 10:14 (10:14 a.m.) Note Text: Resident removed feces from brief and threw in the trash can. Resident made aware that CNA was coming to give care as soon as possible but resident removed feces and threw in trash can." - "2/9/2021 10:14 (10:14 a.m.) Note Text: writer walking down hall heard resident yelling at CNA that he wanted her to give him a bath, writer went into room to inquire on what was going on, resident stated he needed an arbitrator, writer asked again what the problem was, he stated he wanted to file suit to make sure he received	F 600		

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F 600	Continued From page 16 proper hygiene every day that the CNA's bathed him. writer informed resident that she would have can set up his bath water, that he was more than capable of bathing himself. He stated "I didn't say I couldn't". Then he stated that he needed to be changed, CNA was in room to change him when he started yelling at her about the bath. Resident assured that the CNA would perform incontinent care on him and then set him up for bath." - "2/17/2021 10:25 (10:25 a.m.) Note Text: This writer met with resident to advise would be moving to [Room number] and will have a roommate. Resident not on precautions." - "2/23/2021 13:43 (1:43 p.m.) Note Text: Activity Director reported hearing resident call CNA racial slurs and cursing her. CNA stated that she was going to provide him care as soon as she put the tray on the cart. Resident continued to call CNA racial slur and curse her. This writer spoke with Administrator who went and advised resident that cursing and racial slurs would not be tolerated. Resident stated find me another facility. Administrator explained that we have attempted to but all facilities have declined due to resident's behavior." - "2/23/2021 14:11 (2:11 p.m.) Note Text: Staff stated that resident continues to call CNA racial slurs and curse. Administrator again went to speak with resident and advise that this is not acceptable behavior." - "2/28/2021 16:23 (4:23 p.m.) Note Text: resident arguing with his room mate over TV. Accused his roommate of being spoiled & babied by the staff. Stated he was going to "beat his [curse]" to his roommate Writer reminded resident that he was	F 600		

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F 600	Continued From page 17 not able to ambulate or transfer alone. Writer encouraged resident to try to work toward compromise with the TV & share what programs are watched, perhaps take turns. Also explained to him that the staff provide his room mate with time to smoke because it is the roommates right to smoke. It is also the roommates right to have the staff do shopping for him, resident was encouraged to let the activity department know if he wanted items purchased for him at the store on resident shopping day, explained he needed to have funds in his account & that they could find that out for him on Monday. Writer encouraged resident to try to speak nicely & politely to his room mate & to other resident's & staff. Reminded him that polite people do not throw things & yell at others during conversation. Resident stated that he wanted to leave writer explained that the social service department has been trying to find alternate placement for him however due to his behaviors other facilitates are not agreeing to having him transfer there." - "3/1/2021 10:00 (10:00 a.m.) Note Text: On 2/28/21 at approximately 1640 hours (4:40 p.m.) writer was called to resident's room. Resident's roommate [Resident #4] had sustained a 6.5cm (centimeter) laceration on his right lateral lower leg. The room mate [Resident #4] states that this resident [Resident #37] pushed the w/c (wheelchair) that was next to his bed (observed w/c on the left side of this resident's bed) into the privacy curtain pushing the overbed table into his leg. Roommate [Resident #4] yelling he was going to call the police; this resident [Resident #37] yelling "I didn't do anything, I'm calling my dad to pick me up before the cops come. I'm not going to jail". Resident [Resident #37] observed to be rolling onto his side reaching for the w/c	F 600		

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F 600	Continued From page 18 again. Writer removed w/c from the room & placed in the hallway & resident bed lowered to the floor for safety. Writer instructed resident to stop trying to roll out of the bed & to lay on his back & be still. No observable injury from altercation." - "3/1/2021 16:20 (4:20 p.m.) Note Text: staff called code green and stated resident was lying on the floor. Upon entering room resident was lying on his back perpendicular to the bed below the foot of the bed. Resident stated "THE POLICE DON'T BELIEVE I CAN'T WALK". Resident reports back pain. Resident was log Rolled and assessed. moving all extremities. resident was assisted back into bed by staff. Bed in low position. RN (registered nurse) returned to room with equipment to obtain vitals- resident had his legs thrown over the side of the bed and stated he was leaving. Assisted resident back in to bed. Resident has no where to go and is at risk to harm himself or others." - "3/1/2021 16:20 (4:20 p.m.) Note Text: MD [Name of medical doctor] was notified of incident. Resident to be sent to er [emergency room] for evaluation of back pain post fall and for mental health eval as there is concern for his safety. 911 was called for transport to er, report was called to [Name of Staff] at [Name of Hospital] er. Resident expressed to RN he was concerned about missing dinner as that happened the last time he went to the er. Resident then became more agitated and stated he was going to leave AMA (against medical advice) because we want to send him to jail. Resident is unable to get himself to the door and has no place to go. Explained to resident that we	F 600		

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F 600	Continued From page 19 are sending him to the er for concern for his safety. Rescue squad arrived and resident consented to go to the er..." - "3/1/2021 17:31 (5:31 p.m.) Note Text: Investigator and Deputy in to speak with resident [Resident #37] regarding incident of 2/28/21." - "3/2/2021 10:32 (10:32 a.m.) Note Text: Charlotte County Deputy in to serve resident [Resident #37] with assault charges on another resident [Resident #4]. Also was served a protective order against him taken out by his wife. Resident [Resident #37] after deputy left threw leg over side of bed. This writer in to speak with resident that stated he did not bother the other resident today. Explained that it was from the other day when he caused the other resident [Resident #4] to have to have 9 staples in leg." - "3/2/2021 11:34 (11:34 a.m.) Note Text: Received report from Housekeeping Supervisor and CNA that resident stated that he wanted to kill himself and get it over with. Writer asked resident if he had a plan. Received no response. Reported incident to ADON (assistant director of nursing). MD (medical doctor) made aware. Resident to be sent to ER." The psychiatric med management note dated 1/8/2021 for Resident #37 documented in part, "...Reports that he does get angry and yell at times but has not thrown anything recently. Reports he has in the past thrown things out of frustration...He can also be verbally aggressive. He has thrown his table in the past...Social history: Pt is married with children. Reports they are separated. Reports he does not get a long	F 600		

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well with his family. Reports his wife has a restraining order against him because, "I have anger issues and it upset her". Reports he did not hit her. Family does not visit..."

The psychiatric med management note dated 1/22/2021 for Resident #37 documented in part, "...Reports he did yell at staff last evening because his urinal was not close enough. He did not throw anything. He denies any recent sexual behaviors..."

The psychiatric med (medical) management note dated 2/5/2021 for Resident #37 documented in part, "...He was seen today for a f/u (follow up) for moderate intermittent depression, anxiety, sexual behaviors, and verbal abuse that have been ongoing since admission...He can also be verbally aggressive. He has thrown his table in the past. Staff report that they have set limits and behaviors have overall improved. per staff, his wife has a restraining order against him for assault. Family will also not take him back due to him exposing himself to family and children in the past...If unable to maintain safety, please send to the ED (emergency department) for evaluation. Discussed behaviors with pt (patient) who agrees there is better ways to handle his frustration and will attempt talking with staff. Maintain sexual precautions..."

On 3/10/2021 at approximately 2:00 p.m., an interview was conducted with OSM (other staff member) #5, social services. OSM #5 stated that each morning they had a meeting with the administrator and other members of the interdisciplinary team. OSM #5 stated that when a resident needed to be moved to another room they discussed the best placement and potential

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room mate for the resident in the meetings. OSM #5 stated that they talked about which residents they thought would have common interests and get along when assigning room mates. OSM #5 stated that Resident #37 was admitted to the C hallway in a private room and was on quarantine for the required amount of time. OSM #5 stated that after the quarantine period was over Resident #37 was moved into the room with Resident #4 on the A hallway for long term care where Resident #4 was already residing. OSM #5 stated that Resident #37 started displaying inappropriate behaviors a few days after they were admitted. OSM #5 stated that Resident #37 displayed verbally abusive behaviors to staff and exposed himself to female staff but they did not think that those behaviors would transfer to a resident. OSM #5 stated that they had hoped that Resident #37 and Resident #4 would get along because they were both cognitively intact and may have shared common interests. OSM #5 stated that they had sent out requests to other facilities at Resident #37's request for transfer but none would accept them due to his behaviors. OSM #5 stated that Resident #4 had a history of yelling at another resident and slamming doors. OSM #5 stated that when a resident to resident incident occurred the staff were to immediately intervene and separate the residents. When asked if Resident #37's behaviors were taken in to consideration when placing him in the room with Resident #4, OSM #5 stated that they thought that the residents would get along. OSM #5 stated that there were other empty beds on 2/17/21 and Resident #37 could possibly have been placed in a room by himself.

On 3/10/21 at approximately 2:34 p.m., an interview was conducted with RN (registered

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F 600	Continued From page 22 nurse) #1. RN #1 stated that on 2/28/21 she was asked to go to Resident #37 and Resident #4's room because a staff member could hear them arguing about the television from the hallway. RN #1 stated that when she entered the room the residents were not talking and the curtain was pulled between them. RN #1 stated that she told the residents that they had been arguing about the television and then they began arguing again. RN #1 stated that they talked about compromise on TV shows and both residents seemed to agree on the idea so she left the room to document the incident. RN #1 stated that she went to the nurses station and started documenting and was called back to the room by another staff member a few minutes later. RN #1 stated that when she entered the room Resident #4 had their leg over the trashcan and was bleeding. RN #1 stated that when she entered the room the second time Resident #37 and Resident #4 were arguing again. RN #1 stated that Resident #37 was lying in bed smiling and watching TV. RN #1 stated that staff had reported to them that both Resident #37 and Resident #4 had been bickering all day but had not shown any physical aggression. RN #1 stated that the incident occurred near the end of the day shift. RN #1 stated that the first thing she did was to maintain safety so she sent Resident #4 to ER and stayed in room until the ambulance arrived. RN #1 stated that if Resident #4 had not been sent to the ER, she would have separated the two residents at that time. When asked about the progress note dated 2/28/2021 at 4:23 p.m. which documented Resident #37 threatening to "beat his (Resident #4's) [curse]," immediately prior to the physical altercation, RN #1 stated that she had reminded Resident #37 that they could not get out of bed to "beat anyone's [curse]." RN #1 stated that in hindsight,	F 600		

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F 600	Continued From page 23 it was a threat to Resident #4 and she should have separated the residents when they were arguing. RN #1 stated that she did not think Resident #37 was physically capable of moving as well as he did or being able to cause the injury to Resident #4. RN #1 stated that she thought Resident #37 was angry and just talking as he frequently did and was not able to follow through on any physical violence. The facility daily census documented the following: - 43 empty beds in the facility, 13 empty beds on A hall and 20 empty beds on C hall on 2/15/2021. - 42 empty beds in the facility, 12 empty beds on A hall and 20 empty beds on C hall on 2/16/2021. - 41 empty beds in the facility, 9 empty beds on A hall and 24 empty beds on C hall on 2/17/2021. - 42 empty beds in the facility, 9 empty beds on A hall and 24 empty beds on C hall on 2/18/2021. - 40 empty beds in the facility, 8 empty beds on A hall and 24 empty beds on C hall on 2/19/2021. The FRI (facility reported incident) dated 3/1/2021 documented in part, "...Resident to resident altercation with injury, physician contact/intervention and/or transfer to hospital. Resident [Name of Resident #37] was involved with resident [Resident #4] regarding TV and Cable channels. [Resident #37] pushed wheelchair against bedside table causing injury to [Resident #4]. [Resident #4] was sent to ER where he was treated for a laceration. Residents were separated Physician notified and police, Commonwealth Attorney and ombudsman called." The five-day follow up report to the FRI dated 3/5/2021 documented in part, "... [Resident #4] was sent out to the E.R. for evaluation and treatment. Upon his return, he was placed in a	F 600		

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private room away from [Resident #37]. The Charlotte County Sheriffs department was notified and a complaint was filed by [Resident #4] against [Resident #37]. Papers were served on [Resident #37] for assault on 3/2/21...See attached POC..."

The attached plan of correction summary documented a detailed summary of the incident details describing the residents involved, a summary of actions taken by the facility to prevent a recurrence, the facility procedure for monitoring the plan of correction and the person responsible for implementing the plan of correction. The Final Compliance date documented was 3/2/2021.

On 3/10/21 at approximately 12:30 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for all documentation and investigation for the resident-to-resident incident on 2/28/21 for Resident #4 and Resident #37. ASM #2 stated that the facility had completed a FRI (facility reported incident) with investigation and had completed a plan of correction including education, interviews with residents, staff abuse testing, audits and the plan to monitor the plan of correction. ASM #2 stated that they would provide the evidence for review.

On 3/10/2021 at approximately 1:30 p.m., ASM #2, the director of nursing presented a binder, which documented the following:

- Interviews completed by the social worker of all cognitively intact residents in the facility on 3/2/21 regarding abuse.
- An audit of any resident-to-resident altercations

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F 600	Continued From page 25 for the past six months at the facility. No other incidents were identified. - Staff In-service sign in sheets. - Copies of envelopes with in-services on resident-to-resident abuse mailed to staff not currently working at the facility. - Resident to Resident abuse quizzes completed by staff. - Incident reports for each resident dated 2/28/2021. - An investigational summary completed by the Director of Nursing. - Witness statements. The binder further documented a Quality Assurance and Performance Improvement Plan dated 3/2/21 documenting the incident, interventions listed above and monitoring. It documented in part, "...10% of residents with a BIMS score of 13 or above will be interviewed by the facility Social Workers utilizing the Resident Abuse Audit Tool weekly x 4 weeks beginning on 3/3/21 to ensure that resident to resident altercations are being addressed appropriately. The Quality Assurance Nurse will complete interviews of five (5) staff members using the Abuse Quiz questionnaire weekly X 4 weeks to ensure all staff members are informed of the proper interventions for resident-to-resident altercations. The Administrator or Director of Nursing (DON) will review and initial Resident Interview Tool and Abuse Quiz questionnaires weekly x 4 weeks to ensure completion and all areas of concern were addressed appropriately. The administrator will forward the results of the Resident Interview Tool and the Abuse quiz questionnaires to the QAPI committee to determine trends and/or issues that may need further interventions put in place and to determine	F 600		

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F 600	Continued From page 26 the need for further and/or frequency of monitoring." The staff sign-in sheets for the resident-to-resident abuse inservice were reviewed and verified by multiple staff interviews. The other points of the plan of correction as described in this writing were verified with resident interviews and observations. No concerns were identified. The facility policy "Abuse, Neglect, or Misappropriation of Resident Property Policy" with a revision date of 3/10/2017 documented in part, "The facility believes that our residents have the right to be free from abuse, neglect, involuntary seclusion, exploitation, or misappropriation of property. The facility will do whatever is in its control to prevent mistreatment, neglect, exploitation, and abuse of our residents or misappropriation of their property...The facility will access [sic], care plan, and monitor residents with needs and behaviors that might lead to abuse, neglect, or misappropriation of property..." On 3/10/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the facility consultant were notified of the concern and findings of harm at past noncompliance. PAST NONCOMPLIANCE No further information was provided prior to exit. References: 1. Chronic obstructive pulmonary disease	F 600		

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F 600	Continued From page 27 (COPD)- Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 2. Congestive heart failure- a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html 3. Parkinson's disease- a type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 4. Anxiety -Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html#summary.	F 600		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623	F 623- • Resident #41 & #2 have been readmitted to facility. The Ombudsman was notified of resident #41 and #2 previous discharges on 3/12/21 by the Social Worker. • An audit of all transfers in the last 30 days have been reviewed by the Social Worker and any identified areas of concern have been corrected and the Ombudsman has been notified. The audit was completed on 3/24/21. • The Social Worker has been in-serviced on 3/24/21 by the Director of Nursing on the Virginia Bed-hold and Transfer policy. The SW will provide written notification to the Ombudsman of any facility transfer/discharge. Documentation will be entered into the clinical record by the SW of the bed-hold policy given to the resident or RR and the notification to the Ombudsman.	

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F 623	Continued From page 28 Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;	F 623	Continued from page 28 • Transfers and Discharges will be reviewed by the Nurse Managers Monday-Friday weekly x 4 weeks during the Cardinal IDT meeting using the Transfer/Discharge Audit tool. Any areas of concern identified will be given to the Social Worker for correction and notification to the Ombudsman. • The findings of the Transfer/ Discharge audit tool with be reviewed during the monthly QAPI meeting x 1 month.	04/12/21

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F 623	Continued From page 29 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure	F 623		

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F 623	Continued From page 30 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence notification to the ombudsman of a resident discharge from the facility for two of 35 residents in the survey sample, Residents #41 and #2. The facility staff failed to evidence written notification to the ombudsman for Resident #41's and Resident #2's transfer/discharge to a sister facility on 1/28/21. The findings include: 1. The failed to evidence ombudsman was not notified of Resident #41's transfer/discharge to a sister facility on 1/28/21. Resident #41 was admitted to the facility on 8/7/2020 with a recent readmission on 2/12/2021, with diagnoses that included but were not limited to: high blood pressure, stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1) and dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.) (2).	F 623		

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F 623	Continued From page 31 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/16/2021, coded the resident as scoring an "8" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for moving in the bed. The resident was coded as not moving in her room or unit during the lookback period. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. A review of Resident #41's census information sheet revealed that she was discharged from the facility on 1/28/21, and readmitted on 2/12/21. A review of Resident #41's clinical record revealed a progress note dated 2/12/21. The progress note stated the resident had been discharged to a sister facility due to a COVID-19 (3) diagnosis on 1/28/21, and was being readmitted on 2/12/21 to her home facility. Further review of Resident #41's clinical record failed to reveal evidence that the ombudsman was notified of Resident #41's discharge. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #3 was asked about the process staff follows when a resident is discharged from a facility - even if it is a transfer/discharge to a sister facility. ASM #3 stated the staff was	F 623		

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F 623	Continued From page 32 working to "expedite" getting residents out of the facility where they were and getting to the accepting facility as soon as possible. She stated there were many pieces of documentation and many phone calls involved in the discharge/transfer process. ASM #3 stated, "We made a packet of information, which should have included all of the regulatory paperwork." She stated, however, that the facility did not retain the paperwork packet. She also stated that the facility could not produce evidence that the ombudsman had been notified of the transfer/discharge. A review of the facility policy, "Discharge and Transfer," revealed, in part: "Discharge and/or transfer to other medical facilities will be effected only when medically appropriate as indicated by the attending physician...When a resident is transferred or discharged to a hospital or to a nursing home, a copy of an approved transfer and referral record and a copy of any additional medical information, as requested by the facility receiving the resident, will accompany him/her." No further information was provided prior to exit. REFERENCES (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (3) "Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the	F 623		

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F 623	Continued From page 33 outbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments. 2. The failed to evidence ombudsman was not notified of Resident #2's transfer/discharge to a sister facility on 1/28/21. Resident #2 was admitted to the facility 5/17/2015 and was recently readmitted on 2/23/2021 with diagnoses that included but were not limited to: dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.)(1), high blood pressure and schizophrenia (Any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response) (2). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/2021, coded Resident #2 as having no difficulty with short or long-term memory difficulties. The resident was coded as requiring extensive assistance of one staff member for moving in the bed. Resident #2 was coded as requiring limited assistance of one staff member for moving in their room or unit. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. A review of Resident #2's clinical record revealed	F 623		

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F 623	Continued From page 34 a progress note dated 2/23/21. The progress note stated the resident had been discharged to a sister facility due to a COVID-19 (3) diagnosis on 1/28/21, and was being readmitted on 2/23/21 to her home facility. Further review of Resident #2's clinical record failed to reveal evidence that the ombudsman was notified of Resident #2's transfer/ discharge on 1/28/21. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #3 was asked about the process staff follows when a resident is discharged from a facility - even if it is a transfer/discharge to a sister facility. ASM #3 stated the staff was working to "expedite" getting residents out of the facility where they were and getting to the accepting facility as soon as possible. She stated there were many pieces of documentation and many phone calls involved in the discharge/transfer process. ASM #3 stated, "We made a packet of information, which should have included all of the regulatory paperwork." She stated, however, that the facility did not retain the paperwork packet. She also stated that the facility could not produce evidence that the ombudsman had been notified of the transfer/discharge. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 623		

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F 623	Continued From page 35 (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. (3) "Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625	F 625- Resident #41 & #2 have been readmitted to facility. • An audit of transfers in the last 30 days have been reviewed by the Social Worker and any identified areas of concern have been corrected. The residents and Resident representatives have been notified in writing. • The Nurses will be in-serviced by the Director of Nursing on the Virginia Bed-hold and Transfer policy. The nurses will provide written notification of transfer/discharge to the resident and RR and documentation will be entered into the clinical record by the nurse of the bed-hold policy being given to the resident or RR upon transfer/discharge. • Transfers and Discharges will be reviewed Monday-Friday during the Cardinal IDT meeting using the Transfer/Discharge Audit tool, x 4 weeks any areas of concern identified will be given to the nurse for correction. • The findings of the Transfer/ Discharge audit tool with be reviewed during the monthly QAPI meeting x 1 month.	04/12/21

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F 625	Continued From page 36 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to evidence bed hold policy notification to the resident or the RR (resident representative) prior to or at the time of transfer/ discharge for two of 35 residents in the survey sample, Residents #41 and #2. The findings include: 1. Resident #41 was transferred/ discharged from the facility on 1/28/21. The facility staff failed to evidence that the resident or the RR (resident representative) was provided written notification of the bed hold policy prior to or at the time of transfer. Resident #41 was admitted to the facility on 8/7/2020 with a recent readmission on 2/12/2021, with diagnoses that included but were not limited to: high blood pressure, stroke (abnormal condition in which hemorrhage or blockage of the blood vessels of the brain leads to oxygen lack and resulting symptoms - sudden loss of ability to move a body part [as an arm or parts of the face], or to speak, paralysis weakness or if severe, death) (1) and dementia (a progressive state of	F 625		

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	495226	A. BUILDING _____ B. WING _____	03/12/2021

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F 625	Continued From page 37 mental decline, especially memory function and judgement, often accompanied by disorientation.) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/16/2021, coded the resident as scoring an "8" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one staff member for moving in the bed. The resident was coded as not moving in her room or unit during the lookback period. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. A review of Resident #41's census information sheet revealed that she was discharged from the facility on 1/28/21, and readmitted on 2/12/21. A review of Resident #41's clinical record revealed a progress note dated 2/12/21. The progress note stated the resident had been discharged to a sister facility due to a COVID-19 (3) diagnosis on 1/28/21, and was being readmitted on 2/12/21 to her home facility. Further review of Resident #41's clinical record failed to reveal evidence that the resident or the RR received any information about the facility's bed hold policy. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns.	F 625		

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F 625	Continued From page 38 ASM #3 was asked about the process staff follows when a resident is discharged from a facility - even if it is a transfer/discharge to a sister facility. ASM #3 stated the staff was working to "expedite" getting residents out of the facility where they were and getting to the accepting facility as soon as possible. She stated there were many pieces of documentation and many phone calls involved in the discharge/transfer process. ASM #3 stated, "We made a packet of information, which should have included all of the regulatory paperwork." She stated, however, that the facility did not retain the paperwork packet. ASM #1 stated, "We did bed holds for them," but could not evidence the resident or RR was informed of the bed hold policy. A review of the facility policy, "Discharge and Transfer," revealed, in part: "Discharge and/or transfer to other medical facilities will be effected only when medically appropriate as indicated by the attending physician...When a resident is transferred or discharged to a hospital or to a nursing home, a copy of an approved transfer and referral record and a copy of any additional medical information,, as requested by the facility receiving the resident, will accompany him/her." No further information was provided prior to exit. REFERENCES (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 114. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 625		

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F 625	Continued From page 39 (3) "Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments. 2. Resident #2 was transferred/ discharged from the facility on 1/28/21. The facility staff failed to evidence that the resident or the RR (resident representative) was provided written notification of the bed hold policy prior to or at the time of transfer. Resident #2 was admitted to the facility 5/17/2015 and was recently readmitted on 2/23/2021 with diagnoses that included but were not limited to: dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.)(1), high blood pressure and schizophrenia (Any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response) (2). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/2021, coded the resident as having no difficulty with short or long-term memory difficulties. The resident was coded as requiring extensive	F 625		

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F 625	Continued From page 40 assistance of one staff member for moving in the bed. Resident #2 required limited assistance of one staff member for moving in their room or unit. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. A review of Resident #2's clinical record revealed a progress note dated 2/23/21. The progress note stated the resident had been discharged to a sister facility due to a COVID-19 (3) diagnosis on 1/28/21, and was being readmitted on 2/23/21 to her home facility. Further review of Resident #2's clinical record failed to reveal evidence that the ombudsman was notified of Resident #2's discharge. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #3 was asked about the process staff follows when a resident is discharged from a facility - even if it is a transfer/discharge to a sister facility. ASM #3 stated the staff was working to "expedite" getting residents out of the facility where they were and getting to the accepting facility as soon as possible. She stated there were many pieces of documentation and many phone calls involved in the discharge/transfer process. ASM #3 stated, "We made a packet of information, which should have included all of the regulatory paperwork." She stated, however, that the facility did not retain the paperwork packet. ASM #1 stated, "We did bed holds for them," but could not evidence the resident or RR was informed of the bed hold policy.	F 625		

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F 625	Continued From page 41 No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. (3) "Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments	F 625		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to complete an accurate MDS (minimum data set) assessment for one of 35 residents, Resident #7. Resident #7's clinical record documented the resident received dialysis services, however Section O special treatments,	F 641	F 641 • Resident # 7 care plan coding was corrected by the MDS Coordinator on 3/11/21. • 100% audit of Residents Minimum Data Set Assessments were audited by the MDS Coordinator and Facility Consultant for accuracy of Section "O" on 3/17/21, with no negative findings. • In-service on MDS for accuracy per coding rules as per the RAI manual to include Section "O" completed on 3/17/21 by the VP of Health Services. The MDS Coordinator will develop a comprehensive care plan for the dialysis resident and complete Section "O" Special treatments for dialysis. This will be completed with the initial assessment and updated as needed.	

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F 641	Continued From page 42 procedures and programs of Resident #7's MDS, a quarterly assessment with an ARD (assessment reference date) of 12/15/20, coded the resident as "No" for dialysis while a resident. The findings include: Resident #7 was admitted to the facility on 6/12/20. Resident #7's diagnoses included but were not limited to: end stage renal disease (inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance (1), mental disorder (any disorder of the mind such as disturbance of perceptions, memory and emotional equilibrium) (2) and hypertension (high blood pressure) (3). Resident #7's most recent MDS, a quarterly assessment with an ARD (assessment reference date) of 12/15/20, coded that the resident as scoring a of 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely impaired cognitively. A review of the MDS Section G-functional status coded the resident as extensive assistance for bed mobility, locomotion and dressing, total dependence for hygiene, bathing and eating. In Section H- bowel and bladder Resident #7 was coded as always incontinent for bowel and bladder function. A review of MDS Section O-special treatments, procedures and programs coded the resident as "No" for dialysis while a resident. A review of the nursing progress notes dated 12/15/20 at 3:45 AM, documented in part, "Resident out of facility at this time in route to scheduled dialysis. Informed dialysis center of facial swelling and refusal of meals. Resident left	F 641	continued from page 42 • The DON or designee will review all MDS assessments for new resident admissions to ensure Section "O" is completed accurately for Special Treatments one-time weekly x 4 weeks during the Cardinal IDT meeting. The DON or designee will immediately notify the MDS coordinator of all identified areas of concerns for correction. Retraining with the MDS Coordinator will be provided as needed. • The Director of Nursing and/ or designee will submit the audit findings for MDS accuracy per coding rules as per the RAI manual monthly to the QAPI Committee x 1 month.	04/12/21

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F 641	Continued From page 43 in good spirits and in stable condition". A review of the nursing progress notes dated 12/15/20 at 9:45 AM, documented in part, "Resident returned to facility from dialysis via patient transport. No acute distress noted". An interview was conducted on 3/10/21 at 1:44 PM with RN (registered nurse) #2, the MDS coordinator, regarding the purpose of the MDS assessment. RN #2 stated, "The MDS should reflect the resident's status. As long as an item such as dialysis has occurred in the previous 90 days, it should be checked on the quarterly MDS assessment". When ask to review Resident #7's quarterly MDS dated 12/15/20 Section O, RN #2 stated, "Dialysis is marked no. That is incorrect coding; He has consistently received dialysis three times a week since he has been here". On 3/11/21 at 9:45 AM, RN#2 stated, "I corrected the dialysis coding on the MDS Section O for that resident P[Resident #7]". On 9/12/19 at 12:30 PM, ASM (administrative staff member) #1 (administrator), #2 (director of nursing), #3 (medical director), #4 (regional clinical coordinator), #5 (director of nursing for another facility) and #6 (regional quality assurance director) were made aware of the above concern. No further information was presented prior to exit. References: (1) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 498. (2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 363.	F 641		

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F 641	Continued From page 44 (3) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 282.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	F 656	F 656 • The care plan for resident #99 was reviewed and update by the Director of Nursing (DON) on 3/11/21 to reflect interventions for post-operative care. • An audit of care plans for residents admitted post-operatively was conducted by MDS Consultant on 3/26/21, to include the care plan for resident #99, to ensure resident-centered comprehensive care plans have been developed based upon physician orders, assessment of resident needs and preferences, and preadmission screening, and resident review. The care plans were updated by MDS Consultant on 3/26/21 for any identified areas of concern to ensure the care plans address the residents' current status, to include interventions for post-operative care as applicable. • The Minimum Data Set (MDS) Coordinator, Social Worker, Dietary Manager, Activity Director, and licensed nurses will be educated by the DON and MDS Consultant by 4/8/21 on the need to ensure that the comprehensive care plan is resident-centered and based upon physician orders, the assessment of the resident's needs and preferences, and preadmission screening and include interventions for post-operative care as applicable. • The DON or designee will review all comprehensive assessments for subsequent new resident admissions to ensure the care plan reflects current resident status, to include interventions for post-operative care, by reviewing physician orders, discharge summaries, pre-admission screenings, progress notes, and nursing admission	

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F 656	Continued From page 45 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review and clinical record review, it was determined the facility staff failed to develop and / or implement the comprehensive care plan for one of thirty five residents in the survey sample, Resident #99. The facility staff failed to develop and implement a comprehensive care plan to address post-operative care for Resident #99. The findings include: Resident #99 was admitted to the facility on 3/4/21 with diagnoses that included but were not limited to: right total knee replacement (surgical replacement of knee joint with a prosthetic) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and hypertension (high blood pressure) (3). The most recent MDS (minimum data set) assessment, a Medicare 5 day with an ARD (assessment reference date) of 3/10/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring supervision for bed mobility, hygiene, bathing, dressing, locomotion and walking. Resident #99 was	F 656	Continued from page 45 assessments x 4 weeks utilizing a care plan audit tool. The DON or designee will immediately update the care plan for all identified areas of concerns and provide retraining with the identified staff member. • The results of the care plan audit tool will be compiled by the administrator or designee and presented to the Quality Improvement Committee monthly x 1 month. Identification of trends will determine the need for further action and/or change in frequency of required monitoring. Completion Date: 4/12/21	04/12/21

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F 656	Continued From page 46 coded as independent in eating. A review of MDS Section H- bowel and bladder coded the resident as always continent for bowel and bladder. A review of Resident #99's medical diagnosis dated 3/4/21, documented in part, "Rank: Primary diagnosis, Clinical Category: major joint replacement, Description: aftercare following joint replacement surgery". A review of Resident #99's nursing admission evaluation dated 3/4/21, documented in part, "Right knee post surgical scar". Review of nursing progress note dated 3/4/21 at 12:10 PM, documented in part, "Dressing covering post surgical site (right knee) clean, dry and intact". A review of the comprehensive care plan failed to address or evidence documentation of post-operative care for Resident #99. An interview was conducted on 3/10/21 at 1:41 PM with LPN (licensed practical nurse) #1. When regarding the purpose of the comprehensive care plan. LPN #1 stated, "It is how we take care of the resident." When asked about the care plan for a resident who is post knee replacement, LPN #1 stated, "I would expect to see how they transfer, signs and symptoms of infections and pain control". An interview was conducted on 3/10/21 at 2:15 PM with RN (registered nurse) #1 regarding the purpose of the comprehensive care plan. RN #1 stated, "The plan drives the care of the residents with problems, goals and interventions". When asked about a comprehensive care plan for post-operative care, RN #1 stated, "The care plan should include how to assist the resident with movement, pain relief measures and what signs and symptoms of infection you should look for."	F 656		

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F 656	Continued From page 47 On 3/10/21 at 4:30 PM ASM (administrative staff member) #1, the administrator, ASM #2, the director or nursing and ASM #3 the nurse consultant were informed of the above concerns. The comprehensive care plan for Resident #99 was revised on 3/11/21. Review of the revised care plan revealed in part the following: "Focus: At risk for infection related to surgical site status post right total knee replacement. Interventions: Treatments as ordered by physician, encourage resident to drink sufficient fluids and observe for signs/symptoms of infection to include increased temperature, loss of congestion, change in mental status. Notify physician for evaluation and/or intervention for redness, swelling to right lower extremity". A review of the facility's policy "Resident Care Plan" dated 11/13/17, documented in part, "It is the policy of the facility to provide a written resident-centered care plan based upon physician's orders, the assessment of the resident's needs and preferences, and pre-admission screening and resident review. No further information was provided prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 319. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 160. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 282.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 48 §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 resident interview, clinical record review, staff interview and facility document review it was determined facility staff failed to revise the comprehensive care plan for one of 35 residents in the survey sample, Resident #33. Resident #33 returned from the emergency room on 1/8/21 with a splint (immobilizer) in place to the right leg and non-weight bearing status, which was not addressed on Resident #33's	F 657	F 657 • The care plan for resident #33 was reviewed and updated by the MDS coordinator on 3/11/21 to reflect weight bearing status, splint care, recommended monitoring for compartment syndrome, checking dorsalis pedis pulses, and elevating right lower extremity when out of bed in chair. • An audit of all comprehensive care plans was conducted for residents who were transferred to the emergency room or had a consultation visit in the past 60 days, including the care plan for resident #33 by MDS Consultant on 3/26/21 to ensure the comprehensive care plan was updated to reflect new conditions and/or new recommendations for care. Care plans were updated as needed to ensure the comprehensive care plan included provider recommendations and reflect resident's current status by MDS Consultant on 3/23/21. • The Minimum Data Set (MDS) Coordinator, Social Worker, Dietary Manager, and licensed nurses were educated on care planning requirements and need to immediately update a resident's care plan to reflect current status and recommendations made by providers by DON and MDS Consultant by 4/8/21. • Upon a resident's return from the emergency room or consultation visit, the licensed floor nurse will review accompanying progress notes and/or provider instructions and update the resident care plan accordingly to reflect any new provider recommendations and resident's current status. A follow up review will be conducted by the Director of Nursing (DON) and MDS Coordinator during daily Cardinal IDT Meetings, Monday-Friday, x 8 weeks to ensure the resident's care plan was appropriately updated to reflect new provider recommendations and resident status utilizing	

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F 657	Continued From page 49 comprehensive care plan. The findings include: Resident #33 was admitted to the facility with diagnoses that included but were not limited to cerebral infarction (1), hemiplegia (2), hemiparesis (3) affecting right dominant side, and vitamin D deficiency (4). Resident #33's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/20/2021, coded Resident #33 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section G coded Resident #24 as requiring extensive assistance of two persons for transfers and extensive assistance of one person for personal hygiene and toileting. Section J coded Resident #33 as having one fall with major injury. On 3/9/21 at approximately 2:30 p.m., an interview was conducted with Resident #33. Resident #33 was observed in their wheelchair with a splint wrapped in a compression bandage on the right lower leg beginning above the right knee. Resident #33 stated that she fell in the bathroom when the CNA (certified nursing assistant) was assisting her back to the wheelchair. Resident #33 stated that she was not sure if the wheelchair was locked, that it slid back on her and she fell to her knees. Resident #33 stated that she went to the emergency room the next day after an x-ray was done and she was seeing a specialist about the leg. The physician orders dated 3/1/21-3/31/21 for	F 657	continued from page 49 a care plan audit tool. The DON or MDS Nurse will immediately update the care plan for all identified areas of concerns and the DON or designee will provide retraining with the identified staff member. • The results of the care plan audit tool will be compiled by the administrator or designee and presented to the Quality Improvement Committee monthly x 2 months. Identification of trends will determine the need for further action and/or change in frequency of required monitoring.	04/12/21

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F 657	Continued From page 50 Resident #33 documented in part, - "Check Dorsalis Pedel [sic] pulse (pulse in foot) BID (twice a day) (Right leg FX (fracture))." - "Continue Cadalac splint. FYI (for your information)." - "NWB (non- weight bearing) RLE (right lower extremity) x 8 weeks (for eight weeks). Dx (diagnosis) Right tib/fib (tibia/fibula) (long bones in the lower leg) FX. FYI." The progress notes for Resident #33 documented in part, - "1/7/2021 15:32 (3:32 p.m.) Late Entry: Note Text: On 1/7/21, resident was assisted to her knee while attempting to transfer to her wheelchair. MD (medical doctor) made aware with note in communication log. Resident is her own RR (resident representative)." -"1/8/2021 11:24 (11:24 a.m.) Late Entry: Note Text: called to room by CNA (certified nursing assistant) stating resident is crying and complaining of right leg hurting. Writer entered room and resident in bed, when writer attempted to straighten leg in bed to assess it resident grimacing and crying that it hurt. Resident explained that when she fell yesterday that her leg went behind her. On assessment, swelling noted to right lower extremity mid shin to foot, area of pain beginning mid shin. Resident able to flex and retract foot without difficulty. Writer able to palpate pulses proximal and distally to pain point of shin. Writer called MD (medical doctor) to update her on findings and to request xray of tib/fib (tibia/fibula). Telephone order received and passed to floor nurse, [Name of nurse], LPN (licensed practical nurse). Resident is her own RR [resident representative]."	F 657		

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F 657	Continued From page 51 - "1/8/2021 13:31 (1:31 p.m.) Late Entry: Note Text: Writer went to reassess resident, upon entering room resident up in wc (wheelchair) propelling self in room, swelling remains and she states pain is a little better. Informed her that they should be coming to do the xray, she verbalized understanding." - "1/8/2021 22:09 (10:09 p.m.) Note Text: Xray results of right lower leg: fracture of proximal fibula and distal tibia. Advised nurse to sent [sic] to ER (emergency room) for further treatment." - "1/9/2021 06:15 (6:15 p.m.) Note Text: Return from [Name of hospital] by transport. Resident in [Room number]. Resident awake and alert. Oriented x3 (person, place and situation). Long Splint to Rt. (right) leg. [Name of nurse practitioner], NP call and reported x-ray of leg done results Fracture x 2 at tib/fib knee and rt. ankle. Resident to be Non-weight bearing to Rt. leg. Long splint to Rt. leg do not remove. Ortho [orthopedic] consult as soon as possible. Monitor for compartment syndrome (5). Spouse [Name of spouse] made aware." - "2/9/2021 10:41 (10:41 a.m.) Note Text: Care plan meeting held. RN (registered nurse), SW (social worker), Dietary and resident. Resident and team have no issues at this time. Resident is her own RR. Resident is a FULL CODE. Resident stated that she is eating and sleeping good. Enjoys watching cooking shows on TV." The "Radiology Results Report" for Resident #33, dated 1/8/2021 documented in part, " ...Impression: There are acute fractures of the proximal fibula and distal tibia seen ..."	F 657		

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F 657	Continued From page 52 The "Emergency Documentation" for Resident 33, dated 1/8/2021 documented in part, " ...Patient received a full posterior splint with ankle stirrup additional splinting based on the above fractures. It is recommended and the nursing home was notified that the patient would need to be non-weightbearing along with referral to orthopedics as soon as possible ..." The orthopedic "Report of Consultation" for Resident #33, dated 1/18/2021 documented in part, " ..Recommendations: Continue Cadalac splint that she already has on. Keep clean and dry. No weight bearing RLE [right lower extremity] x 8-12 weeks (for eight to twelve weeks). Tylenol as needed for pain- pt (patient) states this helps most of the time. Check DP (dorsalis pedis) pulse BID (twice a day). Pt may sit in wc (wheelchair) with B (both) leg rests, R (right) one elevated ..." The orthopedic "Report of Consultation" for Resident #33, dated 2/4/2021 documented in part, " ...Continue splint for 4 (four) more weeks, keep clean and dry ...NWB (non-weightbearing) RLE 4-8 more weeks ..." The fall investigation for Resident #33, dated 1/7/2021 documented in part, " ...Nursing description: Called to resident's room by CNA (certified nursing assistant) to assist with resident. Observed resident kneeling in front of her wheelchair in her bathroom. Resident Description: "I tried to get in the chair and it slid back. I landed on my knee." ... No injuries observed at time of incident ..." The fall investigation further documented, " ...CNA [Name of CNA] stated that she was assisting resident to wheelchair from toilet; resident crossed her feet	F 657		

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F 657	Continued From page 53 and began to let herself down, CNA was not able to keep her from falling, due to the position of residents feet, so she assisted resident to the floor to her knees. States her legs were crossed under her ..." The fall investigation documented an incident report dated 1/7/2021, witness statements dated 1/9/21 and an investigational summary dated "1/7/21-2/27/21 (due to continued falls)." The comprehensive care plan dated 2/5/2021, for Resident #33 documented in part, "Risk for falls characterized by multiple risk factors related to: impaired balance, impaired mobility, decreased safety awareness, falls from w/c (wheelchair) (2/11/21 & 2/27/21), Date Initiated: 03/19/2020 Revision on: 02/28/2021." Under "Interventions", it documented in part, 'Assist resident to negotiate barriers as necessary. Date Initiated: 01/11/2021 ..." The care plan failed to evidence documentation regarding the interventions put in place after Resident #33's fractures to the right lower leg. On 3/11/21 at approximately 10:37 a.m., an interview was conducted with RN (registered nurse) #2, MDS coordinator. RN #2 stated that they were notified of resident changes in condition in the morning meetings. RN #2 stated that daily care plan updates were completed by the interdisciplinary team and were reviewed by them quarterly. RN #2 stated that when a resident had a fall an investigation was completed and an intervention was added to the care plan to prevent a reoccurrence. RN #2 reviewed the comprehensive care plan for Resident #33 and stated that she did not see any documentation regarding the non-weight bearing status, splint or fracture of the right leg addressed. RN #2 stated	F 657		

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F 657	Continued From page 54 that the splint immobilizer should have been addressed on the care plan. On 3/11/21 at approximately 11:44 a.m., an interview was conducted with LPN (licensed practical nurse) #2, regarding purpose of the comprehensive care plan. LPN #2 stated that the care plan was for staff to know what to do for the specific resident. LPN #2 stated that the care plan also contained a care guide, which helped the CNA (certified nursing assistant) know how to care for the resident. LPN #2 stated that care plans were updated or revised when there was a change in condition. LPN #2 stated that when a resident had a fall the care plan was reviewed and they would add any interventions put into place. LPN #2 stated that when a resident had any fall with injury, or a new weight bearing status they would update the care plan to reflect it. LPN #2 stated that when residents return to the facility from the emergency room the documentation was reviewed and the orders and care plan were updated. LPN #2 stated that any nurse could update the care plan. A review of the facility policy, "Resident Care Plan" dated "Revision 11/13/2017" documented, "It is the policy of the facility to provide a written resident-centered care plan based upon physician's orders, the assessment of the resident needs and preferences, and pre-admissions screening and resident review (PASRR) ..." The policy further documented, "The resident care plan will be an ongoing process and will include current problems and/or needs identified from a complete assessment ..." On 3/11/21 at approximately 2:00 p.m., ASM (administrative staff member) #1, the	F 657		

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F 657	Continued From page 55 administrator, ASM #2, the director of nursing and ASM #3, the regional vice president were made aware of the above concern. No further information was presented prior to exit. References: 1. Cerebrovascular disease, infarction or accident is a stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . 2. Hemiparesis - Paralysis is the loss of muscle function in part of your body. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 3. Hemiplegia- also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread. This information was obtained from the website: https://medlineplus.gov/paralysis.html. 4. Vitamin D deficiency- Vitamin D helps your body absorb calcium. This information was obtained from the website: https://medlineplus.gov/vitamind.html.	F 657		

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F 657	Continued From page 56 5. Compartment syndrome- Acute compartment syndrome is a serious condition that involves increased pressure in a muscle compartment. It can lead to muscle and nerve damage and problems with blood flow. This information was obtained from the website: https://medlineplus.gov/ency/article/001224.htm	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care consistent with professional standards of practice for two of thirty five residents in the survey sample, Resident #47 and Resident #24. 1. The facility staff failed administered oxygen to Resident #47 without a physician order for oxygen. 2. The facility staff failed to provide respiratory services in a sanitary manner for Resident #24. The facility staff stored a nebulizer (1) mask and a yankauer suction catheter (2) uncovered on the nightstand in Resident #24's room.	F 695	F 695- • Resident #47-order for oxygen was received by MD and implemented on 3/12/21. Resident #24 respiratory equipment was replaced and then placed in a plastic bag provided for storage at bedside; Yankeuer suction catheter was replaced, and a plastic bag was provided for storage at bedside. • An audit of Oxygen dependent residents, residents using Yankeuer suction catheters and residents using Nebulizer machines will be performed by the Director of Nursing, this will be completed by 3/26/21. The audit will be done by review of all physician orders and room audits, any identified areas of concern will be corrected immediately by the DON and MD. • Nurses will be in-serviced by the Staff Development Coordinator for all residents requiring Oxygen therapy, use of Yankeuer suction catheters, and Nebulizer machines by 3/29/21, they must have a physician order with specific liters of oxygen identified, how the oxygen is to be delivered via nasal cannula or mask and duration of the oxygen therapy and all suction catheters and Nebulizer tubing must be placed in a plastic bad for storage at the bedside. • Nurses will verify all new admissions for oxygen orders using the Admission Audit Tool. If there is a need for an oxygen order the nurse will contact the MD/NP for the resident •	

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F 695	Continued From page 57 The findings include: 1. Resident #47 was admitted to the facility on 12/4/19 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [COPD] (non-reversible lung disease) (1), syncope (brief loss of consciousness due to temporary insufficient flow of blood to the brain) (2) and atrial fibrillation (rapid and random contraction of atria of the heart) (3). The most recent MDS (minimum data set) assessment, an annual assessment with an ARD (assessment reference date) of 2/10/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring supervision for bed mobility, transfer, hygiene, eating and walking. Resident is independent in locomotion, dressing and bathing. A review of MDS Section H- bowel and bladder coded the resident as always continent for bowel and bladder. Section O- oxygen therapy while a resident was coded as "Yes". On 3/9/21 at 3:25 PM, 3/10/21 at 8:00 AM and 3/10/21 at 2:10 PM., observations of Resident #47 revealed the resident was receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen flow meter was observed set at 3 liters. A review of the physician orders for Resident #47 dated 2/4/21-3/09/21, failed to evidence physician orders for oxygen therapy.	F 695	continued from page 57 and obtain the order and implement. Residents using suction catheters and Nebulizer tubing will be provided with a plastic bag for storage at bedside upon admission. • The DON or designee will audit oxygen dependent residents for physician orders and residents using suction catheters and nebulizer tubing for proper storage weekly x 4 weeks. The audits will be reviewed in the Cardinal IDT meetings and any areas identified of concern will be corrected by the Director of Nursing and the MD. • The findings of the Audits for oxygen, suction catheters and nebulizer tubing will be reviewed during the monthly QAPI committee x 1 month.	04/12/21

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F 695	Continued From page 58 Review of Resident #47's nursing admission dated 2/4/21 at 9:27 PM, documented in part, "Special treatments: Oxygen therapy- 3 liters per minute continuous". Review of Resident #47's nursing progress note dated, 3/9/21 at 3:17 PM, documented in part, "Respiratory- oxygen via nasal cannula". A review of the respiratory care evaluation for Resident #47 dated 3/9/21 at 1:00 AM, documented in part, "Oxygen vial nasal cannula, oxygen saturation 97%. Rate of oxygen 3 liters per minute." A review of the comprehensive care plan for Resident #47 dated 12/4/19 documented in part, "Focus: Potential for or actual ineffective breathing pattern related to COPD (chronic obstructive pulmonary disease) with emphysema, respiratory failure. Interventions: Oxygen therapy as ordered." An interview was conducted on 3/10/21 at 1:41 PM with LPN (licensed practical nurse) #1 regarding Resident #47. LPN #1 stated, "She [Resident #47] has been cleared from observation status and has been moved back to her original room." An interview was conducted on 3/10/21 at 2:15 PM with RN #1, regarding Resident #47 and the administration of oxygen. RN #1 stated, "Yes she (Resident #47) has been moved but I don't have her paperwork. I will have to call the unit she transferred from, as they haven't brought her paper chart, so I cannot tell you how much oxygen she is on". RN #1 was then observed calling LPN #1. RN #1 then stated, "There isn't an order for the oxygen."	F 695		

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F 695	Continued From page 59 On 3/10/21 at 2:30 PM, RN #1 stated, "Resident #47 gets shortness of breath with exertion and walking to the bathroom but at rest is tolerating two liters per minute. I will leave a message for the physician to order the oxygen, maybe she can give us parameters for two liters or three liters." On 3/10/21 at 2:20 PM, RN #1 was accompanied to Resident #47's room. Resident #47 was observed receiving oxygen via nasal cannula connected to the concentrator that was running. RN #1 observed Resident #47's oxygen concentrator flow meter that was set at three liters per minute. At this time Resident #47 was interviewed. When asked if she changed the oxygen setting, Resident #47 stated, "Oh, I never touch it." RN #1 was then observed adjusting the oxygen setting to 2 liters per minute. On 3/10/21 at 2:56 PM RN #1 presented a physician order for Resident #47 that documented in part, "Oxygen two liters to three liters, titrate for shortness of breath and shortness of breath with exertion". On 3/10/21 at 4:30 PM ASM (administrative staff member) #1, the administrator, ASM #2, the director or nursing and ASM #3 the nurse consultant were informed of the above concerns. On 3/9/21, ASM #2 stated that the professional standards followed are the facility policy and procedures. A request was made for a policy for obtaining and implementing orders. No policy was provided. No further information was provided prior to exit. References:	F 695		

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	495226	A. BUILDING _____ B. WING _____	03/12/2021

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F 695	Continued From page 60 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 120. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 551. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 54. 2. The facility staff failed to provide respiratory services in a sanitary manner for Resident #24. The facility staff stored a nebulizer (1) mask and a yankauer suction catheter (2) uncovered on the nightstand in Resident #24's room. Resident #24 was admitted to the facility with diagnoses that included but were not limited to chronic obstructive pulmonary disease (3) and anemia (4). Resident #24's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/25/2021, coded Resident #24 as scoring a 9 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 9- being moderately impaired for making daily decisions. Section O documented Resident #24 receiving oxygen while a resident at the facility. On 3/9/21 at approximately 11:44 a.m., an interview was attempted with Resident #24 in their room. Observation of Resident #24's room revealed a suction machine on top of the nightstand to the left of the bed. A yankauer suction was observed attached to the suction machine and was observed lying on the nightstand uncovered. The yankauer suction was observed touching the surface of the nightstand. A nebulizer machine was observed on the nightstand with a nebulizer administration kit containing a facemask attached to the machine.	F 695		

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F 695	Continued From page 61 The nebulizer mask was observed uncovered and lying on the nightstand touching the suction machine and the nightstand table surface. When asked if the staff used the suction and the nebulizer, Resident #24 nodded in confirmation. Additional observations of Resident #24's room on 3/9/21 at 2:20 p.m., revealed the findings above. Observations on Resident #24's room on 3/10/21 at 9:00 a.m. and 3/10/21 at 11:45 a.m. revealed the findings above. The physician's orders dated 3/1/21-3/31/21 for Resident #24 documented in part, - "Duoneb Ipratropium/Sol (solution) Albuterol 1 premixed unit via nebulizer every four hours as needed for wheezing. 02/21/19." - "Suction PRN (as needed). 2/24/21." The MAR (medication administration record) dated 2/1/21-2/28/21 for Resident #24 documented in part, "Suction prn." The MAR documented Resident #24 being suctioned "X3" (three times) on 2/1/21. The progress notes for Resident #24 documented in part the following: - "2/23/2021 06:45 (6:45 a.m.) Note Text: Resident presenting with moist, rattle cough. Suctioned x 3 (three times) for copious amounts of thick clear sputum. Airway cleared, coughing greatly decreased. PRN (as needed) nebulizer applied for 15 minutes, with good effect. Resting quietly at this time. SpO2% (oxygen saturation) @2L/NC (at two liters per nasal cannula) -97%, no cyanosis (bluish discoloration of skin) observed. Nail beds remain pink with good cap refill. Oral care provided." - "1/23/2021 14:20 (2:20 p.m.) Note Text:	F 695		

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F 695	Continued From page 62 LEGACY CARE PROVIDER RECERTIFICATION NOTE; Federally mandated required provider visit, based on the resident's date of admission, for evaluation of chronic medical conditions and current status. [Resident #24] is an [Age and Sex of Resident #24] long term care resident who has chronic obstructive pulmonary disease. He has a nonproductive cough and shortness of breath at rest. He requires continuous oxygen via nasal cannula for his activities of daily living and sleep. He denies any wheezing, orthopnea (5) or pain with inspiration (inhaling)." The comprehensive care plan for Resident #24 dated 2/2/2021 documented in part, - "Risk for fluid output exceeding intake characterzed [sic] by fluid volume deficit; dry skin and mucous membranes, poor skin turgor and integrity related to: altered intake process, uncontrolled health conditions Date Initiated: 11/09/2020." - "[Resident #24] has care deficit pertaining to the teeth or oral cavity characterized by; altered oral mucous membrane; teeth/gums related to: declining health condition, medication, oxygen, respiratory treatments, need for occasional suctioning Date Initiated: 12/13/2019." - "Potential for or Actual Ineffective Breathing Pattern: COPD Date Initiated: 03/12/2019 Created on: 03/12/2019." On 3/10/21 at approximately 3:00 p.m., an interview was conducted with LPN (licensed practical nurse) #3. When asked about nebulizer administration, LPN #3 stated that the nebulizer was stored in a plastic bag when not in use. LPN #3 stated that the purpose of the plastic bag was to keep it clean and free of germs. When asked about yankauer suction storage, LPN #3 stated	F 695		

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F 695	Continued From page 63 that they were stored in a plastic bag when not in use to keep them clean and prevent contamination. On 3/10/21 at 3:10 p.m., LPN #3 observed Resident #24's room. LPN #3 stated that she saw the problem. LPN #3 stated that the yankauer suction was uncovered and touching the surface of the nightstand and the nebulizer mask was uncovered and touching the surface of the nightstand and the suction machine. LPN #3 stated that she would remove the uncovered respiratory equipment. On 3/9/21 at approximately 10:30 a.m., ASM (administrative staff member) #2, the director of nursing stated that the facility used their policies and procedures as their standard of practice. On 3/11/21 at approximately 2:30 p.m., a request was made to ASM (administrative staff member) #2, the director of nursing for the policy for storage of nebulizer and suction equipment when not in use and oxygen administration. On 3/12/21 at approximately 10:40 a.m., ASM #2 stated via email that the facility did not have a policy for the storage of nebulizer and suction equipment when not in use and provided the oxygen administration policy for review. On 3/10/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the facility consultant were made aware of the findings. No further information was provided prior to exit.	F 695		

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F 695	Continued From page 64 Reference: 1. Nebulizer - a device used to aerosolize medications for delivery to patients." Taken from Encyclopedia & Dictionary of Medicine, Nursing & Allied Health -Seventh Edition, Miller-Keane, page 1182. 2. Yankauer suction- a rigid suction tip used to aspirate secretions from the oropharynx. This information was obtained from the following website: Yankauer suction catheter. (n.d.) Medical Dictionary for the Health Professions and Nursing. (2012). Retrieved March 15 2021 from https://medical-dictionary.thefreedictionary.com/Yankauer+suction+catheter 3 Chronic obstructive pulmonary disease (COPD) - disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. 4. Anemia - low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . 5. Orthopnea- breathing difficulty while lying down is an abnormal condition in which a person has a problem breathing normally when lying flat. The head must be raised by sitting or standing to be able to breathe deeply or comfortably. This information was obtained from the website: https://medlineplus.gov/ency/article/003076.htm	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l)	F 698		

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F 698	Continued From page 65 §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to ensure the provision of dialysis services, consistent with professional standards of practice, the comprehensive person-centered care plan for one of 35 residents, Resident #7. The facility staff failed to evidence ongoing communication and collaboration with the dialysis center for Resident #7. The findings include: Resident #7 was admitted to the facility on 6/12/20. Resident #7's diagnoses included but were not limited to: end stage renal disease (inability of the kidneys to excrete wastes and function in the maintenance of electrolyte balance (1), mental disorder (any disorder of the mind such as disturbance of perceptions, memory and emotional equilibrium) (2) and hypertension (high blood pressure) (3). Resident #7's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/15/20, coded the resident as scoring a 07 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely impaired cognitively. A review of the MDS Section	F 698	F 698- • Resident #7 receives dialysis Tuesday, Thursday, and Saturday. The dialysis communication form was sent with resident on his next dialysis day Saturday 3/13/21 by the nurse. • An audit of dialysis residents was completed on 3/12/21 by the Director of Nursing. The Dialysis Communication form is sent with the resident in a packet that contains all needed information and DNR form when they leave for the appointment. The facility will receive updated information from the dialysis center via the communication form upon return to the facility. The Nurse will place the form in the Medical Director book for review, if there are any orders the MD will return to the nurse. The form is then given to Medical records to be placed in the chart. • In-services for the nursing staff will be conducted on 3/29/21 by the Director of Nursing on the procedure for sending and documenting receipt of communication form from dialysis. The nurse will then document under the dialysis progress note any information from the dialysis center. • The Director of Nursing or designee will audit dialysis residents' charts for communication forms and dialysis progress notes weekly x 4 weeks. • The audit findings of dialysis communication forms and dialysis progress notes will be reviewed with QAPI monthly x 1 month.	04/12/21

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F 698	Continued From page 66 G-functional status coded the resident as requiring extensive assistance for bed mobility, locomotion and dressing, total dependence for hygiene, bathing and eating. A review of MDS Section H- bowel and bladder coded the resident as always incontinent for bowel and bladder. A review of the nursing progress notes documented the following in part: -"3/4/21 at 11:21 AM, documented in part, "Returned to facility at 9:35 AM with dressing intact, no bleeding or drainage noted. Condition of shunt site: + (positive) bruit and thrill, alert and oriented per his norm". - "3/6/21 at 9:58 AM, documented in part, "Returned to facility from dialysis via patient transport in stable condition. No acute distress noted". Resident #7's comprehensive care plan dated 3/27/20, documented in part, Focus: "End state renal disease: at risk for complications due to hemodialysis. The Interventions: dated 3/27/20, documented, "Dialysis (Tuesday, Thursday, Saturday). Assess resident upon return from dialysis treatment and notify physician of any significant changes". A review of the dialysis communication forms for Resident #7 from 1/2/21-3/11/21, a period of 30 Tuesday, Thursday and Saturday dialysis treatments, evidence that 13 out of 30 (43%) of the dialysis communication forms were missing. An interview was conducted on 3/11/21 at 10:50 AM with LPN (licensed practical nurse) #1. When asked the purpose of the dialysis communication form, LPN #1 stated, "It is to communicate the	F 698		

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F 698	Continued From page 67 resident's vital signs and any current issues or concerns". When asked the purpose of communication from the dialysis center on the form, LPN #1 stated, "They communicate vital signs, weight, medications given and any issues or concerns". An interview was conducted on 3/12/21 at 10:20 AM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the dialysis communication form, ASM #2 stated, "It is for sharing of information about the resident between the two facilities". When asked if there were any additional dialysis, communication forms than those sent, ASM #2 stated, "No, there are not". On 3/11/21 at 11:50 AM, ASM (administrative staff member) #1, the administrator, ASM#2 , the director of nursing, ASM#3, the clinical consultant , and ASM# 4, the regional vice president were made aware of the above concern. According to the facility's dialysis contract dated 5/19/11 which documents in part, "The facility shall ensure that all appropriate medical and administrative information accompany all residents at the time of transfer or referral to the Center." No further information was presented prior to exit. References: (1) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 498. (2) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 363. (3) Barron Dictionary of Medical Terms, 7th	F 698		

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F 698	Continued From page 68 edition, Rothenberg and Kaplan, page 282.	F 698		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §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, facility document review, and clinical record review, it was determined that the facility staff failed to evidence documentation of current side rail assessments and consents for four of 35 residents in the survey sample, Residents #21, #10, #2, and #32. The findings include:	F 700	F 700 • Residents #21, #10, #2, and #32 will have physical device use evaluations and consents signed by resident or resident representative completed by 3/26/21 by the Director of Nursing. • An audit of resident's beds frames, mattress and side rail was completed on 3-24-21 by the Maintenance Director. An audit of physical device use evaluation assessments in the clinical record will be completed on 4/2/21 by the Director of Nursing or designee. Upon admission the nurse will complete the physical device evaluation assessment in the clinical record, if the nurse determines the resident will need a side rail for mobility and/or transfers based on the assessment, the maintenance director will be made aware to complete the bed frame, mattress and side rail check, a therapy screen referral will be completed, once it is determined the siderail is an appropriate approach the resident or resident representative will be notified to sign the consent and the side rail will be put into place and the care plan will be updated. • An in-service for clinical staff will be conducted by 4/2/21 by the Director of Nursing on the physical device use evaluation assessment, notification to maintenance and therapy and how to obtain consent from the resident or resident representative if a side rail is needed.	

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F 700	Continued From page 69 1. Resident #21 was observed lying in bed with side rails up during the course of the survey. The facility failed to evidence a current side rail assessment and a current consent for the use of the side rails. Resident #21 was admitted to the facility on 4/4/2020 with diagnoses that included but were not limited to: dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.) (1), and pulmonary fibrosis (an increase in the formation of fibrous connective tissue, either normally as in scar formation, or abnormally to replace normal tissue especially in the lungs) (2). The most recent MDS (minimum data set) assessment, quarterly assessment, with an assessment reference date (ARD) of 1/11/2021, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. Resident #21 was coded as requiring extensive assistance for moving in the bed. For moving in the room or unit, the resident was coded as only having performed this once or twice during the lookback period with the assistance of one staff member. In Section G0600 - Mobility Devices, Resident #21 was coded as using a wheelchair. On the following dates and times, Resident #21 was observed lying in bed with both side rails up: 3/09/21 at 3:22 p.m., 3/10/21 at 8:57 a.m., 3/11/21 at 9:46 a.m. A review of Resident #21's comprehensive care plan 4/15/20 revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility	F 700	continued from page 69 • The Director of Nursing or designee will audit the physical device use evaluation assessment of new admissions during the Cardinal IDT meeting using the Restraint/Side Rail audit tool 1-time weekly x 4 weeks. • The Restraint/Side Rail audit findings will be reviewed with QAPI monthly x 1 month.	04/12/21

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F 700	Continued From page 70 or transfer ability. Muscle weakness, safety in transfer...Assess resident for risk of entrapment from bed rails periodically and as necessary...evaluate use of device periodically for continued effectiveness and appropriateness...use of bedrails to assist resident to increase ability to enter and exit the bed at highest practical mobility level...use of bedrails to assist resident to turn and reposition when in bed." Further review of Resident #21's clinical record failed to reveal evidence of a current side rail assessment or consent for the use of side rails. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #2 stated an assessment was performed for resident safety on original admission, and then quarterly with each care plan conference. She stated if side rail use is indicated, they are put into place, and are documented on the resident's care plan. ASM #2 stated, "I don't know there is a process for checking the side rails before they are put up." She stated the facility's side rail assessment had "fallen off" of the computer software for some of the residents. A review of the facility policy, "Side Rail Guidelines" revealed, in part: "Side rails may be used to enhance resident mobility and transfer to and from the bed, or as a restraining device to keep residents from voluntarily getting out of bed. Use of side rails as a restraint is prohibited unless they are necessary to treat a resident's medical symptoms." The policy did not address the	F 700		

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F 700	Continued From page 71 facility's assessment process. No further information was provided prior to exit. REFERENCES (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 227. 2. Resident #10 was observed lying in bed with side rails up during the course of the survey. The facility failed to evidence a current side rail assessment and a current consent for the use of the side rails. Resident #10 was admitted to the facility on 5/4/2016 with diagnoses that included but were not limited to: Alzheimer's disease (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability.) (1) and Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/21/2020, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #10 was coded as	F 700		

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	495226	A. BUILDING _____ B. WING _____	03/12/2021

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F 700	Continued From page 72 requiring extensive assistance of one staff member for moving in the bed. For moving in the room or unit, the resident was coded as being totally dependent upon one staff member. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. On the following dates and times, Resident #10 was observed lying in bed with both side rails up: 3/9/21 at 3:26 p.m., 3/10/21 at 8:55 a.m., 3/11/21 at 9.48 a.m. A review of Resident #10's comprehensive care plan, dated 10/24/18 and revised on 11/11/20, revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness, Parkinson's Disease...Check bed rails periodically for proper functioning...evaluate use of device periodically for continued effectiveness and appropriateness...use of bedrails to assist resident to increase ability to enter and exit the bed at highest practical mobility level." Further review of Resident #10's clinical record failed to reveal evidence of a current side rail assessment or consent for the use of side rails. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #2 stated an assessment was performed for resident safety on original admission, and then quarterly with each care plan conference. She stated if side rail use is indicated, they are put into place, and are documented on the resident's care plan. ASM #2 stated, "I don't know there is a	F 700		

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F 700	Continued From page 73 process for checking the side rails before they are put up." She stated the facility's side rail assessment had "fallen off" of the computer software for some of the residents. No further information was provided prior to exit. REFERENCES (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 26. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. 3. Resident #2 was observed lying in bed with side rails up during the course of the survey. The facility staff failed to evidence a current side rail assessment and a current consent for the use of the side rails. Resident #2 was admitted to the facility 5/17/2015 and was recently readmitted on 2/23/2021 with diagnoses that included but were not limited to: dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.)(1), high blood pressure and schizophrenia (Any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response) (2). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/2021, coded the resident as having no difficulty with	F 700		

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F 700	Continued From page 74 short or long-term memory difficulties. Resident #2 was coded as requiring extensive assistance of one staff member for moving in the bed. Resident #2 was coded as requiring limited assistance of one staff member for moving in their room or unit. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. On the following dates and times, Resident #2 was observed lying in bed with both side rails up 3/9/21 at 11:16 a.m., 3/10/21 at 9.03 a.m. A review of Resident #2's comprehensive care plan dated 10/24/18 revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Safety in transfers...Assess resident for risk of entrapment from bed rails periodically and as necessary...Check bed rails periodically for proper functioning...evaluate use of device periodically for continued effectiveness and appropriateness...use of bedrails to assist resident to increase ability to enter and exit the bed independently." Further review of Resident #2's clinical record failed to reveal evidence of a current side rail assessment or consent for the use of side rails. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #2 stated an assessment was performed for resident safety on original admission, and then quarterly with each care plan conference. She stated if side rail use is indicated, they are put into	F 700		

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F 700	Continued From page 75 place, and are documented on the resident's care plan. ASM #2 stated, "I don't know there is a process for checking the side rails before they are put up." She stated the facility's side rail assessment had "fallen off" of the computer software for some of the residents. No further information was provided prior to exit. REFERENCES (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. 4. Resident #32 was observed lying in bed with side rails up during the course of the survey. The facility failed to evidence a current side rail assessment and a current consent for the use of the side rails. Resident #32 was admitted to the facility on 1/17/2015 with diagnoses that included but were not limited to: Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (1), congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (2) and bipolar disorder (a mental disorder characterized by episodes of mania and depression) (3). The most recent MDS (minimum data set)	F 700		

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F 700	Continued From page 76 assessment, a quarterly assessment, with an assessment reference date of 1/20/2021, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. Resident #32 was coded as requiring limited assistance of one staff member for moving in the bed. Resident #32 was coded as requiring supervision with set up assistance for moving in their room or unit. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. On the following dates and times, Resident #32 was observed lying in bed with both side rails up. 3/9/21 at 11:27 a.m., 3/11/21 at 8:52 a.m. A review of Resident #32's comprehensive care plan, dated 12/29/17 and updated 12/14/20, revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness. Safety in transfers. Other: maintain independence with bed mobility...Assess resident for risk of entrapment from bed rails periodically and as necessary...Check bed rails periodically for proper functioning...evaluate use of device periodically for continued effectiveness and appropriateness...provide and review with resident and/or resident's representative the risks and benefits of the use of side rails." Further review of Resident #32's clinical record failed to reveal evidence of a current side rail assessment or consent for the use of side rails. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical	F 700		

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F 700	Continued From page 77 consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #2 stated an assessment was performed for resident safety on original admission, and then quarterly with each care plan conference. She stated if side rail use is indicated, they are put into place, and are documented on the resident's care plan. ASM #2 stated, "I don't know there is a process for checking the side rails before they are put up." She stated the facility's side rail assessment had "fallen off" of the computer software for some of the residents. No further information was provided prior to exit. REFERENCES (1)Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.	F 700		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).	F 730		

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F 730	Continued From page 78 This REQUIREMENT is not met as evidenced by: Based on staff interview, employee record review and facility document review, it was determined the facility staff failed to perform an annual performance review for four of 12 CNAs (certified nursing assistants), CNA #1, CNA #2, CNA #3, and CNA #4. The findings include: An email requesting the CNA annual performance reviews was sent to ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing on 3/9/2021 at 4:10 p.m. On 3/9/2021, 6.09 p.m. ASM #2 replied by email and documented, "Employees have not had evaluations d/t (due to) continuous DON (director of nursing) turnover. I am presently in the process of beginning them." CNA #1 was hired on 8/30/2017. The last annual performance evaluation was completed on 5/31/2019. CNA #2 was hired on 11/16/1996. The last annual performance evaluation was completed on 5/3/2019. CNA #3 was hired on 10/5/1918. There was no annual performance evaluation in the employee record. CNA #4 was hired on 2/6/1991. The last annual performance evaluation was completed on 5/31/2019. An interview was conducted with ASM #2, the director of nursing (DON), on 3/10/2021 at 1:08 p.m. When asked who is responsible for the CNA annual performance reviews, ASM #2 stated that she was responsible. ASM #2 stated she had	F 730	F 730 • CNA #1, #2, #3 and #4 to receive Employee performance review on 3/29/21 by the Director of Nursing. • Audit of clinical staff employment file to be completed by 4/2/21, the audit will be conducted by the Director of Nursing and the Staff Development Coordinator. Performance evaluations are to be conducted annually to ensure Certified Nursing Assistants receive twelve (12) hours of in-servicing per year. The performance evaluation will include the completion of a yearly competency review. • An in-service was done with the Director of Nursing on 3/24/21 by the Facility Consultant on the policy and procedure for annual performance evaluations to include review of CNA requirements of 12 hours of in-services per year and annual competency review per the requirements for the Commonwealth of Virginia. An in-service will be done for the SDC on in-service training and completion of competency checklist annually to comply with requirements for the Commonwealth of Virginia, this will be completed by 4/2/21 by the Director of Nursing. • The Administrator will audit 5 clinical staff performance evaluations completed by the DON to include 4 CNA files for completion to include in-servicing and competency 1-time weekly x 4 weeks. If any areas of concern are identified the Administrator will make the DON aware immediately for correction. • The audit findings will be reviewed in the monthly QAPI committee meeting x 1 month.	04/12/21

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F 730	Continued From page 79 gotten a list a week or two ago from human resources as to who needed annual performance reviews and was going to start them but hasn't gotten to them. When asked when she started as the DON, ASM #2 stated February 1, 2021. When asked why they had not been completed prior to now, ASM #2 stated due to the turnover of the DON position and the pandemic. A request was made on 3/11/2021 at 2:21 p.m. for a policy and procedure on annual performance reviews. An email dated 3/12/2021 at 10.40 a.m. documented they did not have a policy on annual performance reviews. ASM #2 was made aware of the above findings on 3/10/2021 at 1:15 p.m. ASM #1, the administrator, was made aware of the above concern on 3/12/2021 at 9:48 a.m. No further information was provided prior to exit.	F 730		
F 761 SS=D	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	F 761	F 761 • The expired medications and medical supply item was Immediately removed from the A/B med room (2 vials of sterile water, Bottle of ASA, & female catheter kit), they were disposed of per Pharmacy policy and procedure manual. The expired Eye drops from Med Cart-300 Hall were removed immediately and disposed of per the Pharmacy policy and procedure manual on 3/11/12 by the Director of Nursing. • An audit was conducted of the medication carts and medication rooms on 3/11/12 by the Director of Nursing and the Facility Consultant. Any areas of concern identified were corrected immediately. • The nurses will be in-serviced on 3/29/21 by the Director of Nursing on Pharmacy policy and procedure for expired medication and medical supplies. The 11-7	

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F 761	Continued From page 80 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 and staff interview it was determined that the facility staff failed to ensure expired medications and medical supplies were not available for use in one of one medication rooms observed, (the B/A medication storage room) and in one of one medication carts observed, (300 Hall medication cart). The findings include: On 03/09/21 at approximately 3:10 p.m., an observation of the B/A medication storage room was conducted in the presence of ASM [administrative staff member] # 2, director of nursing. Observation of the inside of a wall cabinet on the far right wall when entering the room, revealed two 10 mL [milliliter] vials of sterile water [1] located on the top shelf of a cabinet. The two 10 mL vials of sterile water were labeled with an expiration date of 03/01/2021, and were available for use. Observation of a wall cabinet directly to the right of the of the medication storage room door when entering the room revealed one full, unopened bottle of Aspirin [2], 325 mg [milligrams], 100	F 761	continued from page 80 shift nurse will review the facility medication carts and medication rooms for any expired medication and medical supplies nightly, any medication or medical supply found to be expired will be removed from use, the DON will be notified, and the item will be disposed of per the Pharmacy policy and procedure manual. • The 11-7 shift nurse will complete the checklist review from the medication charts and medication rooms and turn into the DON daily. The DON or designee will audit the medication carts and medication rooms 1-time weekly x 4 weeks. • The audit findings will be reviewed in the monthly QAPI committee meeting x 1 month.	04/12/21

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F 761	Continued From page 81 count tablets with an expired date of February 2021, available for use. Observation of a shelf on the back wall of the medication storage room of revealed one "Female Cath [catheter] Kit With Gloves and Swabs" with an expired date of "2021-01-31 [January 31, 2021]", available for use. On 03/09/2021 at approximately 3:30 p.m., an interview with ASM # 2 was conducted regarding the above items found in the medication room. ASM # 2 stated that the above items should have been removed. On 03/10/21 at approximately 8:11 A.m., an observation of the facility's 300 Hall medication cart was conducted with LPN (licensed practical nurse) # 1. Observation of the medication cart drawer labeled "Eye Drops" revealed the following: one 2.5 ml eye drop bottle of Xalatan available for use. Observation of the bottle documented an open date of 1/24/20. Further observation of the bottle documented, "Expires 6 weeks after opening." An interview was conducted with LPN # 1 at this time. LPN #1 agreed that the eye drops were expired and should have been removed from the medication cart. On 03/10/2021 at approximately 8:25 a.m., an interview was conducted with ASM # 2, director of nursing. After examining the bottle of Xalatan, ASM # 2 stated that the bottle was approximately half full. When asked to describe the procedure staff follows to make sure expired medications are not available for use ASM # 2 stated, "The third shift nurses are to go through the med [medication] carts and the medication rooms	F 761		

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F 761	Continued From page 82 every day and remove any expired medication. They use a checklist to mark off what expired. If a nurse sees an expired medication in their cart they should remove it too." On 03/10/2021 at approximately 10:00 a.m. ASM (administrative staff member) # 1, the administrator, and SAM # 2; director of nursing were made aware of the findings. No further information was provided prior to exit. References: [1] Free from germs. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000119.htm. [2] Nonprescription aspirin is used to reduce fever and to relieve mild to moderate pain from headaches, menstrual periods, arthritis, colds, toothaches, and muscle aches. Nonprescription aspirin is also used to prevent heart attacks in people who have had a heart attack in the past or who have angina, reduce the risk of death in people who are experiencing or who have recently experienced a heart attack, prevent ischemic strokes, mini-strokes, prevent hemorrhagic strokes It works by stopping the production of certain natural substances that cause fever, pain, swelling, and blood clots. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682878.html. [3] Also known as Latanoprost. Used to treat glaucoma. Latanoprost comes as eye drops. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a697003.h	F 761		

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F 761	Continued From page 83 tml	F 761		
F 812 SS=D	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 by: Based on observation and staff interview it was determined facility staff failed to serve food in a sanitary manner. The findings include: On 03/09/20 at 12:00 p.m., an observation of the facility's kitchen was conducted during the plating of resident's lunch trays. Observation of the ceiling above the right end of the steam table when standing behind the steam table, revealed a five blade ceiling fan mounted	F 812	F-812 The Ceiling fan was removed from the kitchen during the survey and was replaced by a covered light fixture by the Maintenance Director. An audit was completed on 3-12-21 by the Administrator of all other kitchen ceiling fans. There were no other ceiling fans or portable fans in the kitchen area. An in-service was completed with the kitchen staff on 3/12/21 by Food Service Manager regarding serving food in a sanitary manner. The Administrator will audit the kitchen during a meal service to ensure food is served in a sanitary manner weekly x 4 weeks then monthly x 1 month utilizing a kitchen audit tool. Results of the kitchen audit tools will be reviewed by the QA/PI Committee at its monthly meeting to ensure continued compliance monthly x 1 month.	04/12/21 04/12/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495226	A. BUILDING _____ B. WING _____	03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAYLAND NURSING AND REHABILITATION CENTER	730 LUNENBURG HIGHW KEYSVILLE, VA 23947

(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 84 on the ceiling, operational, [turning] during the plating of resident's food. After all the resident's food was plated at approximately 12:30 p.m., the OSM #1, the cook was asked to turn off the ceiling fan above the right end of the steam table. Observation of the fan blades and motor housing with OSM # 1, revealed that they had a coating of dust on them. In an interview with OSM # 1 they agreed with the findings that the fan blades and motor housing were coated in dust. OSM # 1 stated, "I should've turned it off before I started to serve. Usually I turn the fan off when serving the trays." When asked why it gets turned off OSM # 1 stated, "So the food doesn't cool down and not blow any dust. On 03/10/2021 at approximately 10:00 a.m., ASM [administrative staff member] # 1, the administrator, ASM # 2, director of nursing, were made aware of the findings. No further information was provided prior to exit.	F 812		
F 909 SS=E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it	F 909	F-909 Bed side rail safety assessments were completed for resident #21, #10, #2 and #32 on 3/26/2521 by DON Safety assessments were completed on all other residents with bed rails on DON or designee by 4/8/21. The Administrator completed an in-service with the maintenance director on 3/18/21 regarding completing bed rail assessments. The Maintenance Director will complete bed rail assessments for all residents with bed rails weekly x 4 weeks utilizing a bedrail safety inspection audit tool. Results of the bed rail inspection audit tools will be reviewed by the QA/PI Committee at its monthly meeting to ensure continued compliance monthly x 1 month. Date of Compliance April 12,2021.	04/12/21

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F 909	Continued From page 85 was determined that the facility staff failed to evidence documentation of current bed/side rail safety assessments for four of 35 residents in the survey sample, Residents #21, #10, #2, and #32. The findings include: 1. Resident #21 was observed lying in bed with side rails up during the course of the survey. The facility failed to evidence a current bed/side rail safety assessment for the resident. Resident #21 was admitted to the facility on 4/4/2020 with diagnoses that included but were not limited to: dementia (a progressive state of mental decline, especially memory function and judgement, often accompanied by disorientation.) (1), and pulmonary fibrosis (an increase in the formation of fibrous connective tissue, either normally as in scar formation, or abnormally to replace normal tissue especially in the lungs) (2). The most recent MDS (minimum data set) assessment, quarterly assessment, with an assessment reference date of 1/11/2021, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating she was severely impaired to make daily cognitive decisions. Resident #21 was coded as requiring extensive assistance for moving in the bed, moving in the room or unit, the resident was coded as only having performed this once or twice during the lookback period with the assistance of one staff member. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. On the following dates and times, Resident #21 was observed lying in bed with both side rails up:	F 909		

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F 909	Continued From page 86 3/09/21 at 3:22 p.m , 3/10/21 at 8:57 a.m., 3/11/21 at 9:46 a.m. A review of Resident #21's comprehensive care plan 4/15/20 revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness, safety in transfer...Assess resident for risk of entrapment from bed rails periodically and as necessary...evaluate use of device periodically for continued effectiveness and appropriateness...use of bedrails to assist resident to increase ability to enter and exit the bed at highest practical mobility level...use of bedrails to assist resident to turn and reposition when in bed." Further review of Resident #21's clinical record failed to reveal evidence of a current bed/side rail safety assessment. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #2 stated, "I don't know there is a process for checking the side rails before they are put up." On 3/11/21 at 12:39 p.m., OSM (other staff member) #9, the maintenance director, was interviewed. When asked about bed and side rail safety inspections, he stated the facility contracts with an outside company to come into the facility and do these inspection. OSM #9 stated that neither he nor ASM #1, the administrator was aware of the name of that contract company, and that there was no way to contact the company before the survey ended.	F 909		

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F 909	Continued From page 87 A review of the facility policy, "Side Rail Guidelines" revealed, in part: "Side rails may be used to enhance resident mobility and transfer to and from the bed, or as a restraining device to keep residents from voluntarily getting out of bed. Use of side rails as a restraint is prohibited unless they are necessary to treat a resident's medical symptoms." The policy did not address the facility's process for bed/side rail safety inspections. No further information was provided prior to exit. REFERENCES (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 227. 2. Resident #10 was observed lying in bed with side rails up during the course of the survey. The facility failed to evidence a current bed/side rail assessment for the resident. Resident #10 was admitted to the facility on 5/4/2016 with diagnoses that included but were not limited to: Alzheimer's disease (a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability.) (1) and Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with	F 909		

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F 909	Continued From page 88 emotional instability) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/21/2020, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #10 was coded as requiring extensive assistance of one staff member for moving in the bed. For moving in the room or unit, the resident was coded as being totally dependent upon one staff member. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. On the following dates and times, Resident #10 was observed lying in bed with both side rails up: 3/9/21 at 3:26 p.m., 3/10/21 at 8:55 a.m., 3/11/21 at 9:48 a.m. A review of Resident #10's comprehensive care plan, dated 10/24/18 and revised on 11/11/20, revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness, Parkinson's Disease...Check bed rails periodically for proper functioning...evaluate use of device periodically for continued effectiveness and appropriateness...use of bedrails to assist resident to increase ability to enter and exit the bed at highest practical mobility level." Further review of Resident #10's clinical record failed to reveal evidence of a current bed/side rail safety assessment. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the	F 909		

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F 909	Continued From page 89 director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #2 stated, "I don't know there is a process for checking the side rails before they are put up." On 3/11/21 at 12:39 p.m., OSM (other staff member) #9, the maintenance director, was interviewed. When asked about bed and side rail safety inspections, he stated the facility contracts with an outside company to come into the facility and do these inspection. OSM #9 stated that neither he nor ASM #1, the administrator was aware of the name of that contract company, and that there was no way to contact the company before the survey ended. No further information was provided prior to exit. REFERENCES (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 26. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. 3. Resident #2 was observed lying in bed with side rails up during the course of the survey. The facility failed to produce a current bed/side rail assessment for the resident. Resident #2 was admitted to the facility 5/17/2015 and was recently readmitted on 2/23/2021 with diagnoses that included but were not limited to: dementia (a progressive state of mental decline, especially memory function and judgement, often	F 909		

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F 909	Continued From page 90 accompanied by disorientation.)(1), high blood pressure and schizophrenia (Any of a group of mental disorders characterized by gross distortions of reality, withdrawal of thought, language, perception and emotional response) (2). The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/2/2021, coded the resident as having no difficulty with short or long-term memory difficulties. The resident was coded as requiring extensive assistance of one staff member for moving in the bed. Resident #2 required limited assistance of one staff member for moving in their room or unit. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. On the following dates and times, Resident #2 was observed lying in bed with both side rails up: 3/9/21 at 11:16 a.m., 3/10/21 at 9:03 a.m. A review of Resident #2's comprehensive care plan dated 10/24/18 revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Safety in transfers...Assess resident for risk of entrapment from bed rails periodically and as necessary...Check bed rails periodically for proper functioning...evaluate use of device periodically for continued effectiveness and appropriateness...use of bedrails to assist resident to increase ability to enter and exit the bed independently." Further review of Resident #2's clinical record failed to reveal evidence of a current bed/side rail safety assessment.	F 909		

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F 909	Continued From page 91 On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #2 stated, "I don't know there is a process for checking the side rails before they are put up." On 3/11/21 at 12:39 p.m., OSM (other staff member) #9, the maintenance director, was interviewed. When asked about bed and side rail safety inspections, he stated the facility contracts with an outside company to come into the facility and do these inspection. OSM #9 stated that neither he nor ASM #1, the administrator was aware of the name of that contract company, and that there was no way to contact the company before the survey ended. No further information was provided prior to exit. REFERENCES (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 522. 4. Resident #32 was observed lying in bed with side rails up during the course of the survey. The facility failed to produce a current bed/side rail assessment for the resident. Resident #32 was admitted to the facility on 1/17/2015 with diagnoses that included but were	F 909		

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F 909	Continued From page 92 not limited to: Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability) (1), congestive heart failure (abnormal condition characterized by circulatory congestion and retention of salt and water by the kidneys) (2) and bipolar disorder (a mental disorder characterized by episodes of mania and depression) (3). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/20/2021, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring limited assistance of one staff member for moving in the bed. Resident #32 was coded as requiring supervision with set up assistance for moving in their room or unit. In Section G0600 - Mobility Devices, the resident was coded as using a wheelchair. On the following dates and times, Resident #32 was observed lying in bed with both side rails up: 3/9/21 at 11:27 a.m., 3/11/21 at 8:52 a.m. A review of Resident #32's comprehensive care plan, dated 12/29/17 and updated 12/14/20, revealed, in part: "Use of bed rails for increasing or maintaining current bed mobility or transfer ability. Muscle weakness. Safety in transfers. Other: maintain independence with bed mobility...Assess resident for risk of entrapment from bed rails periodically and as necessary...Check bed rails periodically for proper functioning...evaluate use of device	F 909		

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F 909	Continued From page 93 periodically for continued effectiveness and appropriateness...provide and review with resident and/or resident's representative the risks and benefits of the use of side rails." Further review of Resident #32's clinical record failed to reveal evidence of a current bed/side rail safety assessment. On 3/11/21 at 2:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the clinical consultant, and ASM #4, the regional vice-president, were informed of these concerns. ASM #2 stated, "I don't know there is a process for checking the side rails before they are put up." On 3/11/21 at 12:39 p.m., OSM (other staff member) #9, the maintenance director, was interviewed. When asked about bed and side rail safety inspections, he stated the facility contracts with an outside company to come into the facility and do these inspection. OSM #9 stated that neither he nor ASM #1, the administrator was aware of the name of that contract company, and that there was no way to contact the company before the survey ended. No further information was provided prior to exit. REFERENCES (1)Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 138.	F 909		

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F 909	Continued From page 94 (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 72.	F 909		

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	VA0050	A. BUILDING: _____ B. WING _____	03/12/2021

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 3/9/21 through 3/12/21. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 90 certified bed facility was 50 at the time of the survey. The survey sample consisted of 35 Resident reviews.	F 000	Wayland Nursing and Rehabilitation center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with the applicable rules and provisions of quality of care of residents. This Plan of Correction is submitted as a written allegation of compliance. Wayland Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Wayland Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 140 - B, C Based on staff interview and facility document review, it was determined the facility staff failed to review all policy and procedures on an annual basis. The findings include: A request was made by email on 3/10/2021 at 10:02 a.m. for the documented evidence of the annual policy and procedure review. On 3/11/2021 at 1:53 p.m., an email from ASM (administrative staff member) #2, the director of nursing, was received. This email contained a document titled, "QAPI (quality assurance performance improvement) Revision Review." This document failed to evidence an annual policy and procedure review. An interview was conducted with ASM #2, on 3/12/2021 at 9:41 a.m. When asked where the	F 001	• F001- The QAPI team was called together for impromtu meeting on 3/12/21 to review and accept all dept manuals fo the year of 2021. • Adminstrator, DON, Medical Director and Dept Heads met to review and accept current manuals for 2021 and was placed into QAPI. • Yearly reviews will be continued to maintan reviewing the policy manuals and accepting them accordingly. • Will be reviewed in QAPI yearly.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/29/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	Continued From page 1 policy and procedure reviews were, ASM #2 stated they were having a quick QAPI meeting this morning, for emergent things, to review all of the policy and procedures. When asked the last time the policy and procedures were reviewed, ASM #2 stated, "I can't tell you." An interview was conducted with ASM #1, the administrator, on 3/12/2021 at 9:48 a.m. When asked why the annual policy and procedure review was not completed, ASM #1 stated, "It got away from us, especially with the pandemic and the frequent change in the DON (director of nursing) position. ASM #1 made aware of the above concern on 3/12/2021 at approximately 10:00 a.m. An email request was made on 3/12/2021 at 10:26 a.m. to ASM #1 and ASM #2 for a policy related to the annual policy and procedure review. On 3/12/2021 at 10:42 a.m. ASM #2 responded and stated she could not locate a policy. No further information was provided prior to exit. 12 VAC 5 - 371 - 150 A - cross references to Federal Deficiency F 600 12 VAC 5 - 371 - 150 - cross references to Federal Deficiency F 623 and F 625 12 VAC 5 - 371 - 250 A - cross references to Federal Deficiency F 641 12 VAC 5 - 371 - 250 F - cross references to Federal Deficiency F 656 and F 657 12 VAC 5 - 371 - 220 A - cross references to Federal Deficiency F 698	F 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0050	A. BUILDING _____ B. WING _____	03/12/2021

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F 001	Continued From page 2 12 VAC 5 - 371 - 220 B - cross references to Federal Deficiency F 695 12 VAC 5 - 371 - 330 A - cross references to Federal Deficiency F 700 12 VAC 5 - 371 - 200 B. 3 - cross references to Federal Deficiency F 730 12 VAC 5 - 371 - 300 B - cross references to Federal Deficiency F 761 12 VAC 5 - 371 - 340 - cross references to Federal Deficiency F 812 12 VAC 5 - 371 - 370 G - cross references to Federal Deficiency F 909 12VAC5-371-140. Policies and Procedures: Staff Licenses. See below citation Based on staff interview and facility document review, it was determined that the facility staff failed to evidence verification of a current license or certificate or perform reference checks in accordance with the laws of the State of Virginia, for four of 25 employee records reviewed, (LPN (licensed practical nurse) #3, LPN #5, CNA (certified nursing assistant) #6 and CNA #7). The findings included: On 3/11/21 at approximately 8:00 AM, the employee records for newly hired employees within the past two years were reviewed. Review of the employee records failed to produce evidence of license verifications or reference	F 001	F001- • The files for LPN #3, LPN #5, CNA#6, and #7 were updated. • License verification for staff will occur upon employment and annually there after • License renewal data will be added to the facility's Employee Maintenence Update Program to indicate when license is due. • Evaluations and skills checklists will be entered into employee folders at the time of renewal.	04/12/21

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F 001	Continued From page 3 checks on file for four staff members. The employees identified were: LPN (licensed practical nurse) #3's employee record was reviewed. LPN #3's employee record documented they were hired as an LPN with the facility on 10/21/20. Further review of LPN #3's employee record failed to evidence primary source license verification from the Virginia Department of Health Professionals. The nursing license for LPN #3 in the employee file expired 12/31/20. LPN #5's employee record was reviewed. LPN #5's employee record documented they were hired as an LPN with the facility on 3/24/20. Further review of LPN #5's employee record failed to evidence primary source license verification from the Virginia Department of Health Professionals. The nursing license for LPN #5 in the employee file expired 3/17/20. CNA (certified nursing assistant) #6's employee record was reviewed. CNA #6's employee record documented they were hired as a CNA with the facility on 1/23/20. Further review of CNA #6's employee record failed to evidence primary source license verification from the Virginia Department of Health Professionals. The CNA license in the employee file expired 1/31/20 and CNA #6 was terminated from facility on 2/27/20. CNA #7's employee record was reviewed. CNA #7's employee record documented they were hired as a CNA with the facility on 4/16/19. Further review of CNA #7's employee record failed to evidence primary source license verification from the Virginia Department of Health Professionals. The CNA license in the	F 001		

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F 001	Continued From page 4 employee file expired 3/31/20 and CNA #7 was terminated from facility on 7/22/20 An interview was conducted on 3/11/21 at 9:02 AM with OSM (other staff member) #7, the HR (human resources) coordinator. When asked who is responsible for license primary source verification, OSM #7 stated, "I only pull the original licenses after that the SDC (staff development coordinator) makes sure the licenses are current." An interview was conducted on 3/11/21 at 9:48 AM with ASM (administrative staff member) #2, the director of nursing. When asked to speak with the staff development coordinator (SDC), ASM #2 stated, "The SDC is on family medical leave and has not been here since November I believe." When shown that the license PSV (primary source verification) for LPN #3 had a print date of 3/11/21 at 9:10 AM, ASM #2 stated, "I knew he renewed it and I checked it on line but I didn't print the copy to put in the book. I was trying to correct that before I brought the documents to you. I was the clinical coordinator at the time I looked at this." When asked if the clinical coordinator role was similar to the ADON (assistant director of nursing), ASM #2 stated, "Yes, here the ADON and clinical coordinator are the same." An interview was conducted on 3/11/21 at 10:26 AM with ASM #2, the director of nursing. When asked to validate that LPN #5 had a name change and were the same person, ASM #2 stated, "Yes, they are the same person". On 3/11/21 at 10:35 AM, ASM #3, the clinical consultant brought a license PSV printed for LPN #5 at 10:30 am on 3/11/21, with expiration date of 11/30/21.	F 001		

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F 001	Continued From page 5 On 3/12/21 at 11:50 AM during the exit conference with ASM #4, the regional vice president ASM #4 asked, "They were working without a license? ASM #2, the director or nursing stated they had a current license but the facility did not have a copy of this". ASM #4, was asked how the facility is verifying that the licenses are current if they do not have license primary source verification? ASM #4 state, "I guess we weren't". The facility's policy "Validation of Nursing License" dated 1/12/2016, documented in part, "All licenses are validated with the board of nursing at the time of hire and at time of each renewal. All nursing assistants will provide their social security number for verification with the Virginia board of nursing". The state regulation 12VAC5-371-140 documented "E. Personnel policies and procedures shall include, but are not limited to: 3. An accurate and complete personnel record for each employee including: a. Verification of current professional license, registration, or certificate or completion of a required approved training course; b. Criminal record check; c. Verification that the employee has reviewed or received a copy of the job description ..." On 3/11/21 at approximately 11:50 AM, ASM #1, the administrator was made aware of the findings. No further information was provided prior to exit.	F 001		