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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 4/13/21 through 4/16/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take action set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/13/2021 through 04/16/2021. Two complaints [VA00050237- unsubstantiated with no deficiency and VA00051026- substantiated with deficiency] were investigated during the survey. 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 177 certified bed facility was 92 at the time of the survey. The survey sample consisted of 24 current resident reviews and 5 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550	1.) One to one re- education on serving meals in a manner to promote dignity was provided to the CNA. Current residents who reside at the facility are at risk to be affected by this practice. 2.) CNA's will be educated on serving meals in a manner to promote dignity. 3.)Walking rounds audit will be accomplished weekly x 3 months by the Director of Nursing/Designee to ensure meals are being served in a manner to promote dignity. 4.)Audit findings will be submitted monthly to the QAPI committee for review and recommendations. 5.) Compliance Date: 5/18/2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: [handwritten] (X6) DATE: 4/30/2021

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

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F 550	Continued From page 1 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to serve lunch in a manner to promote resident dignity for one of 24 current residents in the survey sample, (Resident # 9). CNA [certified nursing assistant] # 3 was observed standing next to the bed while feeding Resident # 9 the lunch meal. The findings include:	F 550	3. CNA's will be educated on serving meals in a manner to promote dignity. 4. Walking rounds audit will be accomplished weekly x3 months by the Director of Nursing/ Designee to ensure meals are being served in a manner to promote dignity. Audit findings will be submitted monthly to the QAPI committee for review and recommendations. 5.) Compliance Date: 5/18/2021	

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F 550	Continued From page 2 Resident # 9 was admitted to the facility with diagnoses that included but were not limited to: stroke and swallowing difficulties. Resident # 9's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/17/2021, coded Resident # 9 as scoring a 3 (three) on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 - being severely impaired of cognition for making daily decisions. Resident # 9 was coded as requiring extensive assistance of one staff member for eating. On 04/13/21, an observation of lunch meals being delivered to resident room revealed Resident # 9 received their lunch tray at 1:10 p.m. and placed on a small three drawer dresser across from the foot of their bed. At 1:41 p.m., another observation of Resident # 9's room revealed their lunch tray in the same place. Further observation revealed that none of the food containers had been opened. During this observation, Resident # 9's roommate, Resident # 59 stated, "They [staff] haven't come in to give him [Resident # 9] his meal yet." Further observation of Resident # 59 revealed that they had eaten their meal as evidenced by the empty food containers on their over-the-bed-table. Resident # 59's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/05/2021, coded Resident # 59 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. On 04/13/21 at 1:42 p.m., CNA [certified nursing	F 550		

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F 550	Continued From page 3 assistant] # 3 entered Resident # 9's room, repositioned them upright in their bed and at 1:43 p.m. opened the food container started feeding Resident # 9 while standing next to the bed. On 04/13/21 at 2:30 p.m., an interview was conducted with CNA # 3. When asked to describe their procedure staff follow when feeding a resident their meal CNA # 3 stated, "Sitting in a chair next to the bed facing the resident." When asked if it was dignified to stand and feed a resident CNA # 3 stated no. After informed of the above observation CNA # 3 was asked if was dignified to feed someone while standing. CNA # 3 stated no. On 04/13/2021 at approximately 11:15 a.m., the entrance conference for the survey was conducted with ASM [administrative staff member] # 1, administrator and ASM # 2, the director of nursing. When asked what standards of practice the nursing staff follow ASM # 1 and ASM # 2 stated that they follow Lippincott. On 04/14/2021 at approximately 4:30 p.m., ASM # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 550		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658	F658 1.)One on one re-education was provided to the nurse who failed to administer a generic Symbacort inhaler per the manufacturer's instructions. 2.)Current residents who reside at the facility are at risk to be affected by this practice. 3.)The re-education to the nursing staff on administering inhalers per the manufacturer's instructions will be provided by the DON/Designee	

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F 658	Continued From page 4	F 658	4.) A weekly audit will be conducted by the DON/Designee for compliance in administering inhalers per the manufacturer's instructions. The audit findings will be submitted monthly by the Director of Nursing to QAPI for review and recommendations. 5.) Compliance Date: 5/18/2021	

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview and facility document review it was determined the facility staff failed to ensure services provided or arranged by the facility were in accordance with professional standards of quality for one of five residents in the medication administration observation, (Residents #52). The facility staff failed to administer a generic Symbacort inhaler per the manufacturer's instructions for Resident #52.

The findings include:

Resident #52 was admitted to the facility on 3/20/2021 with diagnoses that included COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (1), high blood pressure and GERD (gastroesophageal reflux disease - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn). (2)

The most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/25/2021, coded the resident as scoring a "11" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make cognitive daily decisions. The resident was coded as requiring extensive assistance for most of her activities of daily living except eating in which she required supervision after set up assistance was

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F 658 Continued From page 5 F 658

provided.

Observation was made of LPN (licensed practical nurse) #6 administering medications to Resident #52 on 4/13/2021 at 4:19 p.m. LPN #6 administered the following medications:
Metformin 850 mg (milligrams) 1 tablet (used to treat diabetes*)
Carvedukik 3.125 mg 1 tablet (used to treat high blood pressure and heart failure*)
Eliquis 5 mg 1 tablet (used to treat and prevent blood clots*)
Entresto 49 - 51 mg 1 tablet (used to treat heart failure*)
Gabapentin 300 mg 1 capsule (treats seizures and nerve pain*)
Famotidine 10 mg 1 tablet (used to treat ulcers and GERD*)
Vitamin C 250 mg 2 tablets (supplement*)
Budesonide and Formoterol Fumarate Dihydrate Inhalant Aerosol (generic Symbacort) (used to treat asthma and COPD*)
Acetaminophen 325 mg - 2 tablets for a complaint of head pain with a pain level of 5 (used to treat pain or fever*)

LPN #6 brought all of the medications to Resident #52's room. She gave Resident #52 the Budesonide and Formoterol Fumarate Dihydrate Inhalant to use. Resident #52 shook the inhaler several times and administered one dose, shook it again after waiting five seconds and administered another dose. LPN #6 then gave Resident #52 a cup of water and the cup containing the above prepared medications. LPN #6 never instructed the resident to rinse her mouth. The resident proceeded to take her pills and drink all of the water.

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F 658	Continued From page 6 Review of the clinical record documented a physician order dated 3/30/2021, "Budesonide and Formoterol Fumarate Dihydrate Inhalant Aerosol 160 - 4.5 mcg/act (micrograms per activation) 2 puff inhale orally two times a day related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) EXACERBATION." An interview was conducted with LPN #6 on 4/14/2021 at 3:16 p.m. LPN #6 was asked if there were any special manufacturer's instructions related to the inhaler she gave Resident #52 on 4/13/2021. LPN #6 stated she should check the resident for shortness of breath. When asked if the resident should rinse her mouth after receiving that inhaler, LPN #6 stated not that she was aware of. At this time the package insert for the inhaler was reviewed with LPN #6 regarding rinsing the mouth after the administration of the inhaler and documented in part, "Patient Counseling Information: Rinsing the mouth without swallowing after inhalation is advised to reduce the risk of thrush." LPN #6 stated she had never heard of that before. The facility drug reference book, "Long Term Care Nursing Drug Handbook" provided by their contracted pharmacy, on page 232, documented in part the following for the physician prescribed Budesonide and Formoterol Fumarate Dihydrate Inhalant Aerosol 160 - 4.5 mcg/act inhaler: "Administration: After use of the inhaler, patient should rinse mouth/oropharynx with water and spit out rinse solution." Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above	F 658		

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F 658	Continued From page 7 information on 4/14/2021 at 4:30 p.m. No further information was provided prior to exit References: * All drug information was obtained from the following website: https://www.medlineplus.gov/ (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 243. (3) Thrush- is a yeast like fungus that may infect the mouth [thrush], skin [diaper rash], or intestines. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 99.	F 658		
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 observations, staff interview, and facility document review, it was determined that the facility staff failed to provide oxygen therapy in a sanitary manner for one of 24 residents, (Resident #46). Resident #46's nasal cannula	F 695	F695 1.) The oxygen tank was removed from the room and the oxygen tubing was discarded. 2.) Current residents who use oxygen are at risk to be affected by this practice. An Audit was conducted by the DON/Designee to ensure oxygen therapy is provided in a sanitary manner. 3.) Staff re-education was provided on providing oxygen therapy in a sanitary manner. 4.) An audit will be accomplished by the Care Keepers 5x per week to ensure oxygen therapy is provided in a sanitary manner. The audit findings will be submitted monthly by the DON/Designee to QAPI for review and recommendation. 5.) Compliance Date: 5/18/2021	

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F 695	Continued From page 8	F 695		

oxygen tubing was observed wrapped around the oxygen tank with the nasal cannula portion on the floor.

The findings include:

The facility staff failed to provide oxygen therapy in a sanitary manner for Resident #46. On 4/13/21 at 12:24 PM during initial resident observation and on 4/13/21 at 1:07 PM, Resident #46's nasal cannula oxygen tubing was observed wrapped around the oxygen tank with the nasal cannula portion on the floor.

Resident #46 was admitted to the facility on 2/17/20 with diagnoses that include but are not limited to:
Chronic obstructive pulmonary disease (chronic, non-reversible lung disease) (1), dementia (progressive state of mental decline) (2) and COVID-19 (coronavirus pandemic 2019). (3)

Resident #46's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 2/23/21, coded the resident as scoring 99 out of 15 on the BIMS (brief interview for mental status score), indicating the resident was unable to complete the interview. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, toileting, locomotion in room, bathing and personal hygiene; limited assistance with eating and walking did not occur.

A review of Resident #46's physician's orders dated 3/17/21, documented in part, "Oxygen at 2 liters per minute via nasal cannula for oxygen saturation rates below 93%."

F 695 | F 695

Continued From page 9

A review of the oxygen saturation rates, for Resident #46, revealed the following documented in part, "Oxygen saturation below 93% on 3/17/21 at 2:01 AM, 9:55 AM, 5:01 PM and 11:18 PM. Oxygen saturation below 93% on 3/18/21 at 6:24 AM and 11:51 PM."

A review of the nurse's progress note dated 3/17/21 at 7:11 AM, documented in part, "Resident's oxygen saturation was averaging at 85% in the middle of the night. Oxygen was provided via nasal cannula at 2 liters per minute. Will continue to monitor."

Resident #46's comprehensive care plan dated 2/12/20 with revision date of 3/10/21, documented in part, "Focus: I have an alteration in respiratory status due to chronic obstructive pulmonary disease. Interventions: Administer oxygen as needed per physician order. Monitor oxygen saturations on room air and/or oxygen."

On 4/13/21 at 1:07 PM, LPN (licensed practical nurse) #3 was informed of the observations of Resident #46's oxygen cannula on floor. LPN #3 stated, "The oxygen tubing should be stored in a plastic bag when not in use and the tubing is changed weekly. If the resident is not using the oxygen currently, we do not leave the tanks in the room. I'll remove the tank as soon as I check her order".

On 4/13/21 at 2:15 PM, observation revealed the oxygen tank had been removed from Resident #46's room.

On 4/13/21 at 5:01 PM, ASM (administrative staff member) #1, the administrator, and ASM #2 the director of nursing were informed of the finding.

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F 695	Continued From page 10 No further information was provided prior to exit. A review of the facility's "Oxygen administration" information provided failed specify anything regarding nasal cannula storage. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 120. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 154. (3) This information was obtained from the website: www.CDC.gov.	F 695		
F 730 SS=E	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). This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review it was determined that the facility staff failed to ensure that received annual performance reviews for 10 of 10 CNA [certified nursing assistant] records reviewed. The findings include: On 03/14/2021 a record review was conducted of the annual performance reviews of 10 CNAs.	F 730	F730 1.) The 10 CNAs identified received an annual performance evaluation. 2.) An audit was completed for facility CNA staff to ensure annual performance evaluations were completed. 3.) Re-education was provided to the Human Resources Director on the requirements of annual performance evaluations by Administrator/Designee. 4.) An audit will be completed by the Administrator/Designee monthly x three months on newly hired CNA staff to ensure ongoing compliance with performance evaluations. The findings of the audit will be submitted by the Administrator/Designee to QAPI for review and recommendation. 5.) Compliance Date: 5/18/2021	

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F 730	Continued From page 11	F 730		

This review failed to evidence the annual performance reviews for the following CNAs:

1. CNA # 1, with a hire date of 12/16/2016, had no evidence of a performance review being completed between 12/16/2019 and 12/16/2020.
2. CNA # 4, with a hire date 01/25/2019, had no evidence of a performance review being completed between 01/25/2020 and 01/25/2021.
3. CNA # 5, with a hire date 12/16/2016, had no evidence of a performance review being completed between 12/16/2019 and 12/16/2020.
4. CNA # 6, with a hire date 12/05/2018, had no evidence of a performance review being completed between 12/05/2019 and 12/05/2020.
5. CNA # 7, with a hire date 12/16/2016, had no evidence of a performance review being completed between 12/16/2019 and 12/16/2020.
6. CNA # 8, with a hire date 02/21/2019, had no evidence of a performance review being completed between 02/21/2019 and 02/21/2020.
7. CNA # 9, with a hire date 03/07/2018, had no evidence of a performance review being completed between 03/07/2020 and 03/07/2021.
8. CNA # 10, with a hire date 12/19/2018, had no evidence of a performance review being completed between 12/19/2019 and 12/19/2020.
9. CNA # 11, with a hire date 04/25/2018, had no evidence of a performance review being completed between 04/25/2019 and 04/25/2020.
10. CNA # 12, with a hire date 11/22/2019, no evidence of a performance review being completed between 11/22/2019 and 11/22/2020.

On 04/15/2021 at 4:54 p.m., a telephone interview was conducted with ASM (Administrative Staff Member) # 1, the administrator. When asked about the missing performance evaluations for the CNAs listed

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F 730	Continued From page 12 above, ASM # 1 stated that they were unable to locate them. ASM # 1 further stated that during the past year the facility has had a frequent turnover of administrative staff and that the performance reviews could have been misplaced. On 04/15/2021 at approximately 5:05 p.m., ASM #1, administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided	F 730		
F 732 SS=D	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732	F732 1.) The daily nurse staffing information was immediately posted. 2.) An audit was completed to ensure daily nurse staffing posting. 3.) Re-education was provided to the scheduler on the requirements for daily nurse staffing posting. 4.) An daily audit will be conducted by the DON/ Designee daily by the DON/Designee to ensure ongoing compliance with the daily nurse staffing posting. The findings of the audits will be submitted by the Administrator/Designee to QAPI for review and recommendations. 5.) Compliance Date: 5/18/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 732	Continued From page 13	F 732		

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, it was determined that the facility staff failed to post daily nurse staffing information.

On 04/13/2021 the facility staff failed to post the daily nurse staffing information.

The findings include:

On 04/13/2021 observations in the facility's lobby at 10:45 a.m. and 3:55 p.m., on the West 1 Unit at 3:56 p.m., on the West 2 Unit at 4:00 p.m. and on the Memory Care Unit at 3:57 p.m., failed to evidence of the daily nurse staffing information.

On 04/14/21 at 10:43 a.m., an interview was conducted with CNA (certified nursing assistant) # 2 (the person responsible for posting the daily nurse staffing information). CNA # 2 was asked the process for posting the nurse staffing information. CNA #2 stated they give the staffing for that day to the facility's receptionist every morning either before or after their morning meeting at approximately 9:00 a.m.

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F 732	Continued From page 14 On 04/14/21 at approximately 11:02 a.m. an interview was conducted with OSM [other staff member] # 8, the facility's receptionist. When asked about the posting of the daily nurse staffing, OSM # 8 stated that they were responsible for posting the nurse staffing every morning about 9:00 a.m. When asked about posting of the nurse staffing for 04/13/2021, OSM # 8 stated, "I forgot to put it out." On 04/13/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 732		
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 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	F 761	F761 1.) The open bottles of multidose of flu or Alfuria Quadrivalent Influenza Vaccine and a vial of Tuberculin Purified Protein Derivate in the Wing 2 medication refrigerator were discarded. 2.)An Audit was conducted by the DON/Designee of medication refrigerators to ensure medications are labeled and stored in accordance to professional standards. 3.) LPN/RN staff members were re-educated on the importance of medication being labeled and stored in accordance to professional standards. 4.) A weekly audit will be conducted by the DON/ Designee for 3 months to ensure ongoing compliance with labeling ans storing medications to professional standards. The audit will be submitted by the DON/ Designee to QAPI monthly for review and recommendations. 5.) Compliance: 5/18/2021	

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F 761	Continued From page 15	F 761		

the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility document review, it was determined that the facility staff failed to label and store medications according to professional standards in one of three observed medication room refrigerators, (Wing 2 West medication refrigerator).

The facility staff failed to label an open date on a opened multidose vial of Afluria Quadrivalent Influenza Vaccine and failed to label an open date on a opened multidose vial of Tuberculin Purified Protein Derivative, in the Wing 2 West medication refrigerator.

The finding include:

Observation was made of the West 2 medication room on 4/14/2021 at 3:31 p.m. accompanied by LPN (licensed practical nurse) #3. A vial of Afluria Quadrivalent Influenza Vaccine (used for the prevention of influenza*) was found in the refrigerator. The vial had been opened. Observation of the vial and the box, it was contained in, failed to reveal any documentation of a date indicating when the vial was opened. When asked about the process staff follows for opening a multi-dose vial, LPN #3 stated when a nurse opens the vial they are to date it.

The package insert in the Influenza Vaccine box documented, "Once the stopper of the multi-dose

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ____ B. WING ____	C 04/16/2021

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F 761	Continued From page 16	F 761		

vial has been pierced, the vial must be discarded within 28 days."

A second multi-dose vial of Tuberculin Purified Protein Derivative 5TU. 0.1 ml (milliliter) (used to test for tuberculosis*) was found in the refrigerator. It was opened, and no date was observed documented on the vial or on the box, it was contained in. The side of the box documented, "Once entered vial should be discarded after 30 days."

The facility policy, "Injectable Vials and Ampules" documented in part, "3. The date opened and the initials of the first person to use the vail are recorded on multi-dose vials (on the vial label or an accessory label affixed for that purpose)...9. Discard multi-dose vials when empty, when suspected or visible contamination occurs or when the manufacturer's stated expiration date is reached, provided the manufacturer's storage condition have been maintained. Expiration dating not specifically referenced in the manufacturer's package insert should not exceed 28 days once the vial has been opened... 11. The nursing staff is responsible for reviewing the dates of opened vials and removal of expired items."

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 4/14/2021 at 4:30 p.m.

No further information was provided prior to exit.

References:
* All drug information was obtained from the following website: https://www.medlineplus.gov/

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F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to serve for the lunch meal at a palatable temperature for one of 24 current residents in the survey sample, (Resident # 9). Resident # 9's lunch sat in their room for thirty-three minutes and was not reheated by staff before the meal was fed to the resident. OSM [other staff member] # 6, regional director for dietary services stated that the resident's (Resident #9's) food would have been cold. The findings include: Resident # 9 was admitted to the facility with diagnoses that included but were not limited to: stroke and swallowing difficulties. Resident # 9's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/17/2021, coded Resident # 9 as scoring a 3 [three] on the brief interview for mental status (BIMS) of a score of 0 - 15, 3 - being severely impaired of cognition for making daily decisions. Resident # 9 was	F 804	F804 1.) One on one re-education was provided to the CNA who failed to serve the lunch meal at a palatable temperature. 2.) Current residents who reside at this facility are at risk to be affected by this practice. 3.) Re-education was provided to the CNA's on serving meals at a palatable temperature. 4.) A weekly audit will be conducted by the DON/Designee for 3 months to ensure ongoing compliance with this practice. The audit will be submitted by the DON/Designee to QAPI monthly for review and recommendations. 5.) Compliance Date: 5/18/2021	

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F 804	Continued From page 18	F 804		

coded as requiring extensive assistance of one staff member for eating.

On 04/13/21, an observation of lunch meals being delivered to resident room revealed Resident # 9 received their lunch tray at 1:10 p.m. and placed on a small three drawer dresser across from the foot of their bed. At 1:41 p.m., another observation of Resident # 9's room revealed their lunch tray in the same place. Further observation revealed that none of the food containers had been opened. During this observation, Resident # 9's roommate, Resident # 59 stated, "They [staff] haven't come in to give him [Resident # 9] his meal yet." Further observation of Resident # 59 revealed that they had eaten their meal as evidenced by the empty food containers on their over-the-bed-table.

Resident # 59's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/05/2021, coded Resident # 59 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions.

On 04/13/21 at 1:42 p.m., CNA [certified nursing assistant] # 3 entered Resident # 9's room, repositioned them upright in their bed and at 1:43 p.m. opened the food containers on the resident's tray and started feeding Resident # 9 while standing next to the bed.

The above observation revealed that Resident # 9's lunch sat in their room for thirty-three minutes before they were given the opportunity to eat.

On 04/13/21 at 2:30 p.m., an interview was

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	495240	A. BUILDING ______ B. WING ______	C 04/16/2021

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F 804	Continued From page 19 conducted with CNA # 3. When asked how long a resident should have wait to be fed with their meal CNA # 3 stated, "Two to five minutes." When asked why two to five minutes CNA # 3 stated, "The food could get cold." When asked to describe the procedure they follow when a resident's food is cold CNA # 3 stated, "When it gets cold we would warm it up in a microwave." When asked how they test the resident's food if the resident is unable to tell them that their food is not hot enough CNA # 3 stated, "I would put a little bit of food on a gloved hand and see it it is warm or not." CNA # 3 was informed of the above observation CNA # 3 was asked if they tested Resident # 9's food to determine if it was warm or hot. CNA # 3 stated, "No, I should have tested the food On 04/14/21 at 8:41 a.m., an interview was conducted with OSM [other staff member] # 6, regional director for dietary services. When asked how long a resident should have wait to be fed with their meal OSM # 6 stated, "It shouldn't sit at all. It should be brought in the room when the staff are ready to feed the resident." After informed of the above observation OSM # 6 stated that the resident's food would have been cold. When asked how the staff can keep the resident's food warm OSM # 6 stated that they would get back to this surveyor. At 10:17 a.m., OSM # 6 provided this surveyor with an answer. OSM # 6 stated, "The tray should stay on the cart until staff are ready to serve it or feed the resident, that way they ensure the food is keep warm." On 04/14/2021 at approximately 4:30 p.m., ASM # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.	F 804		

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	495240	A. BUILDING ______ B. WING ______	C 04/16/2021

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FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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F 804	Continued From page 20 No further information was provided prior to exit. Complaint Deficiency	F 804		
F 812 SS=E	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 observations, staff interview, and facility document review, it was determined that the facility staff failed to maintain the kitchen in a sanitary manner. The facility staff failed to store food in closed containers during the facility task-kitchen observation on 4/13/21 at 11:10 AM. The findings include:	F 812	F812 1.) The open spices and containers were discarded. 2.) Current residents that reside at this facility are at risk to be affected by this practice. 3.) Re-education was provided to the dietary staff on the proper storing of food in accordance with professional standards for food service safety 4.) A weekly audit will be conducted by the Dietary Manager/Designee for 3 months to ensure ongoing compliance with this practice. The audit will be submitted by the Dietary manager/ Designee to QAPI monthly for review and recommendations. 5.) Compliance Date: 5/18/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 04/16/2021

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F 812	Continued From page 21	F 812		

On 4/13/21 at 11:10 AM, an observation was conducted in the dry storage room of the main kitchen. A 16 ounce coffee creamer with the top opened to air was observed on the fourth shelf of the wire cart next to doorway.

An interview was conducted on 4/13/21 at 11:15 AM, with OSM (other staff member) #6, the regional director of dietary services. When shown the opened top of the coffee creamer, OSM #6 stated, "That should not be opened like that".

In the main kitchen, on metal cart there were two spices / seasoning containers that were open to air: 1-gallon sherry cooking wine with no top and hole punched in seal and ground nutmeg 16 ounces with container top opened to air.

An interview was conducted on 4/13/21 at 11:30 AM, with OSM #6. When shown the open containers of spices, and sherry cooking wine, OSM #6 stated, "These should be disposed of."

The facility's "Labeling and Dating" policy dated 2017, documents "Proper labeling and dating ensures that all foods are stored, rotated, and utilized in a First In First Out (FIFO) manner. This will minimize waste and ensure that items that are passed their due date are discarded. Guidelines assume that food is popery stored, covered and handled. Guidelines apply, regardless of storage locations (e.g., kitchen, pantries, etc.)".

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing were made aware of the above concerns on 4/13/21 at 5:01 PM.

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	495240	A. BUILDING ___ B. WING ___	C 04/16/2021

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F 812	Continued From page 22 No further information was provided prior to exit.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		

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

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	495240	A. BUILDING ______ B. WING ______	C 04/16/2021

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F 880	Continued From page 23 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to maintain infection control practice during the medication administration observation for one of five residents in the medication administration observation, (Resident # 57).	F 880	F880 1.) One on one education on infection control practice during medication administration was provided to the nurse. 2.) Current residents that reside at this facility are at risk to be affected by this practice. 3.) Re-education was provided to RN'LPNs on infection control practice during medication administration. 4.) A weekly audit will be conducted by the DON/Designee for 3 months to ensure ongoing compliance with this practice. The audit will be submitted by the DON/Designee to QAPI monthly for review and recommendations 5.) Compliance Date: 5/18/2021	

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F 880	Continued From page 24	F 880		

During the medication pass observation LPN (licensed practical nurse) #8 dropped a pill on the top of her medication cart, picked the pill up with her bare hands placed it in the cup with the other medications and administered the pill to Resident 57.

The findings include:

Resident #57 was admitted to the facility on 10/19/2020 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), depression and anxiety (state of mild to severe apprehension, often without specific cause, resulting in body changes such as quickened heartbeat and sweat.) (2).

Observation was made on 4/14/2021 at 8:35 a.m. of LPN (licensed practical nurse) #8 preparing medications for Resident #57. She had just finished washing her hands. She approached her medication cart and was observed reaching into and taking keys out of her pocket, which she then used to unlock the medication cart. LPN #8 then pulled the narcotic drawer out of the cart and used the keys to open the locked box containing the narcotic cards of medications. She was observed pulling the bubble pack card for Alprazolam 0.25 mg (milligrams) 1 tablet (used to treat anxiety) (3). When LPN #8 popped the pill out of the bubble pack, she dropped the pill on the top of her medication cart. LPN #8, without washing her hands or donning gloves, picked up the pill with her bare hands, and placed it into the cup with the other medications that had already been prepared. LPN #8 then administered the Alprazolam 0.25 mg pill to the Resident 57 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 04/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25 the other medications that had been prepared. An interview was conducted with LPN #8 on 4/14/2021 at 1:00 p.m. When asked if she administered the Alprazolam pill correctly to Resident #57, LPN #8 stated she had dropped the pill on the cart and picked it up with her bare hand. She stated she should have used a glove to pick it up. LPN #8 was asked when the top of her medication cart had been last cleaned. LPN #8 stated she had cleaned it before starting her medication pass that morning. On 04/13/2021 at approximately 11:15 a.m., the entrance conference for the survey was conduced with ASM [administrative staff member] # 1, administrator and ASM # 2, the director of nursing. When asked what standards of practice the nursing staff follow ASM # 1 and ASM # 2 stated that they follow Lippincott. The medication administration policy provided by the facility for review failed to address touching medications with bare hands. "Skill 1: Administering Oral Medications: 6. Prepare the required medications: b. Multidose containers: When removing tablets or capsules... pour the necessary number into the bottle cap and then place the tablets or capsules in a medication cup. .. Do not touch tablets or capsules with hands. Rationale: Pouring capsules or tablets into your hand is unsanitary. 12. Transport medications to patient bedside carefully... 14. Perform hand hygiene and put on PPE [personal protective equipment] if indicated. Rationale: Hand hygiene and PPE prevent the spread of microorganisms. PPE is required based on transmission based precautions. 20.	F 880		

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

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F 880	Continued From page 26	F 880		

Administer the medications. Unexpected Situations and Associated Interventions: - Capsule or tablet falls to the floor during administration: Discard and obtain a new dose for administration. This prevents contamination and transmission of microorganisms." Lippincott Photo Atlas of Medication Administration, Sixth Edition, Pamela B Lynn, EdD, MSN RN, Wolters Kluwe, 2019, pages 2, 3, 4 and 6.

Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above findings on 4/14/2021 at 4:30 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms, 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 43.
(3) This information was taken from the following website:
https://medlineplus.gov/druginfo/meds/a684001.html