STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495385	A. BUILDING ______ B. WING ______	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMRC, COMPLETE LIVING CARE	**1475 VIRGINIA AVENUE HARRISONBURG, VA 22802**

(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 Prepardness survey was conducted 07/20/2021 through 07/21/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 07/20/21 through 07/21/21. Corrections are required for complaince with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 93 at the time of the survey. The survey sample consisted of 19 current resident reviews and 3 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders for 2 of 22 residents in the survey sample, Resident #37 and Resident #287. Fluid intake for Resident #37 and Resident #287 was not	F 684	1. The medical records for residents #37 and #287 was updated to ensure that the C.N.A. task to document fluid intake is triggered, according to the MD orders. 2. The DON or designee will audit the	8/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 07/23/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495385	A. BUILDING ______ B. WING ______	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMRC, COMPLETE LIVING CARE	**1475 VIRGINIA AVENUE HARRISONBURG, VA 22802**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 1 monitored and documented as ordered by the physician. The findings include: 1. Resident #37 was originally admitted to the facility on 07/02/21 and readmitted on 07/11/21 with diagnoses including lumbar fracture, altered mental status, right pubic fracture, hypo-osmolality, hyponatremia, hypertension, a-fib, congestive heart failure and colostomy. The Admission Observation Assessment completed on 07/11/21 assessed Resident #37 as "....alert, and attentive. Oriented to person, place and time. Having an intact memory (past and present), with clear and organized thinking....." On 07/21/21 Resident #37's clinical record was reviewed. Observed on the physician's order report was the following: "...Order Type: POC (plan of care) -Task. Start Date: 07/11/2021. End Date: Open Ended. 1200ml (milliliters)/day fluid restriction 600-500-100. Three Times a Day: 06:00 - 14:00, 14:00 - 22:00, 22:00 - 06:00..." Observed on the care plans was the following: "...Problem Start Date: 07/11/2021. Resident is at risk for alterations in fluid balance r/t (related to) diuretic and fluid restriction..." A review of Resident #37's vitals report including fluid intake was reviewed for the period of 07/11/21 (readmission) through 07/21/21. For the 10 day period (7/10/21 through 7/21/21), the vitals report did not document fluid intake for 1 day (7/20/21) within a 24-hour period and only partial documentation for 9 days within the period reviewed.	F 684	medical records of any resident with a MD order to document fluid intake to ensure appropriate trigger for the documentation is activated and reflected in the medical record. 3. The DON or designee will provide education to nursing staff on how to activate a trigger according to the MD orders so that fluid documentation will flow to the C.N.A. task list and ensure the MD orders are followed for fluid intake documentation. DON or designee will educate the C.N.A.s on completing fluid documentation for residents with fluid intake assigned as a task. 4. The DON or designee will audit the medical records of all residents with MD orders to document fluid intake weekly for 4 weeks to ensure compliance with following the MD order. Findings will be reported to the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495385	A. BUILDING ______ B. WING ______	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMRC, COMPLETE LIVING CARE	1475 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 2	F 684		

On 07/21/21 at 1:40 p.m., the unit manager (LPN #1) where Resident #37 resided was interviewed regarding the documentation of the fluid intake for residents with fluid restriction. LPN #1 stated the certified nursing assistants (CNA) were responsible for documenting the fluid the intake and if the information was not in the electronic record it may have been on the CNA's documentation sheet and not entered into the record yet. LPN #1 stated she would follow up with the information.

On 07/21/21 at 1:53 p.m., LPN #1 returned and stated, "the intakes are not there." LPN #1 was asked if the intakes were monitored and recorded at all. LPN #1 stated, "I don't want to speculate, it must have been a staff oversight."

These findings were discussed during a meeting on 07/21/21 at 3:00 p.m. with the administrator and director of nursing (DON).

2. Resident #287 was admitted to the facility on 07/16/21 with diagnoses that included: C-diff, anemia, type 2 diabetes, stage 4 chronic kidney disease, heart failure, edema and chronic obstructive pulmonary disease (COPD). The Admission Observation Assessment dated 07/16/21 assessed Resident #287 as, "... alert and oriented to person, place, and time. Having an intact memory (past and present), with clear and organized thinking..."

On 07/21/21 Resident #287's clinical record was reviewed. Observed on the physician's order report was the following: "... General POC (plan of care) - Task. Start date: 07/16/21. End Date: Open Ended. Fluid Restriction 1500 daily. 800ml/600ml/100ml (milliliters). Every shift: 1st,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495385	A. BUILDING ______ B. WING ______	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMRC, COMPLETE LIVING CARE	1475 VIRGINIA AVENUE HARRISONBURG, VA 22802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 3	F 684		

2nd, 3rd..."

Observed on the care plans was the following: "...Problem Start Date: 07/16/2021. Resident is at risk for alterations in fluid balance r/t diuretics and fluid restriction... Approach: Document fluid intake...."

A review Resident #287's vitals report including fluid intake was reviewed for the period of 07/16/21 through 07/21/21. Observed on Resident #287's report was no fluid intake documentation.

On 07/21/21 at 2:22 p.m., the unit manager (LPN #1) where Resident #287 resident was interviewed regarding the fluid intakes not documented within the clinical record. LPN #1 stated she would check and follow-up.

On 07/21/21 at 2:30 p.m., a copy of Resident #287's fluid intake was requested from the administrator. The administrator returned at 2:40 p.m. and stated there was no fluid intake documentation for Resident #287.

These findings were discussed during a meeting on 07/21/21 at 3:00 p.m. with the administrator and director of nursing (DON). The DON was interviewed regarding Resident #287's clinical record missing the fluid intake documentation. The DON stated upon investigation it was discovered during the admission that the order was not included as a task on the CNAs task list which resulted in the CNAs not monitoring and documenting the resident's fluid intake.

No other information was received by the survey team prior to exit on 07/21/21 at 4:45 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495385	A. BUILDING ______ B. WING ______	07/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VMRC, COMPLETE LIVING CARE	1475 VIRGINIA AVENUE HARRISONBURG, VA 22802

(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