

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

PRINTED 09/08/2021
FORM APPROVED
OMB NO. 0938-0391

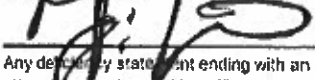
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/01/2021
NAME OF PROVIDER OR SUPPLIER ASHLAND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 8/30/21 through 9/1/21. Complaints were investigated (VA00052278 - unsubstantiated; VA00052955 - unsubstantiated; VA00051759 - substantiated without deficiency; VA00052959 - unsubstantiated) Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 190 certified bed facility was 142 at the time of the survey. The survey sample consisted of four current Resident reviews and four 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 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	F 550	1. On 8/31/2021, CNA #4 was educated on raising resident bed, and resident head while feeding. CNA to be sitting in chair beside resident's bed while maintaining eye-level during duration of resident feeding. CNA to maintain resident dignity. 2. Audit of resident who are being feed to ensure staff are not standing while feeding residents to maintain their dignity. 3. In-service education provided by Staff Developer and/or designee to ensure staff are not standing while feeding residents to maintaining their dignity. The interdisciplinary team will audit to ensure staff are not standing while feeding residents. Will report weekly for 4 weeks, monthly for 3 monthly then quarterly and turn results into the Administrator and/or designee for review.	9/17/2021	

RECEIVED
SEP 21 2021
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Executive Director

9/14/2021

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.

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

PRINTED: 09/08/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/01/2021
NAME OF PROVIDER OR SUPPLIER ASHLAND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005		
(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 550	Continued From page 1 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 provide care and services in a manner to promote/maintain a resident's dignity for one of eight resident in the survey sample, Resident #6. While feeding Resident #6 breakfast on 8/31/21, the facility staff member stood over the resident to feed her. The findings include: Resident #6 was admitted to the facility on 7/17/20, and most recently readmitted on 5/6/21, with diagnoses including, but not limited to a stroke with left-side paralysis and dementia (1). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 8/11/21, Resident #6 was coded as being severely cognitively impaired for	F 550	4. Results will be reviews will be discussed by the administrator and/or designee at the Quality Assurance Performance Improvement meetings monthly for three months. The committee will recommend provisions to the plan as indicated to sustain substantial compliance. Compliance of 9/30/2021.		

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

PRINTED: 09/08/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/01/2021
NAME OF PROVIDER OR SUPPLIER ASHLAND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005		
(X4) ILC 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 550	<p>Continued From page 2</p> <p>making daily decisions. having scored three out of 15 on the BIMS (brief interview for mental status). She was coded as requiring the extensive assistance of one staff member for eating.</p> <p>On 8/31/21 at 9:18 a.m., CNA (certified nursing assistant) #4 was observed standing beside Resident #6's bed, close to the bedside table. Resident #6's breakfast tray was on the bedside table. Resident #6 was sitting up in bed, and his bed was in the lowest position above the floor. CNA #6, while standing reached from Resident #6's breakfast tray over the resident and down to the resident's mouth to feed the resident.</p> <p>On 8/31/21 at 1:55 p.m., CNA #4 was interviewed. When asked if she remembered how she was positioned while she was feeding Resident #6 his breakfast, CNA #4 stated, "I was standing up." When asked if she could think of a better position from which to feed a resident, CNA #4 stated, "Maybe sitting?" When asked if standing over a resident to feed him is maintaining their dignity, CNA #4 stated, "No, I don't think so. I see what you are saying, I agree."</p> <p>On 8/31/21 at 2:37 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the director of clinical services, and RN (registered nurse) #1, the assistant director of clinical services, were informed of these concerns. Policies regarding maintaining resident dignity while feeding them were requested.</p> <p>On 8/31/21 at 3:41 p.m., RN #1 stated the facility does not have policies related to maintaining resident dignity while feeding them.</p> <p>No further information was provided prior to exit.</p>	F 550			

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

PRINTED: 09/08/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495362	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 09/01/2021
NAME OF PROVIDER OR SUPPLIER ASHLAND NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 908 THOMPSON STREET ASHLAND, VA 23005		
(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 550	Continued From page 3 REFERENCES (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm .	F 550			