STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 04/01/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey was conducted 3/31/21 through 4/1/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three (3) complaints were investigated during the survey. The census in this 132 certified bed facility was 98 at the time of the survey. The survey sample consisted of six (6) resident reviews.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		5/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/07/2021

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interviews, the review of documents, and in the course of a complaint investigation, it was determined the facility staff failed to ensure a safe environment for one (1) of six (6) sampled residents (Resident #3). The findings include: The facility staff failed to ensure a door leading to an interior courtyard was maintained in a manner to alert staff of residents exiting the building and entering the courtyard. Resident #3 had been able to exit, unnoticed, into the interior courtyard on the afternoon of 1/23/21 at approximately 1:10 p.m. Resident #3's diagnoses included but were not limited to: COVID-19, chronic obstructive pulmonary disease, schizophrenia, major depressive disorder, psychotic disorder with delusions due to known physiological condition, acute poliomyelitis and postpolio syndrome.	F 584	F584 Safe/Clean/Comfortable/Homelike Environment This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Resident #3 exited the facility into the enclosed courtyard adjacent to his room. Resident #3 was redirected by staff back into the building and immediately assessed upon entry and found to have no ill effects. 2. The director of maintenance installed locks on facility courtyard door Resident #3 exited to prevent egress to align with	

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F 584	Continued From page 2 Resident #3's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 3/24/21, indicated in Section C (cognitive patterns) Resident #3 had a BIMS (brief interview for mental status) of 2 out of 15. Section G (Functional Status) indicated the resident's self-performance score for bathing was a 3, "Physical help in part of bathing activity" and need for support with bathing was a score of 2 which was defined as "one person physical assist." Resident #3 was care planned for assistance by staff with ADLs (activities of daily living) to include bathing/showering. Resident #3's care plan included a "focus" of: "The resident is an elopement risk/wanderer (related to) Impaired [sic] safety awareness, Resident wanders aimlessly". This focus area was initiated on 7/20/20. Interventions for this focus area were: "Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book" and "Wanderguard". Facility documentation of this event indicated the "(r)esident found by housekeeper (housekeeper name omitted) in courtyard near housekeeping and ice room on C wing. Resident was walking on walker. No fall." Resident #3's clinical record included evidence of fifteen (15) minutes checks being immediately implemented after the resident was found in the courtyard. The resident's room was changed to place the resident further away from the door. On the afternoon of 3/30/21, the door used by Resident #3 to exit the facility and enter the interior courtyard was observed. It was noted to have an alarm attached to the top of the door.	F 584	the other doors leading to courtyard. Additionally, the director of maintenance removed the alarm from courtyard door, as it is now locked at all times. Signage was placed on each courtyard door indicating “doors are to remain locked at all times and are not an exit”. 3. The administrator/designee will in-service all facility staff on the importance of ensuring courtyard doors are locked and alarms are in working order. Director of Maintenance/designee will in-service all facility leadership on identifying that the alarms are in working order. 4. Director of maintenance/designee will perform daily checks to ensure egress doors alarms are engaged and in working order. Additionally, director of maintenance/designee will perform twice daily checks to verify courtyard doors remain locked at all times and that all egress doors and their alarms are in working order. The Director of Maintenance/designee will identify any issues, patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. Date of Compliance: 5/28/21	

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The door was opened but the alarm was not very loud and it turned off in less than 60 seconds. SM #36 was asked about the alarm. SM #36 reported the alarm was usually louder.

On the afternoon of 3/30/21, SM #37 was interviewed about the aforementioned door alarm. It was reported, by Staff Member (SM) #37, that the alarm should sound for three minutes when the door is opened. SM #37 reported the batteries needed to be changed in the alarm. After a battery change, the alarm was noted to be louder and continued to sound for a longer time. An area at the top of the door appeared as if something had been removed from the door. SM #37 reported a "wander guard" alarm had been removed from the door. SM #37 was asked about Resident #3 being able to exit the door unnoticed. SM #37 reported the alarm had been turned off at the time Resident #3 exited the door into the courtyard. There was no facility policy/procedure to guide the use/monitoring of the aforementioned door alarms but SM #37 provided a copy of daily (Monday - Friday) documentation of facility staff inspection and testing of "all door functionality, wander system, alarms, etc ..."

On 3/31/21 at 2:35 p.m., the aforementioned findings related to Resident #3 being found outside the facility building, in an interior courtyard was discussed with the facility's Administrator and Director of Nursing (DON). The DON reported at the time Resident #3 had been discovered in the interior courtyard the alarm was off. The DON reported that as part of the investigation the facility's previous DON had reviewed the security camera footage and determined Resident #3 had been outside the building for ten (10) minutes.

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F 584	Continued From page 4 This is a complaint deficiency.	F 584		
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 interviews, the review of documents, and during the course of a complaint investigation, it was determined the facility staff failed to ensure treatment and care were received by providing the administration of medications and/or treatments according to medical provider orders for one (1) of six (6) sampled residents (Resident #1). The findings include: The facility staff failed to ensure Resident #1's fluorouracil cream was applied as ordered by the medical provider. The facility staff failed to ensure Resident #1's oral medications were administered, on the afternoon/evening of 1/14/20, as ordered by the medical provider. Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/2/2020, had the resident assessed as sometimes able to make self understood and as	F 684	F684 Quality of Care This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. The DON/designee has counseled and reeducated LPN #12 for the documentation of medication administration. The second nurse who was not identified by number in the 2567 who stated she administered the medications on the afternoon/evening of 1/14/20 was suspended pending outcome of our investigation and was subsequently terminated and reported to the Department of Health Professions.	5/28/21

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F 684	Continued From page 5 sometimes able to understand others. The resident was assessed as having difficulty with memory and recall. Resident #1 was assessed as being dependent on staff members for transfers, dressing, eating, toilet use, personal hygiene, and bathing. Resident #1's diagnoses included, but were not limited to: high blood pressure, renal disease, diabetes, Alzheimer's disease, and depression. Resident #1's clinical record included an order for fluorouracil cream to be applied to right hand and left forearm every day shift and evening shift for skin cancer. Resident #1's clinical record included the following administration times for the aforementioned fluorouracil cream order: - On 2/1/20, the day shift dose/treatment for the left arm was documented as being administered at 7:44 p.m. On 2/1/20, the evening shift dose/treatment for the left arm was documented as being administered at 7:18 p.m. The evening shift dose/treatment was documented as being provided prior to the day shift dose/treatment. - The 2/5/20 day shift dose/treatment for the right hand was documented as being administered on 2/6/20 at 1:17 a.m. The 2/5/20 evening shift dose/treatment for the right hand was documented as being administered on 2/6/20 at 1:42 a.m. - The 2/6/20 day shift dose/treatment was documented as being administered on 2/7/20 at 12:34 a.m. The 2/6/20 evening shift dose/treatment was documented as being administered on 2/7/20 at 12:45 a.m. - The 2/13/20 day shift dose/treatment was documented as being administered on 2/14/20 at 1:07 a.m. The 2/13/20 evening shift	F 684	2. The Director of Nursing/Designee will review MAR/TAR administration records for accuracy of medications given per order. 3. Licensed staff were re-educated on medication and treatment administration. The training included but was not limited to: “The 5 Rights” of medication administration, as well as timely documentation of all medications and treatments administered. 4. The Director of Nursing/Designee will perform an observation audit on medication and treatment administration to assure that they are administered per the provider’s orders and documented correctly. Audits will be completed on 20% of residents weekly for 6 weeks to ensure that substantial compliance is achieved. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. Date of Compliance: 5/28/2021	

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F 684	Continued From page 6	F 684		

dose/treatment was documented as being administered on 2/14/20 at 12:35 a.m.

LPN #12 was interviewed about the aforementioned documentation of the fluorouracil cream administration. LPN #12 stated they felt as if the medication had been administered at the appropriate time but was documented later. LPN #12 reported that they had at times worked 16 hour shifts therefore could have administered both fluorouracil cream doses/treatments. LPN #12 stated that the facility's electronic documentation system will alert the user to when a medication or treatment has not been documented as completed.

Resident #1's clinical record included orders for the following three (3) medications to be administered at bedtime: (1) Finasteride 5mg, (2) Paroxetine 40mg, and (3) Namenda XR 14mg. Although these medications were ordered to be given "at bedtime" they were scheduled to be administered at 6:00 p.m. Facility documentation indicated the nurse who administered the medications on the afternoon/evening of 1/14/20 reported the medications were administered early at approximately 4:00 p.m. No provider order to administer these medications early was found by or provided to the survey team.

The following information was found in a facility policy titled "Charting and Documentation" (revised on July 2017):
- "The following information is to be documented in the resident medical record: ... Medications administered ... Treatments or services performed ..."
- "Documentation in the medical record will be objective (not opinionated or speculative),

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F 684	Continued From page 7 complete, and accurate." - "Documentation of procedures and treatments will include care-specific details, including: ... The date and time the procedure/treatment was provided ..." The findings related to Resident #1's medication administration was discussed with the facility's Administrator and Director of Nursing during meetings on the afternoon of 4/1/21. This is a complaint deficiency.	F 684		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		5/28/21

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 9 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interviews, the review of documents, and during the course of a complaint investigation it was determined the facility staff failed to ensure complete and accurate documentation for one (1) of six (6) sampled residents (Resident #1). The findings include: The facility staff failed to ensure Resident #1's personal belongings list was co-signed by the resident or the resident's Responsible Party (RP) at the time the belongings was first inventoried. The facility staff failed to ensure Resident #1's RP signed for the resident's personal belongings at the time the belongings was given to the RP. Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/2/2020, had the resident assessed as sometimes able to make self understood and as sometimes able to understand others. The resident was assessed as having difficulty with memory and recall. Resident #1 was assessed as being dependent on staff members for transfers, dressing, eating, toilet use, personal hygiene, and bathing. Resident #1's diagnoses included, but were not limited to: high blood pressure, renal disease, diabetes, Alzheimer's disease, and depression. Review of Resident #1's "INVENTORY LIST" forms which included an itemized list of the resident's belongings were reviewed. One of the "INVENTORY LIST" forms had staff representative signature dated 2/21/19 and the	F 842	F842 Resident Records - Identifiable Information This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Resident #1 had discharged from this facility, no negative outcome reported. 2. The facility implemented an assessment titled “Personal Effects Inventory” this will be completed by licensed staff upon admission or readmission. Upon discharge, residents will have this assessment printed with their discharge paperwork. 3. Licensed staff were educated on assessment titled “Personal Effects Inventory”. The training included but was not limited to ensuring items are labeled upon admission, all items logged in assessment and reviewed with resident and resident’s responsible party to ensure accuracy. 4. The Director of Nursing/Designee will perform an audit on assessment titled “Personal Effects Inventory” to ensure completed accurately on admission and discharge. Audits will be completed on new admissions/readmissions weekly for	

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F 842	Continued From page 10 responsible party (RP) signature dated over a year later on 3/9/20; the RP had written a note indicating they were "not saying (the list was) correct". Another "INVENTORY LIST" which was completed at the time Resident #1's items were returned to the family included facility members signatures but did not include the resident's RP signature. The following information was found in a facility policy titled "Charting and Documentation" (revised on July 2017): "Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." The following information was found in a facility policy titled "Personal Property" (revised December 2016): "Policy Statement ... Residents are permitted to retain and use personal possessions and appropriate clothing, as space permits. Policy Interpretation and Implementation ... 5. The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished. 6. The facility will promptly investigate any complaints of misappropriation or mistreatment of resident property." On 4/1/21 at 8:30 a.m., the facility's Director of Nursing (DON) reported the facility did not have a policy that addressed resident's personal property at the time of discharge. This is a complaint deficiency.	F 842	6 weeks to ensure that substantial compliance is achieved. The Director of Nursing/Designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement Committee at least quarterly. 5. Date of Compliance: 5/28/2021	