| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 495205 | A. BUILDING _____ B. WING _____ | C 03/18/2021 |

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| ILIFF NURSING AND REHABILITATION CENTER | 8000 ILIFF DRIVE DUNN LORING, VA 22027 |

| (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 |
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| E 000 | Initial Comments<br><br>A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health - Office of Licensure and Certification on 03/15/21 - 03/18/21. The facility was found to be in compliance with 42 CFR 483.73. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint survey were conducted by Healthcare Management Solutions, LLC on behalf of the Virginia Department of Health-Office of Licensure and Certification. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.<br><br>Survey Dates: 03/15/21-03/18/21<br>Survey Census: 81<br>Sample Size: 20<br>Supplemental Residents: 18<br><br>A deficiency was related to Intake ID VA00050547 at F689.<br>No deficiencies were issued related to Intake VA00050266. | F 000 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced | F 689 | | 4/26/21 |

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

Electronically Signed | 04/07/2021

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| F 689 | Continued From page 1<br>by:<br>Based on interview, record review, and review of facility policies and documentation, the facility failed to ensure one of 18 sampled residents (Resident (R) 235) received the care necessary to prevent falls. Specifically, the facility failed to put interventions in place to prevent further accidents after R235 fell on 11/09/20.<br><br>Findings include:<br><br>Review of R235's Electronic Health Record (EMR) "Profile" revealed R235 was admitted to the facility on 09/30/20 with diagnoses including Parkinson's Disease, dementia, repeated falls, and disorientation. Review of the admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 10/07/20, revealed R235 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R235's cognitive status was intact at the time of admission. The admission MDS documented R235 required extensive assistance of one person for mobility and ambulation, had an unsteady gait and used a wheelchair for mobility. The MDS assessment indicated R235 received physical therapy services with a start date of 09/30/20.<br><br>Review of a Physical Therapy Assessment, dated 09/30/20, revealed the resident was admitted to the facility for skilled short-term care and physical therapy services due to repeated falls at home prior to admission. The assessment indicated the facility's physical therapy services were working on R235's gait and standing by walking 25 feet providing moderate assistance to the resident. The assessment further indicated R235, "tends to lean forward and has foot crossover when | F 689 | 1. Corrective Action<br>Resident R235 was affected by deficient practice; resident has been discharged from facility on 12/22/2020.<br><br>2. Other Potential Residents<br>All residents experiencing a fall have the potential to be affected by this deficient practice<br><br>3. New Measures/System Changes<br>All falls within facility will be reviewed by IDT, an appropriate intervention will be initiated, and the care plan will be promptly updated. The DON or designee will re-educate MDS staff on updating the residents care plans to reflect the appropriate interventions required after a fall.<br><br>4. Monitoring<br>The DON or designee will complete weekly monitoring of all falls to ensure that care plans are updated and that appropriate interventions are in place The results of these audits will be reviewed in Quality Assurance Meeting monthly for 3 consecutive months.<br><br>5. Completion Date<br>April 26, 2021 | |

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| F 689 | Continued From page 2 | F 689 | | |

ambulating."

A review of a "Fall" note in the EMR, dated 11/09/20, revealed that the resident sustained a fall without injury that day. On 11/09/20 the resident was found on the bathroom floor due to a fall while the resident was attempting to ambulate independently to the bathroom. Review of the "Post Fall Follow Up Note" dated 11/10/20 revealed no evidence that the facility conducted a root cause analysis to determine possible causes of the resident's fall. There was no evidence that the facility identified new interventions that should be used to prevent further falls.

Review of the R235's "Care Plan" revealed R235 had a care plan for falls prior to the accident on 11/09/20. At the time of the 11/09/20 fall, the Falls care plan stated R235 needed assistance from staff due to difficulty with gait and balance and repeated falls at home prior to admission to the facility. Review of the "Care Plan" revealed it was not revised to reflect new interventions after the 11/09/20 incident.

Further review of "Fall" notes in the EMR revealed the resident later sustained two additional falls. On 11/28/20, R235 was found on the floor between their bed and a wheelchair. On 12/22/20, R235 was found on the floor next to their bed. R235 sustained a bruise on the left forehead, was sent to the hospital for further evaluation and did not return to the facility.

On 03/17/21 at 11:52 AM, an interview was conducted with the Director of Nursing (DON). The DON stated R235 did not have any falls at the facility that resulted in major injuries. The DON further stated R235 did not return to the

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| F 689 | Continued From page 3 | F 689 | | |

facility after being sent to the hospital on 12/22/20.

On 03/18/21 at 10:45 AM, a follow-up interview was conducted with the DON to review R235's falls. The DON confirmed that the facility did not complete a root cause analysis after the resident's fall on 11/09/20 and did not identify new interventions or care plan different approaches that were needed to prevent further falls. The DON reviewed approaches that were added after the 11/28/20 fall such as moving the resident nearer to the nurses' station for closer monitoring. The DON acknowledged R235's care plan should have been revised with resident-specific interventions after the resident's 11/09/20 fall.

On 03/18/21 at 10:52 AM, an interview was conducted with the facility's Medical Director. The Medical Director noted that R235 had several falls prior to admission to the facility and stated R235 did not return to the facility after the 12/20/20 hospitalization because R235 required a different level of care related to diagnoses including encephalopathy, advanced dementia, and insertion of gastronomy tube.

The facility's policy titled, "Falls - Clinical Protocol," dated 09/2012, stated, "The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling." In addition, the policy stated, "If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment of the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation."

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| F 812 | Continued From page 4 | F 812 | | |
| F 812 SS=E | Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(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.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and review of facility policies, the facility failed to store food under sanitary conditions. Specifically, one of two nourishment refrigerators located at the nursing stations in the facility was not clean and contained unlabeled and undated foods. This failure had the potential to affect 51 out of 81 residents in the facility who might consume food stored in the refrigerator on the North Unit.<br><br>Findings include:<br><br>Review of the facility's policy titled, "Nursing Services Space," dated 08/15/20, stated, "If a refrigerator is provided in a nursing station, it will | F 812 | 1. Corrective Action<br>Residents suffered no ill effects from this deficient practice<br><br>2. Other Potential Residents<br>All geriatric residents have the potential to be affected by this deficient practice<br><br>3. New Measures/Systems Change<br>Facility purchased a new nourishment refrigerator and placed lock on refrigerator on 04/01/2021.<br>The DON or designee will re-educate all nursing staff that it is their responsibility to monitor the nourishment refrigerators and | 4/26/21 |

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| F 812 | Continued From page 5<br>meet the following standards: a. Be located in a clean area not subject to contamination by human waste;" and "e. If foods are retained in the refrigerator, they will be covered and clearly identified as the contents and date initially covered."<br><br>On 03/15/21 at 10:30 AM, observations were conducted at the nursing station on the North Unit of the facility. Observation of the nourishment refrigerator revealed unlabeled and open food and drink containers in the refrigerator. Two plastic containers of leftover foods were unlabeled and undated. The unlabeled and undated food containers contained steamed broccoli and fruit salad. In addition, an opened, 23 ounce aluminum can of "Arizona Grape Aid Fruit Juice Cocktail" was observed on the bottom shelf of the refrigerator. Further observations of the refrigerator revealed food and drink stains on the shelves and the bottom of the inside of the refrigerator.<br><br>On 03/15/21 at 10:40 AM, an interview was conducted with Registered Nurse (RN)7. RN7 stated food and drink located in the refrigerators at the nursing stations should be labeled and dated.<br><br>On 03/15/21 at 10:45 AM, an interview was conducted with the Director of Nursing (DON). The DON confirmed the nourishment refrigerators were for resident use only and stated the unlabeled foods and drink in the refrigerator appeared to belong to staff. In addition, the DON acknowledged the refrigerator was dirty and needed to be cleaned. However, the DON stated no one had been assigned to clean the refrigerator because he was not aware it was | F 812 | ensure that only the residents food and drinks are placed in the nourishment refrigerators. Refrigerators will be cleaned by unit staff weekly. The DON or designee will educate the nursing staff the importance of maintaining a clean nourishment refrigerator with labeled and dated foods.<br><br>4. Monitoring<br>The night supervisor or designee will be responsible to audit refrigerators weekly to assure cleanliness is maintained and that all foods are labeled or discarded. The DON will summarize and present the results of these audits to the administrator and QAPI monthly over the course of the next three months.<br><br>5. Completion Date<br>April 26, 2021 | |

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| F 812 | Continued From page 6<br>dirty. During the interview, the DON confirmed any foods in the refrigerators at the nursing stations should be labeled with the contents, covered, and dated.<br><br>On 03/17/21 at 12:10 PM, an interview was conducted with the Administrator. The Administrator stated the DON made her aware of the improper food storage in the refrigerator located at the nursing station. The Administrator stated she expected nursing staff to properly store foods in the refrigerator and follow the policies for proper food storage. | F 812 | | |
| F 814 SS=F | Dispose Garbage and Refuse Properly<br>CFR(s): 483.60(i)(4)<br><br>§483.60(i)(4)- Dispose of garbage and refuse properly.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, interviews, and review of the facility policy, the facility failed to ensure garbage was properly disposed of and contained in closed dumpsters. Bagged garbage was left out and not immediately placed in a container. Unsanitary conditions and/or uncontained trash increases the likelihood of pest infestations and had the potential to affect all 81 residents residing in the facility at the time of the survey.<br><br>Findings include:<br><br>A review of the facility's policy titled, "Dispose of Garbage and Refuse," dated 10/2019, stated, "It is the center policy all garbage and refuse will be collected and disposed in a safe and efficient manner." In addition, the policy stated, "The Dining Services Director will ensure proper | F 814 | 1. Corrective Action<br>Residents suffered no ill effects from this deficient practice<br><br>2. Other Potential Residents<br>All residents have the potential to be affected by this deficient practice<br><br>3. New Measures/System Change<br>CDM (Certified Dietary Manager)/Cook will perform AM/PM walk-throughs outside the kitchen facility entrance to ensure there is no kitchen trash/recycling on the ground. Any items found will be put in the dumpster by CDM/Cook<br><br>4. Monitoring<br>CDM (Certified Dietary Manager)/Cook | 4/26/21 |

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| F 814 | Continued From page 7<br>practice for handling garbage and refuse including: Garbage and refuse is removed from the kitchen area routinely during the day and at the end of the workday." The policy further stated, "The Dietary Services Director will be responsible for appropriate recycling practices are in place as outlined by local authorities."<br><br>On 03/15/21 at 9:55 AM, observations were conducted outside the kitchen entrance of the facility, following an initial tour of the kitchen area. Twelve bags of garbage were observed sitting on the ground, approximately five feet from the kitchen entrance.<br><br>On 03/15/21 at 12:12 PM, additional observations of the area outside the kitchen entrance and an interview with the Certified Dietary Manager (CDM) were conducted. The CDM was observed placing the 12 bags of garbage in the facility's garbage dumpster. The CDM stated the 12 bags outside the kitchen contained aluminum cans that were intended for recycling. However, the CDM further stated the bags had not been retrieved at the scheduled time and were left on the ground outside the kitchen entrance. The CDM acknowledged the garbage bags were not supposed to be left on the ground outside the kitchen entrance.<br><br>On 03/15/21 at 12:15 PM, an interview was conducted with the Administrator. The Administrator stated she expected garbage to be placed in the facility's dumpsters and acknowledged the garbage bags should not have been stored on the ground outside the kitchen entrance. | F 814 | will perform AM/PM walk-through audits weekly for 4 weeks and monthly for 3 months until substantial compliance is achieved. CDM will present audit findings and any trends/patterns to QAPI monthly over the course of the next three months.<br><br>5. Completion Date<br>April 26, 2021 | |
| F 880 SS=D | Infection Prevention & Control | F 880 | | 4/26/21 |

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| F 880 | Continued From page 8<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a | F 880 | | |

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| F 880 | Continued From page 9<br>resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, observation, material from the Centers for Disease Control and Prevention (CDC), and facility policy review, the facility failed to ensure two staff members followed transmission-based precautions (TBP) to prevent the potential for spread of COVID-19 for one (Resident (R) 183) of 37 residents reviewed for infection control. Staff failed to wear the appropriate personal protective equipment (PPE) when entering the room of the resident, who was | F 880 | 1. Corrective Action<br>Residents suffered no ill effects from this deficient practice<br><br>2. Other Potential Residents<br>All residents have the potential to be affected by this deficient practice<br><br>3. New Measures/System Change<br>The DON and Administrator will provide | |

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| F 880 | Continued From page 10<br>on quarantine due to being a new admission to the facility with unknown COVID status.<br><br>Findings include:<br><br>Observation on 03/15/21 at 9:45 AM revealed the facility had four quarantine rooms to be used for newly admitted residents whose COVID status was unknown. Each room had four signs on the door. One identified the room as a quarantine room with a large capital Q. The second sign had two stop signs and stated, "Droplet Precautions ...Everyone must: Clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry. Remove face protection before room exit." Two pictures were included on the sign; one depicted a caregiver wearing a face shield and the other picture showed goggles. The sign was identified as being from the "U.S. Department of Health and Human Services, Center for Disease Control and Prevention (CDC)" and included the CDC logo in the bottom right corner of the page. The third provided step by step written directions and pictures for donning (putting on) PPE for use in a room or area on TBP, and the fourth was step by step directions and pictures for doffing (removing) PPE. The third and fourth pages which noted the need for a gown, gloves, face shield or goggles, and N95 mask were also from the CDC.<br><br>On 03/17/21 at about 9:40 AM, Housekeeper (HK)1 was observed to enter the room of R183, who was in a quarantine room due to being a new admission to the facility. HK1 was observed to be wearing a mask and don a gown and gloves to enter the room to clean it. Upon exit from the room at approximately 9:45 AM, he was observed | F 880 | facility current infection control policy and procedures to OLC. The DON and Administrator and QAPI committee will conduct an RCA on April 14, 2021<br>DON or designee will re-educate and train all staff regarding PPE to include wearing Face shields and googles. To be completed by April 26, 2021.<br><br>4. Monitoring<br>The DON, Administrator or Designee will make random visual observations of staff to ensure proper PPE usage is occurring. These visual observations will occur a minimum of 5 times a week and the results of these audits will be reported monthly to the QAPI committee over the course of the next three months.<br><br>5. Completion Date<br>April 26, 2021 | |

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| | 495205 | A. BUILDING _____ B. WING _____ | C 03/18/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ILIFF NURSING AND REHABILITATION CENTER | 8000 ILIFF DRIVE DUNN LORING, VA 22027 |

| (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 |
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to perform hand hygiene with hand sanitizer from a dispenser on the wall across from the resident's room after doffing all PPE except his mask inside the resident's room. Throughout this observation, HK1 was not observed to be wearing a face shield or goggles.

HK1 was interviewed on 03/17/21 at 9:50 AM and asked if he had donned a face shield or goggles prior to entering the quarantine room. HK1 confirmed he had not worn goggles or a face shield while cleaning the room. He stated he should have worn either goggles or a face shield because the resident was in quarantine due to the possibility of COVID-19.

On 03/17/21 at 9:51 AM. Registered Nurse (RN)7 was observed to exit R183's room. She was wearing a face mask at the time she exited the resident room. She was not carrying a face shield or goggles. The RN was interviewed at the time of this observation and asked what PPE she had worn while in R183's room. She stated she wore a gown, gloves, and her face mask. When asked to clarify if she wore a face shield or goggles when she entered and while she was in the room, she stated, "There was nothing to splash me." When asked if goggles or a face shield should have been worn, she acknowledged R183 was on droplet and contact precautions and she should have worn either a face shield or goggles to protect her eyes.

During an interview with the Infection Preventionist (IP) on 03/18/21 at 9:37 AM, she stated she expected all staff entering a quarantine room for any reason to don all the required PPE, including a face shield or goggles. She stated all staff were educated on donning

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 495205 | A. BUILDING _____ B. WING _____ | C 03/18/2021 |

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| ILIFF NURSING AND REHABILITATION CENTER | 8000 ILIFF DRIVE DUNN LORING, VA 22027 |

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and doffing and the required PPE for contact and droplet precautions

Review of the facility policy titled, "Transmission-Based Precautions," last revised 10/28/20, revealed the definition of "Transmission-based precautions are a group of infection prevention and control practices that are used in addition to standard precautions for residents who may by infected ...with infectious agents that require additional control measures to prevent transmission effectively. There are three categories of transmission-based precautions: contact, droplet, and airborne."

Review of the facility policy titled, "Personal Protective Equipment," last revised 10/28/20, revealed, "PPE refers to a variety of barriers used alone or in combination to protect mucous membranes, skin, and clothing from contact with pathogens. It includes gloves, gowns, face protection (facemasks, surgical masks, goggles, and face shields), and respiratory protection (respirators (KN95 and N95))." Under the section covering face protection, the policy stated, "Face protection: ii. Wear goggles or face shield as added face/eye protection. Personal eyeglasses are not a substitute for goggles."