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 12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUST HEALTHCARE AT ILIFF	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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 11/29/2021 through 12/01/2021. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint (VA00053756 - substantiated with deficiency) was investigated during the survey. The census in this 130 certified bed facility was 105 at the time of the survey. The survey sample consisted of 6 resident reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2)	F 580		12/23/21

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

Electronically Signed | 12/20/2021

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F 580	Continued From page 1 is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to promptly inform the responsible party of the speech therapy treatment plan and initiation of speech therapy treatment for one Resident (Resident #1) out of a sample size of 6 Residents. The findings included: On 11/30/2021 at approximately 10:00 A.M., the facility staff provided a copy of Resident #1's speech therapy notes as requested. A review of	F 580	1. Corrective Actions Resident #1 was affected by this deficient practice; resident was discharged from facility on 10/27/2021. 2. Other Potential Residents All residents who have therapy being initiated have the potential to be affected by this deficient practice 3. New Measures System Changes The Director of Rehabilitation or designee will re-educate all therapy staff on	

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F 580	Continued From page 2 the documents revealed that Resident #1 received speech therapy services from 10/08/2021 through 10/26/2021. There was no evidence in the documentation that the responsible party was notified that speech therapy services were initiated and ongoing. On 11/30/2021, Resident #1's closed clinical record was reviewed. A physician's order dated 09/17/2021 (the day of admission) documented, "Speech Therapy evaluation and treatment as indicated." There was not a Speech Therapy Clarification order around the time speech therapy was initiated on 10/08/2021. The progress notes on 10/08/2021 were reviewed. There was no evidence in the progress notes that the responsible party was notified of speech therapy services. Excerpts of a social services discharge summary note dated 11/04/2021 at 3:20 P.M. documented, "This dept [department] along with ADON [assistant director of nursing], therapy director met with RP [responsible party] [name] and RP [name] on the week of the 10/18/21 to discussed [sic] resident's care and overall decline .....Therapy dept [department] also reported that resident was being followed by speech therapy for aspiration precaution and RP [name] stated that a swallow study was previously done and that they are aware of his risks for aspiration and declining cognition but stated that they would like for speech therapy to be stopped as there was no need for it. " On 11/30/2021 at approximately 1:45 P.M., an interview with Employee E, the speech therapist, was conducted. When asked if she notifies the	F 580	notifying family or POA regarding change in condition before initiating therapy services for a resident, and to ensure to document appropriately in the resident□s chart. All current residents on therapy caseload within the facility will be reviewed by Director of Rehabilitation or designee, to ensure that all families are aware of therapy initiations. 4. Monitoring The Director of Rehabilitation or designee will complete 12 weeks of monitoring residents on caseload to ensure that families/POA are updated regarding initiation of therapies and has documentation recorded in residents□ chart. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 3 consecutive months.	

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F 580	Continued From page 3	F 580		

responsible party if speech therapy services are being initiated, the speech therapist indicated that she does not notify families when she evaluates Residents for speech therapy services or initiates a treatment plan. When asked who notifies the family when therapy is being provided, the speech therapist indicated she did not know. When asked if she notified nursing that speech therapy services are being initiated, the speech therapist stated that nursing would know because there's an order for it. When asked why speech therapy services were initiated for Resident #1, the speech therapy referred to her documents and stated that another therapist requested Resident #1 be evaluated for speech therapy services. When asked why speech therapy was initiated, the speech therapist stated it was due to Resident #1's declining cognition.

On 11/30/2021 at approximately 1:50 P.M., an interview with Licensed Practical Nurse C (LPN C) was conducted. When asked who notifies the responsible party when speech therapy is initiated, LPN C stated that the therapist will notify the family.

In summary, Resident #1 received speech therapy services from 10/08/2021 through 10/26/2021. A review of the clinical record and an interview with the speech therapist revealed that Resident #1's responsible party was not notified of the evaluation or initiation of speech therapy services on 10/08/2021 until the week of 10/18/2021 (10 days after services began).

On 12/01/2021 by the end of survey, the administrator and DON were notified of findings and they stated they had no further documentation or information to submit.

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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. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to obtain lab test on 10/14/2021 as ordered by the physician for one Resident (Resident #1) in a sample size of 6 Residents. The findings included: On 11/29/2021 and 11/30/2021, Resident #1's closed clinical record was reviewed. A physician's order dated 10/13/2021 documented, "CBC [complete blood count], BMP [basic metabolic panel] weekly every night shift every Thursday." On 11/30/2021, the administrator provided a copy of all of Resident #1's lab reports as requested. There was not a lab report with a collection date of (Thursday) October 14. There were lab reports with collection dates of 10/08/2021 and 10/18/2021. On 11/30/2021, the administrator was notified of findings and acknowledged a lab was missing for 10/14/2021. The administrator then submitted a letter signed by the Medical Director and dated 11/30/2021. Excerpts of the letter included the following: "On 10/14/2021, resident [Resident #1's name] was scheduled for CBC, BMP to be drawn. Unfortunately, the lab was missed ..." and "I	F 658	1. Corrective Actions Resident 1 was affected by deficient practice; resident was discharged from facility on 10/27/2021. 2. Other Potential Residents All residents have the potential to be affected by this deficient practice 3. New Measures System Changes The Director of Nursing or designee will reeducate all LPNs and RNs on accurate transcription to ensure labs are obtained as ordered by the physicians. 4. Monitoring The DON or designee will be responsible to audit lab orders and the lab binder weekly x4 weeks then monthly x2 months. 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.	12/23/21

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F 658	Continued From page 5 decided the lab could wait to be drawn on the next scheduled lab day which was Monday, October 18, 2021."	F 658		
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 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	F 842		12/23/21

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F 842	Continued From page 6 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 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to maintain an accurate clinical record for one Resident (Resident #1) in a sample size of 6 Residents. Specifically, there was conflicting information about Resident #1's	F 842	1. Corrective Actions Resident 1 was affected by deficient practice; resident was discharged from facility on 10/27/2021. 2. Other Potential Residents	

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F 842	Continued From page 7 code status in the clinical record. The findings included: On 11/29/2021 and 11/30/2021, Resident #1's electronic closed clinical record was reviewed. A physician's order dated 09/17/2021 and an end date of 10/08/2021 documented, "FULL CODE." A physician's order dated 09/30/2021 and an end dated of 10/27/2021 documented, "Do Not Resuscitate - DNR." There were active orders for "Full Code" and "DNR" from 09/30/2021 through 10/08/2021. An excerpt of a provider note dated 09/27/2021 at 9:50 A.M. documented, "[Resident #1] wants to be DNR." A document entitled, "Durable Do Not Resuscitate Order" dated 09/27/2021 was signed by the physician and Resident #1's responsible party. On 11/29/2021, Resident #1's electronic care plan was reviewed. There was a focus with an initiation date of 09/21/2021 (and no end date) entitled, "Resident's Advance Directive is full code." There was not a focus on the electronic care plan addressing the DNR status. On 11/30/2021 at approximately 1:55 P.M., the administrator was notified of findings that the electronic care plan was not revised when the code status changed. The administrator stated that the electronic care plans are locked and updated quarterly. The administrator also stated that she was not clinical and the MDS Coordinator revised the care plans. On 12/01/2021 at 9:55 A.M., an interview with the	F 842	All residents have the potential to be affected by this deficient practice 3. New Measures System Changes Administrator will re-educate the social workers on ensuring that the electronic comprehensive care plan is up to date with current code statuses for all residents The Director of Social Services or designee will be responsible to audit all current residents to ensure that their care plan is reflective of their current and active code status. If a discrepancy between the code status in the care plan and the current physician orders is noted, the Director of Social Services or designee will notify the Director of Nursing to resolve the previous code status and to update the physicians order to reflect the code status in the care plan. 4. Monitoring The Director of Social Services or designee will be responsible to complete weekly auditing of all new resident□s code status and ensure that the resident□s electronic record has no conflicting orders. If a code status has been changed the previous order will be discontinued/resolved and the new order is updated in the residents electronic record. This will be audited for 12 consecutive weeks. The Director of Social Services or designee will summarize and present the	

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F 842	Continued From page 8 Minimum Data Set (MDS) coordinator was conducted. The MDS Coordinator verified that she updates the electronic care plans. When asked about the expectation to revise the care plan if there is a change in code status, the MDS Coordinator stated that she would expect the care plan would be revised the same day the code status changed. The MDS Coordinator also stated that the social worker updates the care plan pertaining to code status. On 12/01/2021 at 10:10 A.M., an interview with the social worker was conducted. The social worker confirmed it was her responsibility to update the care plan with changes in code status. When asked about the code status for Resident #1, the social worker stated that Resident #1 had a full code status when he was first admitted but the responsible party indicated Resident #1 wanted to be a DNR. The social worker then stated once the DNR was signed, she updated the code status in the electronic health record (to be visible on the banner) and the care plan was updated on paper in the hard chart but not in the electronic health record. The social worker stated "normally" she gives a paper copy (of the care plan) to the MDS Coordinator and the MDS Coordinator puts it into the electronic health record. On 12/01/2021, the administrator provided a copy of Resident #1's care plan revision dated 09/30/2021 entitled, "Resident/Patient has a DNR order in place effective 09/30/2021." The administrator also provided a signature sheet of a document dated 09/30/2021 entitled, "Care Plan Review." The document was signed by Resident #1's daughters, the social worker, the wound nurse, and the assistant director of nursing. At	F 842	results of these weekly audits to the administrator and QAPI monthly over the course of the next three months.	

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F 842	Continued From page 9	F 842		

approximately 2:00 P.M., the administrator stated after that care plan review, a paper copy of the revised care plan was placed in the hard chart. The administrator then provided a copy of their policy entitled, "Care Plan Revisions Upon Status Change." In Section 2(f), it was documented, "Care plans will be modified as needed by the MDS Coordinator or other designated staff member. If addendums are required and time has lapsed for electronic submission, addendums may be added to the patient's hard clinical record."

In summary, there were two conflicting active orders for "full code" and "DNR" from 09/30/2021 through 10/08/2021. Also, there was a focus on the electronic care plan for "full code" from 09/21/2021 through to the day of discharge and a paper copy care plan in the hard chart for "DNR" from 09/30/2021 through to the day of discharge.