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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 1/11/22 through 1/13/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 01/11/2022 through 01/13/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during the survey. The census in this 42 certified bed facility was 30 at the time of the survey. The survey sample consisted of 27 resident reviews. Immediate Jeopardy was identified in the area of Quality of Life at a Scope and Severity Level 4, isolated, from 11/21/2021 to 11/23/2021 and was determined to be past non-compliance.	F 000		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation and clinical record review, the facility staff failed to provide consistent basic life support, including	F 678	Past noncompliance: no plan of correction required.	2/3/22

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

Electronically Signed | 02/03/2022

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CPR for 1 Resident (Resident #35) in a survey sample of 27 Residents.

This resulted in Immediate Jeopardy at Level 4 isolated on 11/21/2021. After reviewing the facility documentation, Immediate Jeopardy was determined to be removed at past non-compliance on 11/23/2021.

The findings included:

1. For Resident #35, the facility staff failed to continue cardiopulmonary resuscitation (CPR) on 11/21/2021. Also, the facility staff failed to activate Emergency Medical Services (EMS) when CPR was initiated. Resident #35 was a full code.

Resident # 35 was admitted to the facility on 10/20/2021 and expired on 11/21/2021. Resident # 35's diagnoses included but were not limited to: Parkinson's disease, Orthostatic hypotension and Peripheral Vertigo.

Resident # 35's most recent MDS (Minimum Data Set) assessment with an Assessment Review Date of 10/26/2021 was coded as an Admission Assessment and coded Resident # 35 as having a BIMS (Brief Interview of Mental Status) score of 2 indicating severe cognitive impairment. Resident # 35 was coded as requiring extensive assistance of one staff person for all aspects of ADL (activities of daily living) care except for bathing which was coded as requiring total assistance of one staff person. Resident # 35 had a Full Code status.

On 01/13/2022 at 10:40 a.m., a review of the closed electronic clinical record for Resident # 35 was conducted and revealed Resident # 35

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expired in the facility on 11/21/2021.

Review of the Nursing Progress Notes revealed the following entries (in order of writing):

Progress Note Clinical Notes 11/21/2021 11:30 (EST) 11/21/2021 1:14 (EST) [written by LPN-B name redacted] Late entry. "Resident medicated with Tylenol 650 mg for complaint of generalized discomfort all over. Mobile image here for X-ray. Resident alert and oriented to name. Awaiting X-ray results."

Nursing Progress Note Clinical Notes 11/21/2021 3:33 (EST) 11/21/2021 3:36 (EST) [Written by RN-D name redacted] [name of Doctor of Nursing Practice redacted] in with Residents wife for final view. [name redacted] funeral home called to pick up remains. [name of Funeral Home redacted] arrived and took remains into their care.

Nursing Progress Note Death Clinical Notes 11/21/2021 1:19 (EST) 11/21/2021 1:26 (EST) [Written by RN-D name redacted] "Resident is without Apical pulse, BP, or respirations. Pupil non responsive. At first resident still making some gasping attempts then stopped at 0040. Large amounts of black emesis was expelled from his mouth and nose and PDP [private duty person] described it as projectile. large puddle also on floor. Resident was wet with perspiration. DNP notified at 0045 and Wife at 0114.

Nursing Progress Note Clinical Notes 11/21/2021 0:30 (EST) 11/21/2021 9:22 (EST) [Written by LPN-B name redacted] Late Entry. "Called to room resident covered in dark emesis and unresponsive. Compression given and resident remained on responsive and mouth continued to

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fill with emesis with each compression. Resident turned to side a more produced. [Sic] Charge RN in and no apical pulse. DNP aware."

Nursing Progress Note Clinical Notes 11/20/2021 19:14 (EST) 11/20/2021 19:15 (EST) [written by RN-F name redacted] BP-85/55, apical pulse 76, Metoprolol held per orders, MD and RP aware Resident lying in bed this evening with spouse at bedside Resident's abdomen round firm bladder scanned ...."

Review of the Physicians Orders revealed an order written by the Nurse Practitioner on 10/20/2021 for "FULL Code."

Review of the care plan revealed the following entries:

"ADVANCED DIRECTIVES: Please review my Advanced Directives with me, my representative, and/or my family STATUS: Active (Current) [name redacted] Advanced Directives will be reviewed
STATUS: Active (Current)
GOAL DATE: 2/17/2022
I desire to remain a Full Code."
STATUS: Active (Current) All Disciplines
"Please review my Advanced Directive/Living Will if I am unable to make decisions for myself and enforce my wishes & desires."

"RESPIRATORY: Resident had a change in condition. Noted audible gurgling, increased respirations 24/min at times, then slows down when eyes closed, skin warm to touch - temp 97.8 non contact. Dr. [name redacted] notified with new orders. Possible aspiration as he had been coughing during lunch. On 11/21/21 @ 24:30ish [Sic] resident unresponsive with large

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amount of dark emesis on him, the floor, etc. CPR started without success. Emesis con't [Sic] to produce during each compression. Pronounced deceased at 24:40.
STATUS: Active (Current)

Thorough review of the Nurses Progress Notes revealed evidence that CPR was started with compressions but no evidence of CPR being continued In addition, there was no evidence of Emergency Medical Services being called .

Review of the Nurse Practitioner's Discharge Final Progress Note reads the following.

"11/21/2021 [Resident # 35's name redacted] Discharge
Notified at 1242am that resident had passed. Large amount of dark emesis and rapid death. Breathless, pulseless. Suspect this represents stress ulcer with GI (gastrointestinal) hemorrhage. Patient had complex course with underlying advanced Parkinson's disease, at time of admission had UTI, developed neurogenic bladder with indwelling catheter.
Recent clinical change + CXR [Chest x ray] bibasilar pneumonia suspected aspiration with MODS as noted in Dr. [name redacted] notes. Negative urine culture."

On 1/13/2022 at 10:50 a.m., an interview was conducted with the Administrator who stated Resident # 35 expired in the facility. The Administrator stated the facility staff did not continue to perform CPR for Resident # 35 and Emergency Medical Services was not called to the facility to assist with the emergency. The Administrator stated the Licensed Practical Nurse (LPN-B) initiated CPR and Registered Nurse

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(RN-D) called the physician to notify of the resident's death in the facility. The Administrator stated the incident was very upsetting to all involved. The facility staff should have called EMS and continued to perform CPR until EMS arrived.

On 1/13/2022 at 11:15 a.m., an interview was conducted with the Director of Nursing who stated her expectation was for the CPR (Cardiopulmonary Resuscitation) policy to be followed by the staff, activated EMS (Emergency Medical Services and continue CPR until EMS arrives. The Director of Nursing stated the incident with Resident # 35 involved two nurses LPN-B (Licensed Practical Nurse-B) and RN-D (Registered Nurse-D) working night shift that night. One of the nurses (LPN-B) usually was assigned to day shift. It was reported that the private duty person working with Resident # 35 came to the nurses stated the resident was vomiting. The nurses, LPN-B (Licensed Practical Nurse-B) and RN-D (Registered Nurse-D), "observed excessive vomiting, no pulse and breathless." The nurse (RN-D) called the Nurse Practitioner who "was on the phone with them when CPR was determined to be futile and CPR was stopped." The Director of Nursing stated "that was where it seemed to be a misunderstanding. The Nurse Practitioner thought the staff was just telling her the resident had expired.

The Director of Nursing stated that the Nurse Practitioner did not give an official order to stop CPR. The Director of Nursing stated through the facility's investigation it was determined that the Nurse Practitioner was under the impression that Resident # 35 was already deceased when the

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call was placed and the call was for notification but not for orders to be obtained."

On 1/13/2022 at approximately 2:45 PM, a meeting was held with the Administrator, Director of Nursing and the Corporate Chief Operations Officer. They were made aware of the concerns with staff not following standard CPR/BLS (Basic Life Support) procedures for Resident # 35 and that it constituted Immediate Jeopardy. They were asked to provide any and all documentation regarding the facility's response to this incident.

The Administrator stated when she was informed of Resident # 35's death, she immediately asked if EMS had been called. The Administrator stated she and the Director of Nursing came to the facility immediately to address the issue, educated the staff on the CPR Policy and instituted a new policy entitled Medical Emergency Response on 11/21/2021. The Administrator stated the facility staff should have followed the CPR policy, called 911 to access the Emergency Medical Services and that CPR should have continued until the EMS arrived to take over. The Administrator stated she submitted a FRI (Facility Reported Incident) to the State Agency. The Administrator stated nothing like this incident had ever happened before and they realized the importance of correcting the problem.

The Administrator stated both nurses involved in this incident were suspended pending investigation. Both nurses were referred to the Department of Health Professions for review. The Administrator stated LPN-B had been employed over 25 years and Registered Nurse-D for 15 years.

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Both employees were suspended.

Immediate Jeopardy was called on 1/13/2022 at 2:45 PM.

Documentation was received and reviewed.

The facility's removal plan included:
Under "Corrective Action Following Event":
On 11/21/2021, the CPR (Cardiopulmonary Resuscitation) policy was reviewed, the Emergency Medical Response policy was adapted and both policies in serviced with staff and placed on all shifts to review and acknowledge.
11/21/21 Both directly involved staff members placed on administrative leave pending investigation.

11/22-23/21 Investigation of incident performed; staff statements collected"

Review of the facility's documentation revealed:
Nurses scheduled to work from 11/21/2021 through 11/22/2021 were educated on the facility's CPR policy, the "Medical Emergency Response Policy" Date implemented 11/21/2021 (to include calling 911, notifying the physician, and performing continuous CPR until care is transferred) prior to the start of their next scheduled shift. There was education provided to staff on Communication Book Information Sheet on 11/21/2021 and 11/22/2021. Both inservices were repeated for staff scheduled to work on their next scheduled shift.

Review of the Facility documentation revealed the following policy:

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"Policy name: Medical Emergency Response, date implemented: 11/21/21
Policy: It is the policy of this facility to respond to medical emergencies for residents, staff and visitors.
Policy Explanation and Compliance Guidelines:
1. The employee who first witnesses or is first on the site of a medical emergency, that are trained, will initiate immediate action, including CPR as appropriate, basic first aid and summon for assistance.
2. CPR will continue unless:
a. There is a DNR order in place
b. There are obvious signs of clinical death (rigor mortis, dependent lividity, decapitation, transection or decomposition.
c. Initiating CPR could cause injury or peril to the rescuer
3. A nurse will
a. Assess the situation and determine the severity of the emergency.
b. Stay with the resident.
c. Designate a staff member to announce a Code Blue if necessary, call 911 as needed, notify the physician.
4. A Code Blue will be announced over the intercom system, if necessary.
5. All available staff will respond to the emergency accordingly.
6. The RN supervisor or Charge Nurse of the unit will take the Emergency Cart to the code site, ensure accurate documentation of the event and delegate any other duties or tasks needed.
7. This will continue until emergency personnel arrive and resident is transported to the Emergency Room by the EMS
8. If the resident experiences cardiac arrest, the facility must provide basic lice support, including CPR prior to the arrival of emergency medical

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services and :
a. In accordance with the resident's advance directives, or
b. In absence of advance directives or a Do Not Resuscitate order, and
c. If the resident does not show obvious signs of clinical death.
9. The RN supervisor or designee will ensure emergency medications and equipment are inventoried and restocked.
10. The facility will ensure that CPR certified staff are available at all times.
11. Current certified staff must maintain CPR-Certification for Healthcare Providers through a CPR provider whose training includes hands-on skills practice and in-person assessment and demonstration of skills. Online certification is not acceptable."

The survey team verified the removal plan by doing the following:

Staff at the facility were interviewed for training on the Emergency Response policy and CPR Policy and Mock Codes. Nurses who were not at the facility were called and interviewed. The survey team reviewed copies of the Emergency Policy received by nurses and Certified Nursing Assistants. The survey team reviewed copies of CPR Cards for nursing staff. The survey team confirmed that staff had been educated about CPR, knew to call 911 so that EMS could respond and that CPR would continue uninterrupted until EMS took over after arriving on-site. The survey team reviewed the staff education/training on the CPR Policy and Emergency Response Policy. The survey team reviewed charts of current Residents to ensure the code status was correctly identified in the charts.

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F 678	Continued From page 10 Review of the facility staff listing revealed that all Nurses had current CPR certification. Therefore, trained staff would be available to provide CPR until EMS arrived in the event of a Resident with a Full Code Status being found unresponsive. The Immediate Jeopardy was determined to be Past Non-compliance and removed on 11/23/2021 at 5:00 PM. On 1/13/2022 at approximately 5:30 PM, the facility Administrator was asked if she had any further information regarding the incident for Resident # 35. The Administrator reported she had no further records or information to provide. The Administrator, Director of Nursing, MDS Coordinator and Chief Operations Officer were informed of the findings that the facility failed to provide CPR to the Resident with a FULL Code order and Advance directive. The facility failed to ensure the staff was familiar with the facility's policies regarding basic life support and CPR and staff failed to confirm Resident # 35's code status in an emergency resulting in Immediate Jeopardy. On 01/13/2022 at 6:45 PM, the facility Administrator, the Director of Nursing and Chief Operation Officer were made aware that Immediate Jeopardy was being cited at Past Non-compliance. No further information was provided.	F 678		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		2/8/22

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F 689	Continued From page 11 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interviews and clinical record review, the facility staff failed to ensure the environment was free of accident hazards by allowing Resident access to medication/treatment and sharps for 1 Resident (Resident #6) in a survey sample of 27 Residents. The findings included: A clinical record review for Resident #6 was conducted. This review revealed that Resident #6 had the following diagnosis: Alzheimer's disease with late onset, visual hallucinations and auditory hallucinations. Resident #6's most recent MDS (minimum data set) (an assessment tool) with an ARD (assessment reference date) of 10/7/21, was coded as an annual assessment. On this assessment Resident #6 was coded as having had a BIMS (brief interview for mental status) score of 6, which indicated severe cognitive impairment. Resident #6 was also coded on this assessment as having had hallucinations and delusions. Resident #6 required extensive assistance of one staff person for personal hygiene. Resident #6's clinical record revealed no physician orders for self-administration of medications.	F 689	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in this plan of correction. The plan constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates included. Disposable razor and cream in medicine cups were disposed of properly. All residents have the potential to be affected by this practice. All nursing staff will be educated on proper disposal of sharps and administration of medications. A weekly observation audit will be conducted by the Director of Nursing or Designee for 2 months. The audit will be submitted to QAPI monthly for review.	

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F 689	Continued From page 12 On 01/11/22 at 04:24 PM, observations of Resident #6's room were conducted. Surveyor C noted a razor in bathroom on the sink which did not have a cap on it. On 01/11/22 at 04:41 PM, an interview was conducted with Resident #6. During this interview it was noted that Resident #6 was confused and had trouble answering questions. On 01/12/22 at 12:36 PM, observations were again made in Resident #6's room. This observation revealed the razor was still in bathroom and a medicine cup was also on the bathroom sink and contained what appeared to be a white cream within. On 01/12/22 at 12:37 PM, an interview was conducted with LPN C. LPN C accompanied Surveyor C into Resident #6's room and was asked to identify the medicine cup with the white cream. LPN C said, "I don't know what it is, but it shouldn't be there". LPN C then went to the nursing station to discard of the cup of cream and looked into Resident #6's electronic health record. LPN C said, "she gets remedy twice a day, I went in this morning and put it on her, I can only assume that is what it is". LPN C confirmed that Resident #6 is not able to self-administer medications and they do have Residents who wander into other Resident's rooms at times. LPN C further confirmed that Resident #6's safety awareness varies. LPN C stated she had not noticed the razor but razors are considered sharps and should be disposed of in the sharps container and "I wouldn't leave it in the room". LPN C said the	F 689	Date of Compliance: February 8, 2022	

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	495160	A. BUILDING _____ B. WING _____	01/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAPPAHANNOCK WESTMINSTER CANTERBURY	132 LANCASTER DRIVE IRVINGTON, VA 22480

(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 689	Continued From page 13	F 689		

risks are "someone could cut themselves".

On 01/12/22 at 12:46 PM, RN C, the Supervisor, was in Resident #6's room. RN C observed the razor in the bathroom and she removed it and said "It should be disposed in the sharps container".

On 1/13/33 at 9:29 AM, Surveyor C was provided a tube of the Remedy Cream. This cream revealed the following warnings on the product tube: "For external use only. When using this product do not get into eyes. Keep out of reach of children. If swallowed get medical help or contact Poison Control Center right away".

On 1/13/21 at approximately 11:50 AM, an interview was conducted with RN A. RN A said razors are supposed to be discarded in the sharps container because there is a danger of them [Residents] hurting themselves. It is for everybody's safety".

On 1/13/21 at 11:57 AM, an interview was conducted with CNA B. CNA B said she was assigned to care for Resident #6. CNA B confirmed that she had never shaved Resident #6. She said she disposes of razors in the sharps containers "so no one gets cut or injured". CNA B said, "Someone could wander in" and get hurt if it is left out. CNA B confirmed that they do currently have residents who wander into other resident's rooms.

The facility policy regarding the disposal of sharps was reviewed. This policy didn't address the disposal of razors.

The facility policy regarding the "Administration of

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F 689	Continued From page 14 medications" was reviewed. This policy read, "...9. Administering medication to resident: ...G. Do not leave medication on a table in bedroom or on table in dining room..." The Administrator and Director of Nursing were made aware of the safety hazards on 1/12/22 at 3:30 PM, during the end of day meeting. The Director of Nursing confirmed that razors left in Resident's rooms pose a potential safety hazard. No further information was provided.	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, the facility staff failed to	F 812	F812	2/8/22

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F 812	Continued From page 15 store food in a manner to identify the food item and the date opened or to be used by, in 2 of 4 food storage areas inspected. The findings included: On 1/11/22 at 2:59 PM, observations were made in the facility kitchen. Surveyor C was accompanied by Employee F, the dietary manager. In the walk-in freezer, two bags of mixed vegetables and a bag of green peas were open to air, not secured in a manner to protect from environmental contaminates, and had no date. A bag of green beans were observed to be wrapped in saran wrap and had no date. Observations of the walk-in freezer labeled as "#4" contained an item in a zip lock bag that Surveyor C was not able to identify. It had no labeling and no date. Employee F, the dietary manager identified the item as, "Muffin mix dough". Employee F confirmed all of the observations as they were being made and stated ..."I expect every item opened to be labeled and dated, properly wrapped and sealed after each use. The potential risks of not doing this is, if they [Residents] are allergic, it could cause allergic reaction, reaction to outdated products and the quality of the product isn't good". Review of the facility policy titled, "Storage of Food and Non-Food Supplies", was conducted. This policy read, "...2. d. Opened containers of food will be stored in tightly closed non-corrosive containers or in sealed plastic bags. No exposed	F 812	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in this plan of correction. The plan constitutes the center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates included. All items without a proper label and use-by-date were discarded. All residents have the potential to be affected. All Culinary Services will be educated on proper labeling and dating items with use-by-dates. A weekly audit will be conducted by the Director of Culinary Services or Designee for 2 months. The audit will be submitted to QAPI monthly for review. Date of Compliance: February 8, 2022	

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F 812	Continued From page 16	F 812		

food will be stored in the storeroom, refrigerators or freezer. Open and use-by-dates will be placed on these items....4. l. All food items in refrigerators are properly dated, labeled, and placed in containers with tight fitting lids, or are wrapped... Items are dated with received date and use-by-date per manufacturer's guidelines or expiration date. m. Once opened, frozen food is dated, labeled, and wrapped. Moisture-proof, right fitting materials are used to prevent freezer burn and use-by-dated per manufacturer's expiration date or guidelines".

The CFR [Federal code] read, "3-305.11 Food Storage"..."D. A date marking system that meets the criteria...(2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded...".

On 1/11/22 and on 1/12/21, during end of day meetings, the facility Administrator was made aware of the findings.

No further information was provided.