State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0395	A. BUILDING: ______ B. WING ______	C 01/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARRIAGE HILL HEALTH AND REHAB CENTER	**6106 HEALTH CENTER LANE FREDERICKSBURG, VA 22407**

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 1/25/22 through 1/27/22. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 150 licensed bed facility was 125 at the time of the survey. The survey sample consisted of 52 resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: COV 32.1-138.01 (A)(8) please cross reference to F-600 12VAC5-371-110 (B)(3) please cross reference to F-607 12VAC5-371-250 (F) please cross reference to F-657 12VAC5-371-220 (D) please cross reference to F-677 12VAC5-371-220 (C) please cross reference to F-689 12VAC5-371-180 (A) please cross reference to F-880 12VAC5-371-150(H) Based on staff interview, facility documentation	F 001	COV 32.1-138.01 (A)(8) please cross reference to F-600 12VAC5-371-110 (B)(3) please cross reference to F-607 12VAC5-371-250 (F) please cross reference to F-657 12VAC5-371-220 (D) please cross reference to F-677 12VAC5-371-220 (C) please cross reference to F-689 12VAC5-371-180 (A) please cross reference to F-880 F001 12VAC5-371-150(H) 1) Resident # 411 sex offender registry completed 1-27-22 2) All residents have the potential to be affected by the deficient practice. A 100%	3/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/17/22

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F 001	Continued From page 1	F 001		

review and clinical record review, the facility staff failed to verify/determine if a Resident was a registered sex offender for one Resident (Resident #411) in a survey sample of 5 Residents reviewed for this regulatory requirement.

The findings included:

On 1/27/22 at approximately 9 AM, Surveyor C was provided a list of Residents who had been admitted in the past 30 days. From this listing, Surveyor C selected a random sample of 5 Residents to review for the verification of registered sex offender status.

Review of the documents submitted revealed that Resident #411's sex offender registry check was conducted 6/6/2019.

Review of the electronic health record for Resident #411 revealed she had multiple admissions at the facility. They were as follows:
1. 10/21/2013-12/17/2013
2. 05/14/2016-6/13/2016
3. 4/30/2019-5/28/2019
4. 6/6/2019-6/26/2019
5. 9/3/2020-10/22/2020
6. 1/25/2022-current Resident

On 1/27/22 at approximately 11:00 AM, Surveyor C met with Employee M, the admissions director. Employee M stated the facility process/protocol for the SOR (sex offender registry) is: once we start working on a potential admission we check it prior to accepting them. "It plays into if we can admit them or not because if they are a registered sex offender they could potentially pose a risk to everyone". When asked if a Resident has had a prior stay, Employee M said, "If a Resident is

audit was complete of current resident completed on 2-8-22, no issues identified.
3) The Administrator or designee will re-educate the admission department on sex offender registry policy.
4) Administrator or designee will audit new admission to ensure sex offender registry's conducted weekly for 12 weeks and report findings to QAPI committee.
5) Date of compliance is 03-08-2022.

F001 12 VAC5-371-260(B) (1), (7), (8), & (10)
1) Employee D, Registered Nurse (RN) B, License Practical Nurse (LPN) B, Certified Nurse Assistant (CNA) B, and CNA D. Employee D, Registered Nurse (RN) B, License Practical Nurse (LPN) B, Certified Nurse Assistant (CNA) B, and CNA D education will be completed on 3-7-22.
2) All residents have the potential to be affected by the deficient practice
3) The DON or designee will re-educate all staff on completion of their annual training requirements.
4) The DON or designee will audit 10 employee's education record to ensure annual training complete weekly for 12 weeks and report findings to QAPI committee.
5) Date of compliance is 03-08-2022.

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F 001	Continued From page 2	F 001		

gone from the facility for a period of greater than 30 days then a new verification of the sex offender registry should be done prior to admission".

Employee M confirmed the dates of stay for Resident #411 as noted above. Employee M further stated that a sex offender registry verification should have been done for the following admission dates: 10/21/13, 5/14/16, 4/30/19, 9/3/20, and 1/25/22.

Surveyor C showed Employee M the verification she was provided that was dated 6/6/2019. In the EHR for Resident #411 there were 2 documents under the miscellaneous tab titled as sex offender registry but neither were the verification document. Employee M confirmed that it had not been checked prior to admission on 9/3/20 or 1/25/22.

Employee N, who was the admissions coordinator was in the office when Surveyor C was talking to Employee M. She [Employee N] then spoke up and said, "The one from the 25th is here on my desk". Surveyor C then reviewed that document and it had a date of 1/27/22 at 9:49 AM on it. Surveyor C asked Employee M what this meant [pointing to the date of 1/27/22] and asked Employee M if it had been checked on 1/25 as Employee N had indicated and Employee M said, "No it was not, it is from the 27th".

On 1/27/22 at approximately 2:30 PM the facility Administrator, Director of Nursing and Corporate Clinical Consultant were made aware of the findings. The facility Administrator stated that the Residents have the right to know if someone is a registered sex offender living in the facility. The Corporate clinical consultant said, "It is for the

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F 001	Continued From page 3 safety of the residents so we can provide proper care and safety", the reason it is important to know if someone is a registered sex offender. The Corporate clinical consultant confirmed the facility had no policy regarding the verification of the sex offender registry. No further information was provided. 12 VAC5-371-260(B) (1), (7), (8), & (10) Based on staff interview and facility documentation review, the facility staff failed to ensure resident care staff received annual in-service training for 5 employees (Employee D, RN B, LPN B, CNA B, and CNA D) in a sample of 5 employee training records. The facility staff failed to ensure completion of mandated annual in-service training for Employee D, Registered Nurse (RN) B, License Practical Nurse (LPN) B, Certified Nurse Assistant (CNA) B, and CNA D. The findings included: On 1/26/2022, a copy of facility training records was reviewed by Surveyor E for the selected employee sample and revealed, in the year 2019, the following: 1. Employee D (the Social Worker) did not have record of required annual in-service training in the areas of (1) Special Needs and (7) Understanding the Needs of the Aged/Disabled.	F 001		

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F 001	Continued From page 4 2. RN B did not have record of required annual in-service training in the areas of (1) Special Needs and (7) Understanding the Needs of the Aged/Disabled. 3. LPN B did not have record of required annual in-service training in the areas of (1) Special Needs,and (7) Understanding the Needs of the Aged/Disabled. 4. CNA B did not have record of required annual in-service training in the areas of (1) Special Needs, (7) Understanding the Needs of the Aged/Disabled, (8) Resident Rights and (10) Heimlich maneuver. 5. CNA D did not have record of required annual in-service training in the areas of (1) Special Needs, (7) Understanding the Needs of the Aged/Disabled and (10) Heimlich maneuver. On 1/27/2022 at 11:20 a.m., a group interview was conducted with the Facility Administrator and the Regional Clinical Services Specialist (Employee J) who had provided the staff training records. The Clinical Services Specialist stated she wanted an opportunity to look for more records for each employee since she had "some difficulty running the reports" from the computerized training system used by the facility. . On 1/27/2022 at 3:10 p.m., the Regional Clinical Services Specialist submitted additional records and stated that was the extent of what she was able to find in the computerized training records and the handwritten in-service training sign in sheets. She stated she was unable to find any more documentation of the selected staff	F 001		

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F 001	Continued From page 5 members completing the required education. The additional documentation was reviewed at 3:30 p.m. and revealed lack of documentation of the required education. The Regional Clinical Services Specialist stated the educational requirements had not been met and also stated it was her expectation that "all staff should complete their education". The Facility Administrator stated that the expectation was for the facility staff to complete the required education. No further information was provided.	F 001		