STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RURAL RETREAT CARE CENTER	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 03/15/22 through 03/18/22. Four complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 120 certified bed facility was 101 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1 through #3) and 4 closed record reviews (Residents #4 through #7). VA00054271-Substantiated with deficient practice. VA00054574-Substantiated with deficient practice. VA00054510-Substantiated with deficient practice. VA00054691-Substantiated with deficient practice.	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);	F 580		5/2/22

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

Electronically Signed | 04/22/2022

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F 580	Continued From page 1 (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) 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 interviews, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure a resident's	F 580	1. Resident #4 expired on 10/14/2021. No further action necessary at this time.	

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F 580	Continued From page 2 Responsible Party (RP) was notified of changes in the resident's skin condition for 1 of 7 sampled residents, Resident #4. Resident #4's Responsible Party (RP) was not notified of changes in the condition and treatment of the resident's foot wounds. The findings include: Resident #4's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/13/21, was dated as completed on 9/22/21. Resident #4 was assessed as able to make self understood and as usually able to understand others. Resident #4's BIMS (Brief Interview for Mental Status) Summary Score was a three (3) out of 15; this indicated severe cognitive impairment. Resident #4 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #4's diagnoses included, but were not limited to: anemia, high blood pressure, diabetes, Alzheimer's disease, anxiety, and depression. Resident #4's clinical record included the following information found as part of the provider documentation: - On 9/1/21, " ... resident placed on rounds per staff for bilateral (lower extremity) wounds. Right great toe > [sic] darkened area with no breaks in the skin or erythema noted. Left lateral bunion + [sic] necrotic area with surrounding erythema ... Plan: Skin prep daily right great toe [sic] Cleanse wound left foot with betadine, (normal saline), pat dry and apply calcium alginate dressing daily. Monitor closely and follow up prn (as needed)." - On 9/29/21, " ...resident placed on rounds per	F 580	2. An audit of current resident□s skin integrity was completed on 3/18/2022 by facility nurses with no new areas identified. Notification to residents and/or their responsible party of current wound care status for the week of April 11, 2022 through April 17, 2022 was completed on April 20, 2022 by facility nurses. 3. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for licensed staff to notify the resident and/or their responsible party of significant changes in medical or mental condition, skin integrity status, accidents, injuries, transfers or discharges, new physician□s orders, and discontinued physician□s orders and will be completed by 4/29/2022. 4. The Unit Managers or designee will review new orders, significant changes in medical or mental condition, skin integrity status, accidents, injuries, transfers or discharges, new physician□s orders, and discontinued physician□s orders to ensure residents and/or their responsible party was notified 5 times weekly for 4 weeks and submit to the DON or designee for review weekly. The DON or designee will review the monitoring tools weekly and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. 5. Our date of compliance for this alleged deficient practice is 5/2/2022.	

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F 580	Continued From page 3	F 580		

staff fro [sic] edematous left foot> [sic] resident also has wound on Medial side of left great toe ... Skin: Necrotic wound left great toe (medial)> + [sic] surrounding erythema ... Plan: X-ray left foot (complete views) CBC today, wound culture ... Cleanse wound left foot with betadine, (normal saline), pat dry and apply calcium alginate and dressing daily ... Start Doxycycline 100mg (by mouth twice a day for ten (10)days".
- On 10/1/21, "(left) medial side of foot near great toe. Wound measures 4.2 x 3.0 (centimeters). Great toe is cool to touch. No exudate wound bed is dry, black eschar ... Plan: Paint with betadine (and) cover with cushion disc (change Monday, Wednesday, and Friday and as needed). No wet dressing post shower. Vascular surgeon consult."
- On 10/1/21, " ... + swelling/erythema left (lower extremity) ... Necrotic wound left great toe (medial)> + [sic] surrounding erythema ..."
- On 10/4/21, " ...resident placed on rounds per staff for follow up on Wound culture left foot/great toe: + MRSA ... PHYSICAL EXAM: ... + swelling/erythema left (lower extremity) ... Necrotic wound left great toe (medial)> + [sic] surrounding erythema ..."

Resident #4's clinical documentation included the following entries:
- On 8/30/21 at 3:40 p.m., "(Patient) has a scab with redness on (right) big toe and on (left) big toe. Cleaned and dressed. Put on rounding book for doctor to look at in (the morning)."
- On 9/1/21 at 5:31 p.m., "Resident saw by (nurse practitioner) today for right and left feet. New order obtained to apply skin prep to right great toe daily, and cleanse left foot with (normal saline), pat dry, paint with betadine, apply calcium alginate and cover daily."

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F 580	Continued From page 4	F 580		

- On 9/29/21 at 6:27 p.m., "(new order) received and noted. CBC, wound culture from left foot obtained and set to lab." On 9/29/21 at 6:46 p.m., "(Responsible Party) aware."
- On 9/30/21 at 4:46 p.m., "(X-ray) done on left foot today. Receiving (oral antibiotics) therapy (due to) wound left foot. No signs of adverse reactions noted."
- On 10/4/21 at 12:10 p.m., "Resident seen by (wound nurse practitioner name omitted) with wound to Left [sic] medial side of foot near great toe measuring 4.2 x 3.0. Great toe is cool to touch. No exudate noted. Wound bed dry with black eschar. Treatment written as ordered."
- On 10/7/21 at 5:23 p.m., "(Right) foot has wound to medial side of great toe, wound is black with a large amount of edema and is red [sic]. (Left) foot is edematous and red. Wound care is being done. Patient has a surgical referal [sic]."

The following information was found in a facility policy titled "Charting and Documentation" (with a revised date of April 2008):
- "All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record."
- "Documentation of procedures and treatments shall include care-specific details and shall include at a minimum ... Notification of family, physician or other staff, if indicated ..."

The above documentation of changes in Resident #4's skin condition and skin treatment was found as part of the resident's clinical record. The only Responsible Party (RP) notification related to these issues was documented for the 9/29/21 treatment changes. (On 3/16/22 at 3:45 p.m., the Assistant Director of Nursing (ADON) was

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F 580	Continued From page 5 interviewed about a RP notification dated 10/4/21 at 1:47 p.m.; the ADON reported this notification was related to a pain medication change not changes in the resident's skin assessment.) During an interview on 3/15/22 at 4:30 p.m., the Director of Nursing (DON) was informed the only RP notification of the changes/developments found related to Resident #4's foot/toe condition was dated on 9/29/21. During an interview on 3/16/22 at 4:50 p.m., the DON confirmed the only RP notification related to the aforementioned skin assessment and treatment changes was the 9/29/21 note indicating the Responsible Party (RP) was "aware" of the new orders and of a wound culture being obtained from the left foot. During an interview on 3/16/22 at 10:20 a.m., the DON reported the facility staff should notify the RP of changes in residents' condition and/or changes in residents' orders. This is a complaint deficiency.	F 580		
F 635 SS=D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to obtain physician orders upon the residents	F 635	1. Resident #5 discharged on 2/5/2022. No further action necessary at this time. 2. An audit of new admission charts from	5/2/22

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F 635	Continued From page 6 admission to the facility for 1 of 7 residents, Resident #5. This resulted in the resident not receiving any medications until day 2 of their admission. The findings included: This was a closed record review. Resident #5's diagnoses included, but were not limited to, acute respiratory failure with hypoxia, gout, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of the residents Medicare 5 day assessment with an ARD (assessment reference date) of 02/05/22 had been coded (0/0/1) to indicate the resident had no problems with long and/or short term memory and had modified independence in cognitive skills for daily decision making. A review of Resident #5's clinical record revealed that the resident had been admitted to the facility from an acute care hospital on 02/03/22 at approximately 7:00 p.m. FNP (family nurse practitioner) #1 assessed the resident and transcribed orders on 02/04/22. One day after their admission to the facility. The residents clinical record included an admission completed by FNP #1 "...Resident sitting up in bed today upset because she says that she has not had her medications "in days"..." 03/15/22, review of the eMARS (electronic medication administration records) revealed that Resident #5 had not received any medications until 9:00 p.m. on 02/04/22.	F 635	4/18/2022 to 4/21/22 was completed by facility nurses on 4/22/22 to ensure medication orders were entered and medications received from the pharmacy timely with no issues identified. 3. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for licensed staff to notify the attending provider of the admission, to transcribe medication orders upon admission and administer medications utilizing pharmacy services to include the Omnicell and will be completed by 4/29/2022. 4. The ADON or designee will review new admission charts to ensure medication orders were entered, medications received from the pharmacy timely, and medications administered utilizing pharmacy services to include the Omnicell per providers orders 5 times weekly for 4 weeks and submit findings to DON or designee for review weekly. The DON or designee will review the monitoring tools weekly and investigate any variances with responsive action as appropriate. The DON/designee will submit findings to QAPI Committee monthly for follow up to ensure POC is effective. 5. Our date of compliance for this alleged deficient practice is 5/2/2022.	

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F 635	Continued From page 7 03/16/22 9:50 a.m., LPN (licensed practical nurse) #6 stated Resident #5 arrived at the facility on 2nd shift and the oncoming nurse (LPN #12) stated they would complete the admission process. 03/16/22 10:10 a.m., LPN #12 stated they did have paperwork from the hospital. However, they did not complete an admission assessment and they did not call the physician. LPN #12 stated they had tried to put the orders into the computer system and it may not have taken it "I dropped the ball on that." 03/16/22 10:40 a.m., FNP #1 stated they had completed Resident #5's admission assessment on 02/04/22 and the nursing staff should have called and obtained orders when the resident had been admitted. 03/16/22 2:00 p.m., the DON (director of nursing) provided the surveyor with copies of the following policies: "Reconciliation of Medication on Admission. This policy read in part, "The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility..." "Admission Assessment and Follow Up: Role of the Nurse." This policy read in part, "Contact the Attending Physician to communicate and review the findings of the initial assessment and any other pertinent information and obtain admission orders..." 03/16/22 4:30 p.m., during an end of the day meeting with the survey team the DON stated they would have expected the nursing staff to	F 635		

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F 635	Continued From page 8 complete an admission, assessment, document the assessment, and of course obtain medication orders upon the residents admission to the facility. No further information regarding this issue was provided to the survey team prior to the exit conference. This is a complaint deficiency.	F 635		
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 staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure the highest practicable well-being for 5 of 7 residents, Resident's #6, #5, #7, #4, and #2. The facility nursing staff failed to initiate a medical emergency when a resident became choked (Resident #6), failed to obtain physician orders when a resident was admitted to the facility resulting in the resident not receiving any medications until day 2 of their admission (Resident #5), failed to administer medications as ordered by the provider (Residents #7 and #2),	F 684	1.a. Resident #6 expired on 11/17/2021. No further action possible at this time. 1.b. Resident #5 discharged on 2/5/2022. No further action necessary at this time. 1.c. Resident #7 discharged on 1/22/2022. No further action necessary at this time. 1.d. Resident #4 expired on 10/14/2021. No further action possible at this time. 1.e. Resident #2 discharged on	5/2/22

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F 684	Continued From page 9 failed to consistently provide antibiotics and wound treatment as ordered by a medical provider, and failed to obtain a vascular surgeon consult as ordered by a medical provider (Resident #4). The findings included: 1. Resident #6's diagnoses included, but were not limited to, Alzheimer's disease, acute respiratory failure with hypoxia, vascular dementia without behavioral disturbance, major depressive disorder, insomnia, and unspecified psychosis not due to a substance or known physiological condition. This was a closed record review. Section C (cognitive patterns) of Resident #6's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/04/21 included a BIMS (brief interview for mental status) summary score of 7. Per the MDS manual a score of 0-7=severe impairment in cognitive skills. Section G (functional status) was coded 3/3 for transfers indicating the resident required extensive assistance of two persons for this task. Eating was coded 1/3 for supervision of two persons. Resident #6 was coded as having no limitations in range of motion and as using a wheelchair for mobility. Resident #6's comprehensive care plan included the problem areas of communication has unclear speech at times, cognitive loss/dementia, at nutrition risk related to need for altered textured diet, requires assistance eating, advance directive to be followed by my wish and MD order. Approaches included but were not limited to, diet	F 684	3/17/2022. No further action necessary at this time. 2.a. An audit of medical emergencies experienced by current residents for March 19 - April 20, 2022 was completed by facility nurses on 4/22/2022. If variances are identified the attending physician will be notified and the incident will be thoroughly investigated by the DON and/or designee. 2.b. An audit of new admission charts from 3/19/2022 to 4/20/2022 was completed by facility nurses on 4/22/22 to ensure medication orders were entered and medications received from the pharmacy timely. The prescribing practitioner will be notified of any variances. 2.c & e. An audit of April Medication Administration Records was completed by facility nurses on 4/22/2022 with corrections completed at that time. Licensed staff were re-educated and/or counseled by the DON and/or designee as appropriate with the findings. 2.d. An audit of April Treatment Administration Records and medical provider consults was completed by facility staff on 4/22/2022 with corrections made at that time. Licensed staff were re-educated and/or counseled by the DON and/or designee as appropriate with the findings. 3.a. On 4/21/2022, education was initiated	

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F 684	Continued From page 10 per order regular, dysphagia advanced, offer routine snacks between meals, monitor and document PO (by mouth) intake, and DNR (do not resuscitate). Resident #6's clinical record included a signed DDNR (durable do not resuscitate order) from the Virginia Department of Health dated 06/25/21. Resident #6's "Order Summary Report" included a DNR order (09/30/21). The residents diet was documented as a regular diet, dysphagia advanced texture, regular/thin consistency (03/20/21). 11/17/21 1:30 a.m., LPN (licensed practical nurse) #3 documented, "Called to nurses desk to observe resident choking and attempted to get resident to cough unable to cough. Attempted to clear airway by doing a blind finger sweep removed a large amount of food from airway. Then continued to perform Heimlich maneuver. Resident became limp and unable to obtain vital sings. Resident expired at 1:45 am on 11/17/2021. DON (director of nursing) aware and _____ FNP and new order to send to Funeral Home of choice..." 11/17/21 12:27 p.m., LPN #13 documented the residents body was released to the funeral home at 12:25 p.m. There was no documentation to indicate an RN (registered nurse) had pronounced the resident. 03/17/22 10:30 a.m., DON stated while doing the Heimlich their expectation would have been to call a code. The DON stated they were not aware of this occurrence. It was later determined the	F 684	by the ADON and/or Unit Managers for all licensed staff to initiate EMS via 911 with medical emergencies, regardless of code status and will be completed by 4/29/2022. 3.b. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for licensed staff to transcribe medication orders upon admission and administer medications utilizing pharmacy services to include the Omnicell. Education will be completed by 4/29/2022. 3.c & e. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for licensed staff to order medications from the pharmacy upon admission, readmission, when current supply is nearly exhausted and to notify the provider when a medication is ordered but cannot be obtained so a new order can be initiated. Education will be completed by 4/29/2022. 3.d. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for licensed staff to administer medications per the physician□s orders utilizing pharmacy services to include the Omnicell, complete treatments per the physician□s orders, and obtain consults as ordered by a medical provider. Education will be completed by 4/29/2022. 4.a.1. The Unit Managers or designee will review all reported medical emergencies to ensure that facility staff appropriately initiate EMS via 911 per facility protocol or	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RURAL RETREAT CARE CENTER	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 684	Continued From page 11 ADON (assistant director of nursing) had been the contact person and not the DON as LPN #3 transcribed. 03/17/22 11:18 a.m., FNP (family nurse practitioner) #2, stated they did not remember this incident but would have called EMS (emergency medical services). FNP #2 stated if the staff waited to call after the resident had expired/did not have a pulse, they would tell them to send them to the funeral home. 03/17/22 11:40 a.m., interview with FNP #1. When asked if they would have expected the facility staff to call EMS FNP stated, they probably should have called EMS since this was not natural causes. 03/17/22 7:30 p.m., LPN #3 Resident #6 was behind the nurses station/desk and they saw something in their mouth. The unit helper gave the resident a fudge round and they were able to clear that out. After removing the fudge round LPN #3 stated they then started getting a stringy white substance and they had tried to clear the residents airway numerous times with their fingers. The resident was responsive and then they became unresponsive, they kept clearing the residents mouth, and for about 30 minutes they had tried to clear the residents airway and do the Heimlich maneuver. LPN #3 stated they did not attempt to call 911, no one was called, they did not remember asking anyone to call 911, and stated they were just trying to get the resident to breathe. LPN #3 stated the CNA (certified nursing assistant) working with them was trying to help find something to suction the resident with, went to the other side (unit) of the building, but they did not come back with anything. LPN #3 stated the	F 684	resident advanced directives weekly for 4 weeks and submit to the DON or designee for review weekly. All variances will be thoroughly investigated with appropriate re-education/counseling to the involved team members by the DON and/or designee. 4.a.2. The DON and/or designee will conduct unannounced emergency drills twice monthly for 2 months to observe that staff appropriately respond to the emergency situation and follow facility protocol and honor the resident□s plan of care. Findings from the emergency drills will be reported to the facility QAPI committee monthly. The DON or designee will review the monitoring tools weekly and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. 4.b. The ADON or designee will review new admission charts to ensure medication orders were entered and medications received from the pharmacy timely 5 times weekly for 4 weeks and submit findings to DON or designee for review weekly. All variances will be thoroughly investigated with appropriate re-education/counseling to the involved team members by the DON and/or designee. The DON or designee will review the monitoring tools weekly and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. 4.c & e. The Unit Managers or designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RURAL RETREAT CARE CENTER	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 684	Continued From page 12 other nurse working on this side of the building was on break and did not return until the incident was over. The nurse on the other side did not know anything had happened. When asked about calling 911 LPN #3 stated in the moment I was just trying to get him (the resident) to breathe. LPN #3 asked what she had been instructed to do when someone chokes, stated clear their airway, start the Heimlich maneuver, if they are a full code CPR, and then turn them on their side. LPN #3 stated this resident was a DNR. 03/18/22, the DON identified the CNA working with LPN #3 as CNA #2. 03/18/22 2:30 p.m., CNA #2 stated the unit helper gave the resident a drink, snack cake, and a sandwich, the resident got choked, and along with LPN #3 they tried the Heimlich, tried to get the food out of the residents mouth and it did not work. CNA #2 stated they were unable to find any suction supplies so they had grabbed a bunch of toothettes and tried to dig the substance up and out of the residents mouth. CNA #2 had went to the other side of the building to find these supplies. CNA #2 stated they did not remember telling anyone else working that the resident was having any difficulty and the resident was still coughing and gagging when they returned. When asked if there was any discussion about calling 911 or any issues with performing the Heimlich CNA #2 stated they tried standing the resident up but by then they were getting limber. CNA #2 stated they did not know if this resident was a full code or DNR. 03/18/22 10:05 a.m., DON identified the unit helper as a staff that was suspended due to another issue and since the staff had been	F 684	will review Medication Administration Records to ensure ordered medications have been administered per provider□s orders 5 times weekly for 4 weeks and submit to the DON or designee for review each week. All variances will be thoroughly investigated with appropriate re-education/counseling to the involved team members by the DON and/or designee. The DON or designee will review the monitoring tools weekly and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. 4.d. The Unit Managers or designee will review Treatment Administration Records to ensure ordered treatments have been completed per the provider□s orders and will review provider consults to ensure completion 5 times weekly for 4 weeks and submit to the DON or designee for review each week. All variances will be thoroughly investigated with appropriate re-education/counseling to the involved team members by the DON and/or designee. The DON or designee will review the monitoring tools weekly and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. 5. Our date of compliance for this alleged deficient practice is 5/2/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RURAL RETREAT CARE CENTER	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

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F 684	Continued From page 13	F 684		

suspended they had not heard back from them.

03/18/22 10:10 a.m., MD (medical director) stated that if the patient was responsive the Heimlich maneuver and finger sweep was appropriate and they would not have resuscitated this resident. When asked about the staff calling 911 the MD stated, there is room for argument there. The MD added over the last 24 hours after having a conversation with someone (no name given) they had learned that it is reasonable to perform CPR or activate 911 during an occurrence such as this and then added as of yesterday morning I would not have felt that way.

03/18/22, the facility staff provided the surveyor with a copy of the residents certificate of death. The immediate cause of death was documented as chronic obstructive pulmonary disease, Alzheimer's dementia, oropharyngeal dysphasia, and atrial fibrillation.

No further information regarding this issue was provided to the survey team prior to the exit conference.

This is a complaint deficiency.

2. Resident #5's diagnoses included, but were not limited to, acute respiratory failure with hypoxia, gout, and chronic obstructive pulmonary disease.

This was a closed record review.

Section C (cognitive patterns) of the residents Medicare 5 day assessment with an ARD (assessment reference date) of 02/05/22 had been coded (0/0/1) to indicate the resident had no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 14	F 684		

problems with long and/or short term memory and had modified independence in cognitive skills for daily decision making.

A review of Resident #5's clinical record revealed that the resident had been admitted to the facility from an acute care hospital on 02/03/22 at approximately 7:00 p.m. The FNP (family nurse practitioner) assessed the resident and transcribed physician orders on 02/04/22. One day after the residents admission to the facility.

03/15/22, review of the eMARS (electronic medication administration records) revealed that Resident #5 had not received any medications until 9:00 p.m. on 02/04/22.

03/16/22 9:50 a.m., LPN (licensed practical nurse) #1 stated Resident #5 arrived at the facility on 2nd shift and the oncoming nurse (LPN #2) stated they would finish up the residents admission.

03/16/22 10:10 a.m., LPN #2 stated they did have paperwork from the hospital. However, they did not complete an admission assessment and they did not call the physician. LPN #2 also stated they had tried to put the orders into the computer system and it may not have taken it "I dropped the ball on that."

03/16/22 10:40 a.m., FNP #1 stated they had completed Resident #5's admission on 02/04/22 and the nursing staff should have called and obtained orders when the resident had been admitted.

03/16/22 2:00 p.m., the DON (director of nursing) provided the surveyor with a copy of a policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 684	Continued From page 15 titled, ""Admission Notes." This policy read in part, "Preliminary resident information shall be documented upon a resident's admission to the facility. l. When a resident is admitted to the nursing unit, the admitting Nurse must document the following information (as each may apply) in the nurses' notes, admission form, or other appropriate place, as designated by facility protocol: a. The date and time of the resident's admission; b. The resident's age, sex, race, and marital status; c. From where the resident was admitted (i.e., hospital, home, other facility); d. Reason for the admission; e. The admitting diagnosis; f. The general condition of the resident upon admission; g. The time the Attending Physician was notified of the resident's admission; h. The time the physician's orders were received and verified; i. Description of any lab work completed or the time specimens were sent to the lab: j. The presence of a catheter, dressings, etc.; k. The time the Dietary Department was notified of the diet order; l. The time medications were ordered from the pharmacy; m. A brief description of any disabilities (i.e., blind, deaf, hemiplegia, speech impairment, paralysis, mobility, etc.); n. Any known allergies; o. Prosthesis required (i.e., glasses, dentures, hearing aid, artificial limbs, eye, etc.); p. The height and weight of the resident; q. A statement indicating that the nursing history and preliminary assessment is completed or has	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 16	F 684		

been started;
r. Notation of any signs or symptoms of an infectious or communicable disease;
s. Notation as to whether or not advance directives apply; and
t. The signature and title of the person recording the data.
2. This initial information-gathering precedes the complete history and physical assessment that also accompanies the resident admission process."

03/16/22 4:30 p.m., during an end of the day meeting with the survey team the DON stated they would have expected the nursing staff to complete an admission assessment, document the assessment, and obtain medication orders upon the residents admission to the facility.

No further information regarding this issue was provided to the survey team prior to the exit conference.
3. Resident #4's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/13/21, was dated as completed on 9/22/21. Resident #4 was assessed as able to make self understood and as usually able to understand others. Resident #4's BIMS (Brief Interview for Mental Status) Summary Score was a three (3) out of 15; this indicated severe cognitive impairment. Resident #4 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #4's diagnoses included, but were not limited to: anemia, high blood pressure, diabetes, Alzheimer's disease, anxiety, and depression.

Resident #4's clinical documentation included the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 17	F 684		

following nursing entries:
- On 8/30/21 at 3:40 p.m., "(Patient) has a scab with redness on (right) big toe and on (left) big toe. Cleaned and dressed. Put on rounding book for doctor to look at in (the morning)."
- On 10/4/21 at 12:10 p.m., "Resident seen by (wound nurse practitioner name omitted) with wound to Left [sic] medial side of foot near great toe measuring 4.2 x 3.0. Great toe is cool to touch. No exudate noted. Wound bed dry with black eschar. Treatment written as ordered."
- On 10/7/21 at 5:23 p.m., "(Right) foot has wound to medial side of great toe, wound is black with a large amount of edema and is red [sic]. (Left) foot is edematous and red. Wound care is being done. Patient has a surgical referal [sic]."

A "Skin Only Evaluation" form, dated 10/10/21 at 4:22 p.m., was found in Resident #4's clinical record. This form indicated the resident had an infection of the left foot with cellulitis and purulent drainage. The wound was documented as having no odor. The skin tissue was documented as painful, boggy, and warm. This form did not include measurements of the wound.

During an interview on 3/15/22 at 2:17 p.m., the facility's Assistant Director of Nursing (ADON) reported there should be weekly documentation of residents' skin assessments. Documentation of Resident #4's skin/wound nursing assessments, from 9/1/21 through the resident's discharge, were requested.

On 3/16/22 at 9:19 a.m., the ADON reported, during the time of Resident #4's foot wounds, the facility's wound nurse was documenting on paper but not putting the assessments in the clinical record. The ADON reported they were unable to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RURAL RETREAT CARE CENTER	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 684	Continued From page 18	F 684		

find the aforementioned wound nurse's documentation for Resident #4.

On 3/16/22 at 3:20, the Director of Nursing (DON) was made aware of Resident #4's nursing skin assessments not being available due to paper documentation not being included in the clinical record.

On 3/17/22 at 11:41 a.m., the DON and the ADON was interviewed about Resident #4's nursing skin assessments. It was reported no additional nursing skin assessments for Resident #4 were available.

Resident #4's clinical record included Nurse Practitioner (NP) #9's note dated 10/1/21. This note included the following information: "(left) medial side of foot near great toe. Wound measures 4.2 x 3.0 (centimeters). Great toe is cool to touch. No exudate wound bed is dry, black eschar ... Plan: Paint with betadine (and) cover with cushion disc (change Monday, Wednesday, and Friday and as needed). No wet dressing post shower. Vascular surgeon consult."

Resident #4's clinical record also included an order for a vascular surgeon consult with an effective date of 10/4/21.

Resident #4's clinical record did not include documentation indicating the vascular surgeon consult was scheduled, or that facility staff attempt to schedule the vascular surgeon consult.

During an interview on 3/15/22 at 2:17 p.m., the facility's Assistant Director of Nursing (ADON) was asked for documentation related to Resident #4's vascular surgeon consult.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RURAL RETREAT CARE CENTER	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 684	Continued From page 19 On 3/16/22 at 4:25 p.m., the facility's DON and ADON was asked about Resident #4's vascular surgeon consult. The DON reported they were still working on the vascular surgeon consult. On 3/17/22 at 8:31 a.m., the DON stated, they were informed by the ADON and the Director of Medical Records (DMR), that Resident #4's family initially did not want the vascular surgeon consult; the DON stated this was not documented. On 3/17/22 at 9:28 a.m., the ADON was unable to provide documentation to address the aforementioned vascular surgeon consult. The ADON reported that a unit secretary sent ten (10) different referrals; the ADON reported they were unable to get an appointment. The ADON stated this was during the COVID-19 pandemic and some of the providers were not taking new patients. The ADON reported there was no documentation, of the medical provider who ordered the vascular consult, being notified of the inability to schedule the consult. During an interview on 3/17/22 at 9:54 a.m., the ADON reported they were unable to find documentation of the attempts to schedule the vascular consult. The ADON reported that usually staff would notify the provider if a referral/consult could not be arranged after seven (7) days. The unit secretary who attempted to schedule this consult was no longer employed at the facility. On 3/17/21 at 10:01 a.m., the DMR confirmed Resident #4's clinical record did not include documentation of attempts to schedule the vascular surgeon consult.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 20	F 684		

Review of a "log book" for the Wound Care Nurse Practitioner (WCNP) (NP #9) revealed Resident #4's name on a page dated 10/8/21 for the resident to be seen to "Recheck surg. wound". One of the orders documented on this page was for a "Vascular surgeon consult ASAP'. On 3/18/22 at 9:50 a.m. the DON was asked about the aforementioned surgical wound; the DON confirmed Resident #4 did not have a surgical wound.

NP #9 was interviewed, about Resident #4, on 3/17/22 at 9:35 a.m. NP #9 reported the left foot was cool to touch and the left dorsalis pedis pulse was not palpable. NP #9 confirmed they had ordered a vascular consult and expected it to be provided "as soon as possible". NP #9 stated they did not see Resident #4 on 10/8/21; NP #9 stated they thought the resident was out of the building on 10/8/21. (No documentation was found to indicate Resident #4 was out of the building on 10/8/21.) NP #9 stated Resident #4's left foot wound was probably not an emergent issue due to the other toes being warm. NP #9 stated it was a vascular issue due to decreased blood flow.

Review of Resident #4's TARs (treatment administration records) revealed the absence of documentation to indicate the following provider ordered treatments were provided:
- There was no documentation on 9/6/21, 9/8/21, 9/9/21, 9/10/21, 9/18/21, 9/23/21, and 10/2/21 to indicate skin prep was applied to the right great toe as ordered.
- There was no documentation on 9/6/21, 9/8/21, 9/9/21, 9/10/21, 9/18/21, 9/21/21, 9/23/21, 10/2/21, and 10/4/21 to indicate the left foot wound was cleansed with normal saline, patted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 21	F 684		

dry, painted with betadine, had calcium alginate applied and covered with a dry dressing as ordered.

On 3/16/22 at 4:25 p.m., the absent documentation of Resident #4's provider ordered wound/skin treatments was discussed with the facility's DON and ADON; the DON reported no additional treatment documentation was available.

The following information was found in a facility policy/procedure titled "Wound Care" (with a revised date of October 2010):
- "Purpose ... The purpose of this procedure is to provide guidelines for the care of wounds to promote healing."
- "Documentation ... The following information should be recorded in the resident's medical record. 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data."
- "Reporting ... 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice."

Review of Resident #4's MARs (medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 22	F 684		

administration records) indicated Bactrim DS was not administered as ordered for the 10/4/21 4:00 p.m. dose and the 10/6/21 4:00 p.m. dose.

Nursing documentation, for the 10/4/21 dose, indicated they were "awaiting delivery from pharmacy" to administer the medication. Nursing documentation, for the 10/6/21 dose, indicated the medication was not sent by pharmacy and was not in the facility's stat/emergency medication supply.

The DON was interviewed about the missing medications on 3/17/22 at 8:31 a.m. The DON confirmed the Bactrim DS was in the facility's stat/emergency medication supply. The DON confirmed no documentation was found to indicate an attempt to obtain the medication for the aforementioned missed doses. The DON stated a medical provider should be notified if a medication is not available as ordered; the DON reported no documentation was found of provider notification of the aforementioned missed Bactrim DS doses.

The following information was found in a pharmacy policy titled "Unavailable Medications" (with an effective date of September 2018):
- "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, or manufacturer's shortage of an ingredient, or may be a permanent situation due to the medication no longer being produced. The facility must make every effort to ensure that medications are available to meet the needs of each resident."
- "The nursing staff shall: 1. Notify the attending

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RURAL RETREAT CARE CENTER	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 684	Continued From page 23	F 684		

physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 2. Obtain a new order and cancel/discontinue the order for the non-available medication. 3. Notify the pharmacy of the replacement order."

Emergency Department (ED) documentation indicated Resident #4 presented with weakness and fatigue with "worsening diabetic foot ulcer" which has been treated with antibiotics (Bactrim and doxycycline). The resident was assessed as having +1 dorsalis pedis and posterior tibial pulses bilaterally. The following was included in the ED provider notes: "(Bilateral lower extremity) +2 edema. Left foot has diabetic foot ulcer plantar side of first (metatarsophalangeal) joint with necrotic tissue radiating outward covering span of big toe, down into medial arch and laterally across midfoot. There is erythema extended proximally up foot into mid shin. Appears tender to palpation, decreased pulses and (capillary) refill noted bilaterally. No abnormal discharge or fluctuance." The History and Physical (H&P) document at the local hospital included the following information as part of the "Assessment & Plan": "Severe sepsis/ (right lower extremity) cellulitis/R toe/foot necrosis ... [sic]" This was treated with antibiotics and intravenous fluids. This H&P (and the hospital Discharge Summary) indicted Resident #4's family requested hospice services.

The failure of facility staff members to provide the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 24	F 684		

aforementioned wound care and antibiotics was discussed for a final time during a survey team meeting with the facility's DON, on 3/18/22 at 2:00 p.m.

This is a complaint deficiency.

4. Resident #7's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/3/21, was dated as completed on 12/14/21. Resident #7 was documented as able to make self understood and as able to understand others. Resident #7's BIMS (Brief Interview for Mental Status) Summary Score was documented as an eight (8) out of 15; this indicated moderate cognitive impairment. Resident #7 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #7's diagnoses included, but were not limited to: heart failure, high blood pressure, kidney disease, diabetes, Alzheimer's disease, anxiety, Bipolar Disorder, and Schizophrenia.

Resident #7's medical provider orders included an order dated 9/28/21 for "Ativan Tablet 0.5 mg (LORazepam) Give 0.5 mg by mouth two times a day ..." This order was to start on 10/1/21 and this order had no stop date.

Resident #7's medication administration records (MARs) for January 2022 indicated the following four (4) doses of Ativan 0.5 mg was not provided: (1) 10:00 a.m. on 1/19/22, (2) 10:00 a.m. on 1/20/22, (3) 10:00 a.m. on 1/21/22, and (4) 10:00 p.m. on 1/21/22. These doses were documented with a "5" which indicated "Hold/See Progress Notes". Nursing notes, dated for 1/21/22 at 11:27 a.m. and 1/21/22 at 10:15 p.m., indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

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F 684	Continued From page 25	F 684		

medication was "on hold pharmacy needed new script" [sic]. A nursing note, dated 1/20/22 at 9:09 a.m., documented "ativan on hold awaiting script from (physician)". A nursing note, dated 1/19/22 at 9:37 a.m., documented "ativan not available at this time." (Resident #7 was documented as being provided the Ativan on 1/19/22 at 10:00 p.m. dose and on 1/20/22 at the 10:00 p.m. dose.)

On 3/17/22 at 3:40 p.m., the failure of the facility staff to administer the aforementioned Ativan doses was discussed with the facility's DON (Director of Nursing). The DON reported the medications should have been given because the medicine was available as part of the facility's stat/emergent medication supply.

This is a complaint deficiency.

5. Resident #2's admission record noted their diagnoses included, but were not limited to, other sequelae of cerebral infarction (death of brain tissue), bipolar disorder (mental health condition causing extreme mood swings), adult failure to thrive, generalized anxiety disorder, pressure ulcer of sacral region, discoid lupus erythematosus (chronic skin condition), lymphedema (tissue swelling), and major depressive disorder. Resident #2's minimum data set with an assessment reference date of 02/28/2022 coded a brief interview for mental status summary score of 10 out of 15 in Section C (cognitive patterns).

Resident #2's clinical record was reviewed on 03/15/2022 through 03/18/2022. The resident was admitted on 01/15/2022 and the provider orders for medications included but were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

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F 684	Continued From page 26	F 684		

limited to:
1. Olanzapine Tablet 2.5 MG. Give 2.5 mg by mouth at bedtime for mood disorder with psychosis, sleep with a start date of 01/15/2022 at 9:00 p.m., and
2. Gabapentin Capsule 100 MG. Give 100 capsule by mouth two times a day for pain with a start date of 01/15/2022 at 9:00 p.m., and
3. Lorazepam Tablet 0.5 MG. Give 0.25 mg by mouth two times a day for anxiety with a start date of 01/15/2022 at 9:00 p.m.
The MAR (medication administration record) noted on 01/15/2022, the 9:00 p.m. doses Olanzapine, Gabapentin, and Lorazepam had not been given.

The RN (registered nurse) who documented the medications were not administered was interviewed on 03/16/2022 at 10:46 a.m. She reported she did not have access to the facility's medication distribution system (Omnicell) which may have contained the medications and that she normally asks someone with access to retrieve medications for her. The RN provided two notes where she wrote for both the Lorazepam and Gabapentin doses, "Will give when medication comes in." The nurse reported that she didn't give the medications, "I didn't give it. It never came in, I guess." The RN did not recall notifying the physician about the unavailable medications.

A review of the Omnicell Inventory revealed the system contained both Lorazepam and Gabapentin but not Olanzapine. The surveyor called the facility's offsite pharmacy and spoke with the Director of Quality who was also a pharmacist. The first request for a code (narco code) to access Gabapentin and Lorazepam for Resident #2 was on 01/17/2022. The director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

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F 684	Continued From page 27	F 684		

reported the admission order for Olanzapine was dispensed and went out on the evening of 01/15/2022 and arrived at the facility in the early morning of 01/16/2022.

During a meeting with the director of nursing (DON) on 03/18/2022 at 2:00 p.m., the DON reported her expectation related to availability of admission medications were for the nurse to call the pharmacy to receive a "pull code" and provide a prescription to be on file. If the nurse had no prescription, they should call the physician to obtain a prescription. The DON explained the nurse could have called the on-call physician but also could have called the facility's nurse practitioner. The DON stated there was never only one person in the facility with access to Omnicell and that the RN who failed to administer the medications actually did have access to Omnicell and that at a minimum, the staff should have notified the physician about the medications that were unavailable.

The facility's pharmacy policy titled, "Unavailable Medications" with a revision date of 08-2020 read, in part, "The nursing staff shall: 1. Notify the attending physician (or on-call physician when applicable) of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available. 2. Obtain a new order and cancel/discontinue the order for the non-available medication. 3. Notify the pharmacy of the replacement order."

No further information was provided prior to the exit conference.

This is a complaint deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

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F 755	Continued From page 28	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure medications were available for	F 755	1. Resident #1 discharged on 3/28/2022. No further action necessary at this time.	5/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

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F 755	Continued From page 29 administration for 1 of 7 Residents, Resident #1. This resulted in Resident #1 not receiving all of their physician ordered medications. The findings included: Resident #1's diagnosis included, but was not limited to, chronic systolic congestive heart failure, type 2 diabetes, essential hypertension, gastro-esophageal reflux disease, chronic obstructive pulmonary disease, gout, and chronic kidney disease. There was no completed MDS (minimum data set) assessment completed on this resident. Resident #1 was alert and orientated to person, place, and time. 03/10/22 10:52 a.m., LPN (licensed practical nurse) #10 documented an "Admission Summary" stating "Resident arrived to the facility via family's personal vehicle..." Resident #1's order summary report included the following orders: Zenpep 1 capsule by mouth with meals for digestion. Order date 03/10/22 start date 03/10/22. Losartan 100 mg one time a day for hypertension. Order date 03/10/22 start date 03/11/22. Spiriva 2 puffs inhale orally one time a day for allergies. Order date 03/10/22 start date 03/11/22. A review of Resident #1's eMARs (electronic medication administration records) revealed that the nursing staff had documented a "9" for the Losartan and Spiriva on 03/11/22 at 9:00 a.m. For the Zenpep the facility nursing staff had documented a "9" on 03/10/22 at 12:00 p.m. and	F 755	2. An audit of all medication carts was completed on 4/14/2022 by facility nurses to ensure that all medications are available per the physician□s orders with no issues identified. 3.a. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for licensed staff to order medications from the pharmacy upon admission, readmission, or when current supply is nearly exhausted and to notify the provider when a medication is ordered but cannot be obtained from the pharmacy or from the Omnicell so a new order can be initiated. Nursing staff will report any difficulty in obtaining prescribed medications to the DON and/or designee. 3.b. The facility will coordinate with the pharmacy in reviewing the medications typically used within the facility to ensure that appropriate supply is maintained in the Omnicell. When ordered medications are not available in a timely manner, the prescribing practitioner will be notified and/or assistance may be obtained from a back-up pharmacy. 4. The Unit Managers or designee will review medication carts and active pharmacy orders to ensure ordered medications are available per the physician□s orders weekly for 4 weeks and submit to the DON or designee for review weekly. The DON or designee will review the monitoring tools weekly, investigate any variances, and submit findings to QAPI Committee monthly for	

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F 755	Continued From page 30 5:00 p.m. Per the preprinted code on this form a 9="Other/See Progress Notes." A review of Resident #1's progress notes revealed the following nursing documentation: 03/10/22 11:58 a.m., LPN #10 Zenpep-waiting arrival from pharmacy new admit. 03/10/22 4:02 p.m., LPN #10 Zenpep-waiting arrival from pharmacy new admit. 03/11/22 8:45 a.m., LPN #4 Losartan-waiting on pharmacy delivery. 03/11/22 8:46 a.m., LPN #4 Spiriva-waiting on pharmacy delivery. Resident #1's care plan included the intervention, "Administer medications as ordered..." 03/15/22 1:30 p.m., LPN #10 stated if the residents medications were not available for administration they would call the pharmacy to see if it would be on the next shipment and if the medication(s) were available in the omnicell, we would get authorization to pull it. A review of the omnicell list revealed these medications would not have been available in the omnicell for administration. 03/16/22 4:30 p.m., during an end of the day meeting with the DON (director of nursing) and ADON (assistant director of nursing) these staff were made aware of the issue regarding Resident #1 medications not being available for administration. 03/17/22 9:05 a.m., the facility provided the survey team with a copy of a policy titled, "Unavailable Medications" this policy read in part, "...The facility must make every effort to ensure	F 755	follow up to ensure POC is effective. 5. Our date of compliance for this alleged deficient practice is 5/2/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 755	Continued From page 31 that medications are available to meet the needs of each resident...the nursing staff shall notify the attending physician of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the Family Medical Director for orders and/or direction. Obtain a new order and cancel/discontinue the order for the non-available medication. Notify the pharmacy of the replacement order." The facility did not provide any information to the surveyor to indicate this had been done. 03/18/22 8:14 a.m., the DON provided the survey team with a document indicating their pharmacy delivered three times a day. Late afternoon for requests prior to 9:00 a.m., late evening for requests made prior to 4:00 p.m., and over-night for request made prior to 9:00 p.m. 03/18/22 11:02 a.m., LPN #2 stated if medications were not available for administration they would go to the cubex (omnicell/back up supply) and if the medication was not available/stocked they would call the pharmacy to do a stat (immediate) delivery. If the pharmacy were unable to do a stat run, they would obtain the medication from the nearest pharmacy. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 755		
F 756 SS=F	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)	F 756		5/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 756	Continued From page 32 §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 756	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on interviews and facility document review, the facility staff failed to ensure monthly medication regimen reviews (MRRs) were completed for the facility's residents. Resident #7's clinical record failed to include monthly pharmacy medication regimen reviews (MRRs). The facility's Director of Nursing (DON) reported the monthly pharmacy MRRs had not been completed since October 2021. The findings include: Review of Resident #7's clinical record, on 3/17/22, failed to reveal evidence of monthly medication regimen reviews (MRRs) being completed by a pharmacist. Resident #7's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/3/21, was dated as completed on 12/14/21. Resident #7 was documented as able to make self understood and as able to understand others. Resident #7's BIMS (Brief Interview for Mental Status) Summary Score was documented as an eight (8) out of 15; this indicated moderate cognitive impairment. Resident #7 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #7's diagnoses included, but were not limited to: heart failure, high blood pressure, kidney disease, diabetes, Alzheimer's disease, anxiety, Bipolar Disorder, and Schizophrenia.	F 756	1. Resident #7 discharged on 1/22/2022. A new Consultant Pharmacist Service was immediately obtained by the facility to complete the Monthly Pharmacy Medication Regime Reviews on 3/18/2022. 2. Senior Care Consultant Groups, LLC completed an audit of all current residents□ medications, generated a Medication Regime Review for each resident as appropriate on 3/18/2022 and submitted them to the facility for the Medical Providers review. 3. On 3/18/2022, education was initiated by the DON and/or designee for the Nurse Managers to ensure that the Monthly Pharmacy Medication Regime Reviews are submitted to the Medical Providers upon receipt from the Consultant Pharmacist. Once the Medical Providers have reviewed and signed the Drug Regime Reviews, facility nursing staff will document the provider□s response and any new orders obtained and submit completed forms to the Medical Records Department to scan into the resident□s electronic medical record. 4. The ADON or designee will review medication regime reviews submitted by the Consultant Pharmacist to ensure that the provider has responded to the review as needed and new orders by the Medical Providers are noted and documented timely every month for 3 months and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

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F 756	Continued From page 34 The absence of Resident #7's monthly pharmacy MRRs was discussed during a survey team meeting the with facility's DON and ADON (Assistant Director of Nursing) on 3/17/22 at 4:25 p.m. The DON reported the missing MRRs was identified during the week prior to this interview. The DON reported the facility changed pharmacies on 10/1/21 and that no MRRs had been completed at the facility since that date. During an interview on 3/18/22 at 1:00 p.m., the DON reported the facility's agreement/contract with a pharmacy did not include a consultant pharmacist for the monthly MRRs. The DON was asked for the facility's MRR policy. On 3/18/22 at 1:42 p.m., the DON provided a pharmacy policy titled "Consultant Pharmacist Services Provider Requirements" (with an effective date of August 2020). This policy contained the following information: "Specific activities that the consultant pharmacist performs may include, but are not limited to: a. Reviewing the medication regimen (medication regimen review) of each resident at least monthly, or more frequently under certain conditions (e.g., upon admissions or with a significant change in condition), incorporating federally mandated standards of care in addition to other applicable professional standards as outlined in the procedure for medication regimen review, and documenting the review and findings in the resident's medical record or in a readily retrievable format if utilizing electronic documentation. b. Communicating to the responsible prescriber and the facility leadership potential or actual problems detected and other findings related to medication therapy orders including recommendations for changes in	F 756	submit to the DON or designee for review monthly. The DON or designee will review the monitoring tools monthly and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. 5. Our date of compliance for this alleged deficient practice is 5/2/2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RURAL RETREAT CARE CENTER	514 NORTH MAIN STREET RURAL RETREAT, VA 24368

(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 756	Continued From page 35 medication therapy and monitoring of medication therapy, as well as regulatory compliance issues at least monthly." The failure of the facility staff to ensure the completion monthly MRRs, for residents since October of 2021, was discussed during a survey team meeting with the DON on 3/18/22 at 2:00 p.m. The DON reported a pharmacist was contacted on 3/17/22 and the MRRs for the facility's residents were started on 3/17/22.	F 756		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure 1 of 7 residents were free of a significant medication error. Resident #1 did not receive their Humulin R insulin per the physicians orders. The findings included: Resident #1's diagnosis included type 2 diabetes. There was no completed MDS (minimum data set) assessment on this resident. Resident #1 was alert and orientated to person, place, and time. A review of Resident #1's EHR (electronic health record) revealed that the facility nursing staff had transcribed an order for Humulin R insulin 23	F 760	1. Resident #1 discharged on 3/28/2022. No further action necessary at this time. 2. An audit of new admission charts from 4/18/2022 to 4/21/2022 was completed by facility nurses on 4/22/22 to ensure medication orders were entered, ordered medications were received from the pharmacy timely and medications, including insulin, were administered upon admission per the physician□s orders with no issues identified. 3.a. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for licensed staff to transcribe medication orders upon admission and administer medications, including insulin, utilizing pharmacy services to include the Omnicell	5/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

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F 760	Continued From page 36 units subcutaneously before meals for diabetes. Start date 03/10/22 at 11:00 a.m. Discontinued date 03/11/22 at 11:35 a.m. On 03/11/22, the facility nursing staff documented an order for Humulin R solution inject 23 units subcutaneously before meals diabetes hold if less than 140. Start date 03/11/22 4:00 p.m. A review of Resident #1's eMARs (electronic medication administration records) revealed that the nursing staff had documented a "9" in the administration blocks on the eMARs on 03/10 at 11:00 a.m. and 4:00 p.m. and again on 03/11/22 at 4:00 p.m. Per the preprinted code on the eMAR a "9=Other/See Progress Notes." LPN (licensed practical nurse) #10 documented the following progress notes in regards to the Humulin R insulin. 03/10/22 at 12:08 p.m. and at 4:01 p.m., "Awaiting arrival from pharmacy new admission." 03/11/22 at 5:28 p.m., "awaiting pharmacy delivery; not provided with home medications." 03/11/22 for the administration of times of 7:30 a.m. and 11:00 a.m. the nursing staff documented the medication had been administered. Resident #1's blood sugars were documented as follows: 03/10/22-174 at 11:00 a.m., 188 at 4:00 p.m., and 184 at 9:00 p.m. 03/11/22-267 at 7:30 a.m., 167 at 11:00 a.m., 243 at 4:00 p.m., and 222 at 9:00 p.m. 03/12/22-289 at 7:30 a.m., 254 at 11:00 a.m., 217 at 4:00 p.m., and 256 at 9:00 p.m. Resident #1's care plan included the focus area has diabetes mellitus. Interventions included,	F 760	and any appropriate medications brought in by the resident at the time of admission. Education will be completed by 4/29/2022. 3.b. The facility will re-educate staff to use a 2-person chart check system for new admissions to ensure that admission orders have been transcribed correctly for timely administration by the ADON and/or Unit Managers by April 29, 2022. 4. The ADON or designee will review new admission charts to ensure medication orders were entered, medications, including insulin, were received from the pharmacy timely and medications were administered utilizing pharmacy services to include the Omnicell and/or medications brought in by the resident at the time of admission per the provider□s orders 5 times weekly for 4 weeks and submit findings to DON or designee for review weekly. The DON or designee will review the monitoring tools weekly, thoroughly investigate any variances, initiate appropriate actions and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. 5. Our date of compliance for this alleged deficient practice is 5/2/2022.	

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F 760	Continued From page 37 "Diabetes medication as ordered by doctor..." 03/15/22 1:30 p.m., LPN #10 stated if the residents medications were not available for administration they would call the pharmacy to see if it would be on the next shipment. If the medication(s) were available in the omnicell, we would get authorization to pull it. A review of the omnicell list revealed the insulin would not have been available in the omnicell for administration. 03/16/22 4:30 p.m., during an end of the day meeting with the DON (director of nursing) and ADON (assistant director of nursing) these staff were made aware of the issue regarding Resident #1 medications not being available for administration. 03/17/22 9:05 a.m., the facility provided the survey team with a copy of a policy titled, "Unavailable Medications" this policy read in part, "...The facility must make every effort to ensure that medications are available to meet the needs of each resident...the nursing staff shall notify the attending physician of the situation and explain the circumstances, expected availability, and alternative therapy(ies) available. If the facility nurse is unable to obtain a response from the attending physician or on-call physician, the nurse should notify the nursing supervisor and contact the Family Medical Director for orders and/or direction. Obtain a new order and cancel/discontinue the order for the non-available medication. Notify the pharmacy of the replacement order." The facility did not provide any information to the	F 760		

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F 760	Continued From page 38 surveyor to indicate this had been done. 03/18/2022 8:14 a.m., the DON provided the survey team with a document indicating their pharmacy delivered three times a day. Late afternoon for requests prior to 9:00 a.m., late evening for requests made prior to 4:00 p.m., and over-night for request made prior to 9:00 p.m. 03/18/22 11:02 a.m., LPN #2 stated if medications were not available for administration they would go to the cubex (omnicell) and if the medication was not available in the omnicell they would call the pharmacy to do a stat (immediate) delivery. If the pharmacy were unable to do a stat run, they would obtain the medication from the nearest pharmacy. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 760		
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	F 842		5/2/22

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F 842	Continued From page 39 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 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-	F 842		

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F 842	Continued From page 40 (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 facility document review the facility staff failed to ensure a complete and accurate clinical record for 3 of 7 residents, Resident #1, #6, and #4. The facility staff failed to document for the administration of medications (Resident #1), failed to document who pronounced a resident when they expired, and failed to follow their policy/procedure in regards to the physician and nurse documentation of residents deaths (Residents #6 and #4). The findings included: 1. Resident #1's diagnosis included, but not limited to, chronic systolic congestive heart failure, type 2 diabetes, essential hypertension, gastro-esophageal reflux disease, chronic obstructive pulmonary disease, gout, and chronic kidney disease. There was no completed MDS (minimum data set) assessment completed on this resident. Resident #1 was alert and orientated to person, place, and time.	F 842	1.a. Resident #1 discharged on 3/28/2022. No further action necessary at this time. 1.b. Resident #6 expired on 11/17/2021. No further action possible at this time. 1.c. Resident #4 expired on 10/14/2021. No further action possible at this time. 2.a. An audit of insulin orders from 4/18/2022 to 4/21/2022 was completed by facility nurses on 4/22/22 to ensure insulin orders were completed and administered timely. If any variances are found, the prescribing practitioner will be notified and the nurse will be re-educated. 2.b. An audit of deceased residents from March 19, 2022 to April 20, 2022 was completed by facility nurses on 4/22/2022 to ensure that the medical records include a progress note by the pronouncing registered nurse and the Record of Death was scanned into the electronic medical record. Any variances will be corrected	

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F 842	Continued From page 41 A review of Resident #1's eMARs (electronic medication administration records) revealed that the eMARs included numerous holes where the nursing staff would have documented for the administration of medications. There was no documentation for the following medications: Baclofen and Vitamin D3 on 03/11/22 for 9:00 a.m. Baclofen and Vitamin D3 on 03/12/22 for 9:00 a.m. Ipratropium-Albuterol inhaler on 03/10/22 at 12:00 p.m. and 6:00 p.m. Ipratropium-Albuterol inhaler on 03/11/22 for 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. Ipratropium-Albuterol inhaler on 03/12/22 for 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m. Ipratropium-Albuterol inhaler on 03/13/22 for 12:00 a.m. or 6:00 a.m. 03/15/22 3:05 p.m., LPN (licensed practical nurse) #4 stated they must have failed to sign for the medication as Resident #1 had brought this medication from home upon their admission. 03/17/22 9:05 a.m., the facility staff provided the survey team with a copy of their policy titled, "Charting and Documentation." This policy read in part, "All services provided to the resident...shall be documented in the residents medical record. All observations, medications administered, services performed etc., must be documented in the residents clinical record..." 03/17/22 4:17 p.m., during an end of the day meeting with the survey team the DON (director of nursing) and ADON (assistant director of nursing) were notified of the holes/missing documentation in Resident #1's EHR (electronic health record) in regards to medication	F 842	and staff re-educated as appropriate. 2.c. An audit of policy manuals was completed by the DON on 4/22/2022 to ensure each copy of the manual included the updated Death of a Resident, Documenting policy with no issues identified. 3.a. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for licensed staff to accurately document medication administration, including insulin. Education will be completed by 4/29/2022. 3.b. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for licensed staff to ensure that a resident□s electronic medical record includes a progress note by the registered nurse that pronounces death as well as a clearly signed and completed Record of Death. The Record of Death must be uploaded into the resident□s electronic medical record. Education will be completed by 4/29/2022. 3.c. On 4/21/22, education was initiated by the ADON and/or Unit Managers to inform licensed staff of a policy update to our Death of a Resident, Documenting policy as stipulated by state law: 3. The Attending Physician must complete and file a death certificate with the appropriate agency within 72 hours of the resident□s death or as may be prescribed by state law. Education will be completed by 4/29/2022.	

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F 842	Continued From page 42 administration. No further information regarding this issue was provided to the survey team prior to the exit conference on 03/19/22. 2. Resident #6's diagnosis included, but were not limited to, acute respiratory failure with hypoxia, vascular dementia, and inflammatory disorder. Section C (cognitive patterns) of Resident #6's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/04/2021 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. Resident #6's had expired at the facility in November 2021. During the clinical record review, the surveyor was unable to locate documentation when a RN (registered nurse) had pronounced the resident or any documentation by the attending physician indicating the resident had expired. On 11/17/2021 LPN (licensed practical nurse) #13 documented the resident's body was released to _____ funeral home. 03/17/2022 11:40 a.m., the physician stated there was no discharge summary or recap of stay and this would not be completed when a resident expired. 03/17/2022 3:15 p.m., the ADON (assistant director of nursing) stated there was no completed attending physician statement regarding the residents death and acknowledged it was in their policy to complete a progress note.	F 842	4.a. The unit Manager or designee will review Medication Administration Records to ensure that medications, including insulin, was documented accurately per the physician□s order 5 times weekly for 4 weeks and submit findings to DON or designee for review weekly. The DON or designee will review the monitoring tools weekly and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. Identified variances will be investigated by the DON/designee and appropriate actions will be taken to ensure ongoing compliance. 4.b & c. The ADON or designee will review the electronic medical record of deceased residents to ensure that a resident□s electronic medical record includes a progress note by the registered nurse that pronounces death as well as a clearly signed and completed Record of Death that has been uploaded into the resident□s electronic medical record with each resident□s death weekly for 4 weeks and submit findings to DON or designee for review weekly. The DON or designee will review the monitoring tools weekly and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. Identified variances will be investigated by the DON/designee and appropriate actions will be taken to ensure ongoing compliance. 5. Our date of compliance for this alleged deficient practice is 5/2/2022.	

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F 842	Continued From page 43 03/17/2022, The ADON provided the survey team with a copy of a policy titled, "Death of a Resident, Documenting." This policy read in part, "Appropriate documentation shall be made in the clinical record concerning the death of a resident...All information pertaining to a resident's death (i.e., date, time of death, the name and title of the individual pronouncing the resident dead, etc.) must be recorded on the nurse's note. The Attending Physician must record the cause of death in the progress notes..." 03/17/2022 4:17 p.m., during an end of the day meeting with the survey team the DON (director of nursing) and ADON were made aware of the missing documentation in regards to Resident #6 death. 03/18/2022 9:35 a.m., RN #1 stated they had pronounced this resident around 7:30 a.m. when they arrived to work. RN #1 stated they had made a nursing note. However, after reviewing the clinical record they were unable to find this documentation. No further information regarding the missing documentation was provided to the survey team prior to the exit conference. 3. Resident #4's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/13/21, was dated as completed on 9/22/21. Resident #4 was assessed as able to make self understood and as usually able to understand others. Resident #4's BIMS (Brief Interview for Mental Status) Summary Score was a three (3) out of 15; this indicated severe cognitive impairment. Resident #4 was	F 842		

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F 842	Continued From page 44	F 842		

documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #4's diagnoses included, but were not limited to: anemia, high blood pressure, diabetes, Alzheimer's disease, anxiety, and depression.

The following note was documented, in Resident #4's chart, by an LPN (licensed practical nurse) on the day of the resident's death at 6:32 p.m.: "Resident found at 0715 with no pulse, lifeless. RN in to pronounce. (nurse practitioner's name omitted) notified. Order to release body to funeral home of choice. (Responsible Party's name omitted) notified. Family wishes to have resident sent to (funeral home name and location omitted). Resident released to funeral home at 1100. No belongings sent with resident." The LPN who documented this note was no longer employed at the facility. The name of the RN who pronounced Resident #4's death was not found in the resident's clinical record; a note by the RN who pronounced Resident #4's death was not found in the resident's clinical record.

On 3/16/22 at 10:57 a.m., the ADON (Assistant Director of Nursing) was interviewed about who pronounced Resident #4's death. The ADON reported they did not know who pronounced the death because the RN's name was not documented.

The DON (Director of Nursing) provided a copy of a document titled "Record of Death" for Resident #4. This document was dated as being faxed to the facility on 3/16/22 at 10:49 a.m. This document included the name of the RN who pronounced Resident #4's death; the document also included a date and time for when the RN

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F 842	Continued From page 45 pronounced Resident #4's death. During an interview on 3/18/22 at 10:20 a.m., the DON reported the "Record of Death" form was faxed to the facility from the funeral home. The following information was found in a facility policy titled "Death of a Resident, Documenting" (with a revised date of April 2010): - "Appropriate documentation shall be made in the clinical record concerning the death of a resident." - "A resident may be declared dead by a Licensed Physician or a Registered Nurse with physician authorization in accordance with state law." - "All information pertaining to a resident's death (i.e., date, time, the name and title of the individual pronouncing the resident dead, etc.) must be recorded on the nurses' notes." - "The Attending Physician must record the cause of death in the progress notes, and must complete and file a death certificate with the appropriate agency within twenty-four (24) hours of the resident's death or as may be prescribed by state law." On 3/17/22 at 3:15 p.m., the facility's ADON (assistant director of nursing) confirmed the Attending Physician did not document the cause of death in Resident #7's clinical record. The failure of the facility staff to ensure Resident #4's chart included documentation of the name of the RN who pronounced the resident's death and failed to include documentation by the attending physician of the cause of death was discussed with the DON, during a survey team meeting, on 3/18/22 at 2:00 p.m.	F 842		
F 908 SS=E	Essential Equipment, Safe Operating Condition	F 908		5/2/22

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F 908	Continued From page 46 CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility document reviews, the facility staff failed to ensure the AED (automated external defibrillator) was stored/maintained according to manufacturer's guidance. The facility has one AED; it was stored on the East section of the facility. This AED was not stored with the battery inserted. The findings include: On 3/18/22 at 10:40 a.m., the storage of the facility's AED was observed with the DON (Director of Nursing). The DON reported the facility had one (1) AED. The AED was noted to be stored in a mobile cabinet on the East section of the building. The cabinet drawer containing the AED also contain a battery for the AED; this battery was not inserted into the AED. The following information was found in the 'owner's manual' of facility's AED (January 2012): - "The (AED) will automatically run a self-test when the battery is inserted." - "The green Ready light will be blinking to show the (AED) is ready for use." - "Always store the (AED) with a pads cartridge and a battery installed, so it will be ready to use and can perform daily self-tests." - "As long as a battery is installed, turning the (AED) "off" puts it into standby mode, which means that it is ready for use."	F 908	1. The battery for the AED (Automated External Defibrillator) was immediately re-installed per the manufacturer□s guidance. Per the Manufacturer□s Guidance, the AED was functioning correctly once the battery was re-installed. 2. On 4/21/2022, education was initiated by the ADON and/or Unit Managers for all licensed staff assigned to check the Crash Cart to ensure that the battery is correctly installed in the AED as part of the itemized Daily Emergency Crash Cart Checklist, which was updated to include AED checks, located on the crash cart. Education will be completed by 4/29/2022. 3. An audit of the Daily Emergency Crash Cart Checklists was completed from 4/20/2022 to 4/22/2022 by facility nurses on 4/22/22 to ensure Daily Emergency Crash Cart Checklists have been completed accurately and documented with no issues identified. 4. The Unit Manager or designee will review the Daily Emergency Crash Cart Checklist and ensure that the AED battery is correctly installed per the manufacturer□s guidance 5 times weekly for 4 weeks and submit findings to DON or designee for review weekly. The DON	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495417	A. BUILDING _____ B. WING _____	C 03/18/2022

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F 908	Continued From page 47 (An AED is an automated external defibrillator. It is a machine used to provide electric shocks, when indicated, to help individuals whose hearts have stopped working.) On 3/18/22 at 11:07 a.m., LPN (licensed practical nurse) #21 was interviewed about checking the facility's emergency equipment. LPN #21 reported they, at times, were responsible for checking the emergency equipment. LPN #21 reported, when checking the emergency equipment, they did not look for a light on the AED. On 3/18/22 at 11:08 a.m., LPN #14 was interviewed about checking the facility's emergency equipment. LPN #14 reported they, at times, were responsible for checking the emergency equipment. LPN #14 reported, when checking the emergency equipment, they did not look for a light on the AED. LPN #14 reported they check to make sure all the equipment/supplies were present. LPN #14 reported they did not check to see if the AED equipment/supplies were connected. Review of the facility's "DAILY EMERGENCY CART CHECK" form was reviewed on 3/18/22. This form did not include the AED or AED checks as part of the itemized daily checklist. The DON was asked for the facility policy to guide the checking of emergency equipment. The DON reported the facility did not have a policy to guide the checking of emergency equipment. The failure of the facility staff to store/maintain the AED as per the manufacturer's guidance was discussed with the DON, during a survey team	F 908	or designee will review the monitoring tools weekly and submit findings to QAPI Committee monthly for follow up to ensure POC is effective. 5. Our date of compliance for this alleged deficient practice is 5/2/2022.	

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F 908	Continued From page 48 meeting, on 3/18/22 at 2:00 p.m. The failure of facility staff to check AED functioning as part of the daily emergency cart checks was also discussed during this meeting.	F 908		