DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495358		C 04/07/2022

NAME OF PROVIDER OR SUPPLIER
AMELIA REHABILITATION AND HEALTHCARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
8830 VIRGINIA STREET
AMELIA, VA 23002

(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
E 000	Initial Comments	E 000		4/19/22
	An unannounced Emergency Preparedness survey was conducted 04/05/2022 through 04/07/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.			
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid standard survey was conducted 4/5/22 through 4/7/22. Two complaints were investigated during the survey, VA00054506 was substantiated without deficiency and VA00054564 was substantiated with deficiency. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 100 certified bed facility was 95 at the time of the survey. The survey sample consisted of 32 current resident reviews and 4 closed record reviews.			
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the	F 584	F-584 *The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated* **It is the intended practice of the facility to establish and maintain a safe, clean, comfortable, and homelike environment.**	4/19/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kaitlyn Seyler
TITLE: Administrator
(X6) DATE: 4/19/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to provide a homelike environment for one of 36 residents in the survey sample, Resident # 64. The facility staff failed to clean a black substance on the floor around the base of the sink and the wall behind and to the right of the sink and failed to repair a hole in the wall behind R64's head-of the-bed. The findings include:	F 584	1. Upon notification from surveyor on 4/6/22 that resident #64 room had a black substance on the floor around the base of the sink and the wall behind and to the right of the sink along with a hole in the wall behind the bed the maintenance and environmental staff immediately cleaned the area and fixed the hole in the wall. 2. Residents who reside in the facility have the potential to be affected. 3. Admin and/or designee will re-educate maintenance and environmental staff on maintaining a homelike environment. 4. Maintenance/Environmental Services and/or designee will audit 5 residents' rooms within the facility 3 days a week x 4 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be 5/12/2022.	4/19/22

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F 584	Continued From page 2 On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/04/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. On 04/05/22 at approximately 1:51 p.m., R64 was interviewed and expressed concerns about a black substance around the base of the pedestal sink and the base of the wall behind and to the right of the sink. The pedestal sink was and the base of the wall behind and to the right of the sink was observed and confirmed R64's statement. R64 also expressed concerns about about insects in the corner of the room behind the head of the bed. An observation failed to evidence insects; however, the wall behind the head of the bed revealed a hole in the wall approximately four inches long and two-and-a- half inches wide. On 04/05/22 at approximately 4:05 p.m., an observation of R64's room revealed a black substance around the base of the pedestal sink and the base of the wall behind and to the right of the sink and the hole in the wall behind the head of the bed. On 04/06/22 at approximately 8:15 a.m an observation of R64's room revealed a black substance around the base of the pedestal sink and the base of the wall behind and to the right of the sink and the hole in the wall behind the head of the bed. On 04/06/2022 at approximately 11:30 a.m., an interview and observation of R64's room was conducted with OSM (other staff member) # 4,	F 584		4/19/22

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F 584	Continued From page 3 director of environmental services. When asked to describe the procedure for cleaning a resident's room OSM # 4 stated that they change out the trash, clean the over-the-bed tables, clean the bathroom, clean and disinfect all the door handles, dust, sweep and mop the floor and check the supply of soap, paper towels and toilet paper. When asked how often a resident's room is cleaned OSM # 4 stated that it is done once a day. When asked about the floors in the resident's rooms OSM # 4 stated that they expect the housekeepers to make sure the floors are clean and free of dirt and debris. When asked to describe the procedure when there is substances on the floor that the housekeeper may not be able to clean OSM # 4 stated that they should let them know and they would the room on a schedule to have the floor stripped and waxed. After observing the floor around the base of the sink and the base of the wall behind the sink and to the right of the sink OSM # 4 stated that it was not clean and that they were not made aware of the concern. On 04/06/2022 at approximately 11:35 a.m., an interview and observation of (R64's) room was conducted with OSM # 3, director of maintenance. When asked to describe to procedure they follow for checking for repairs OSM # 3 stated that each department head is assigned a number of resident rooms that they check every morning for anything that is in need of repair and if anything is found it is put in tels (computerized work order). OSM # 3 also stated that they rely on the housekeepers to identify any problems in the resident's room. After being shown the hole in the wall behind the head of the bed in (R64's) room, OSM # 3 stated that they were not aware of it. Using a standardized	F 584		4/19/22

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F 584	Continued From page 4 measuring tape OSM # X was asked to measure the size of the hole. OSM # 3 stated it was approximately five-and-a-half inches high and approximately two-and-a-half inches wide. The facility's policy "Maintenance Services" documented in part, "2. Functions of maintenance personnel include, but are not limited to: b. maintaining the building in good repair and free from hazards." On 04/06/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 584		4/19/22
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice.	F 623	F – 623 *The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated* It is the intended practice of the facility to establish and maintain written documentation to the resident or RP upon residents transfer to the hospital.	

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F 623	Continued From page 5 (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State	F 623	1. Upon notification from surveyor on 4/6/22 of no evidence regarding the transfer to the hospital for residents #18, #71, #69, #81, #17, and #36 the clinical management team were educated on the necessary process of written notifications. 2. Residents who reside in the facility have the potential to be affected. 3. Admin and/or designee will educate social services on the process of providing written notification to residents and/or RP upon transfer to the hospital. 4. Social Services will audit all residents who have a hospital transfer/dc from the facility 3 days a week x 4 weeks and then will audit 5 residents monthly x2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be 5/12/2022.	4/19/22

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F 623	Continued From page 6 Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff	F 623		4/19/22

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F 623	Continued From page 7 failed to evidence written documentation to the Resident or RP (responsible party) upon transfer for six out of 36 residents in the survey sample who were transferred to the hospital; Residents #18, #71, #69, #81, #17 and #36. The findings include: 1. Resident #18 was admitted to the facility with diagnoses that included but were not limited to: cerebrovascular accident with right hemiparesis and diabetes mellitus. Resident #18's most recent MDS (minimum data set) assessment, an annual assessment, with an assessment reference date of 1/21/22, coded the resident as scoring 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the nursing progress note dated 11/30/21 at 4:20 PM, revealed the following, "Resident aware of need for transfer, reason, RP aware of new order for transfer and reason. RP aware of bed hold policy and agreement being sent with resident to the emergency room. Face sheet, history/physical, physician progress notes, labs and x-ray results, care plan sent with resident. Director of nursing and administrator aware of transfer out." On 4/5/22 at approximately 5:00 PM a request was made for the evidence of written notification to the RP and ombudsman when Resident #18 was transferred to the hospital on 11/30/21. On 4/6/22 at approximately 8:30 AM, an interview was conducted with LPN (licensed practical nurse) #3. When asked who provides the written	F 623		4/19/22

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F 623	Continued From page 8 notification to the RP and ombudsman when a resident is transferred to the hospital, LPN #3 stated, "We call the RP and notify them, I do not know who does the written notification to the RP or the ombudsman." On 4/6/22 at 11:55 AM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked for the evidence of written notification to the RP, ASM #2 stated, "We're checking on the RP written notification. We changed social workers and they also moved offices. I called the previous social worker and she told me where to look but we cannot find it. The ombudsman is helping us look for their notification." On 4/6/22 at 1:40 PM, an interview was conducted with OSM (other staff member) #9, the social services director. When asked do you play a part in written notification to the RP or ombudsman, OSM #9stated, "I would think social services does but I have not taken that on." On 4/6/22/22 at 5:00 PM, ASM #1, the administrator and ASM #2, the director of nursing, were informed of the above concern. No further information was provided prior to exit. 2. Resident #69 was admitted to the facility with diagnoses that included but were not limited to: encephalopathy, neurogenic bladder and diabetes mellitus. Resident #69's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/8/22, coded the resident as scoring 10 out of 15 on the BIMS	F 623		4/19/22

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F 623	Continued From page 9 (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the nursing progress note dated 2/25/22 at 9:40 AM, revealed the following, "Resident noted with increased voluntary movements, increased confusion with yelling out, 'I've got to get out of here!', attempting to get out of bed continuously despite redirection. NP (nurse practitioner) in to evaluate, new order noted to transfer to emergency room for evaluation for AMS. Resident notified of transfer order and reason, first contact phoned and notified of above, transfer to emergency room (ER) order and reason. Aware that bed hold agreement is sent to ER with resident. Given copies of pertinent information, recent labs, face sheet, care plan. Director of nursing and administrator aware of transfer. On 4/5/22 at approximately 5:00 PM a request was made for the evidence of written notification to the RP and ombudsman when Resident #18 was transferred to the hospital on 11/30/21. On 4/6/22 at approximately 8:30 AM, an interview was conducted with LPN (licensed practical nurse) #3, when asked who provides the written notification to the RP and ombudsman when a resident is transferred to the hospital, LPN #3 stated, "We call the RP and notify them, I do not know who does the written notification to the RP or the ombudsman." On 4/6/22 at 11:55 AM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked for the evidence of written notification to the RP, ASM #2 stated, "We're checking on the	F 623		4/19/22

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F 623	Continued From page 10 RP written notification. We changed social workers and they also moved offices. I called the previous social worker and she told me where to look but we cannot find it. The ombudsman is helping us look for their notification." On 4/6/22 at 1:40 PM, an interview was conducted with OSM (other staff member) #9, the social services director. When asked do you play a part in written notification to the RP or ombudsman, OSM #9stated, "I would think social services does but I have not taken that on." On 4/6/22/22 at 5:00 PM, ASM #1, the administrator and ASM #2, the director of nursing, were informed of the above concern. No further information was provided prior to exit. 3. Resident #71 was admitted to the facility with diagnoses that included but were not limited to: cerebral infarction, congestive heart failure and dementia. Resident #71's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 3/9/22, coded the resident as scoring 10 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the nursing progress note dated 2/19/22 at 3:09 PM, revealed the following, "CNA (certified nursing assistant) asked for writer to come look at resident. CNA reported resident was reluctant to receiving care, complained of pain to his all over, and crying out. Writer into assess resident and resident refused for writer to assess resident. Resident stated to writer, 'No baby I'm	F 623		4/19/22

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F 623	Continued From page 11 hurting too bad'. Writer spoke with charge nurse who stated no abnormal reports were given to her from previous shift. Writer asked for labs to be faxed, writer received labs. Writer called NP (nurse practitioner), and expressed the above to NP who gave orders to send resident to the ER (emergency room) for evaluation. Writer called RP and left message. Called for transport, charge nurse aware. RP notified of bed hold policy." On 4/5/22 at approximately 5:00 PM a request was made for the evidence of written notification to the RP and ombudsman when Resident #18 was transferred to the hospital on 11/30/21. On 4/6/22 at approximately 8:30 AM, an interview was conducted with LPN (licensed practical nurse) #3, when asked who provides the written notification to the RP and ombudsman when a resident is transferred to the hospital, LPN #3 stated, "We call the RP and notify them, I do not know who does the written notification to the RP or the ombudsman." On 4/6/22 at 11:55 AM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked for the evidence of written notification to the RP, ASM #2 stated, "We're checking on the RP written notification. We changed social workers and they also moved offices. I called the previous social worker and she told me where to look but we cannot find it. The ombudsman is helping us look for their notification." On 4/6/22 at 1:40 PM, an interview was conducted with OSM (other staff member) #9, the social services director. When asked do you play	F 623		4/19/22

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F 623	Continued From page 12 a part in written notification to the RP or ombudsman, OSM #9stated, "I would think social services does but I have not taken that on." On 4/6/22/22 at 5:00 PM, ASM #1, the administrator and ASM #2, the director of nursing, were informed of the above concern. No further information was provided prior to exit. 4. On the most recent MDS (minimum data set), a five-day assessment with an ARD (assessment reference date) of 3/14/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. The progress notes for R81 documented in part: "2/16/2022 17:14 (5:14 p.m.) Resident called writer to room, resident noted SOB (short of breath) with O2 (oxygen) on, widespread crackles heard throughout bilateral upper and lower lung fields, vitals checked. N.P. (nurse practitioner) (Name of nurse practitioner) called, vitals recorded, N.P. (Name of nurse practitioner) gave orders to bump O2 up high as it goes, and call 911, writer staying in room with resident and communicating with staff to assist, 911 called, O2 increased to 6 liters, O2 came up to 80 percent, 911 on way, writer R.P (responsible party) (Name of responsible party) called and notified of the resident condition, and orders to send resident to the ER (emergency room), and gave permission as well to do this, emergency services here and resident is being taken to the hospital. Per EMT's (emergency medical technicians) going to take to (Name of hospital). R.P. (Name of responsible party) called and made aware of this."	F 623		4/19/22

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F 623	Continued From page 13 "2/17/2022 08:24 (8:24 a.m.) Per hospital receptionist resident admitted to (Name of hospital) ICU (intensive care unit). Unable to reach nurse. No known dx (diagnosis) at this time. NP (Name of nurse practitioner) aware." The clinical record failed to evidence documentation of written notification provided to the responsible party for the transfer on 2/16/2022 for R81. On 4/6/2022 at approximately 10:00 a.m., a request was made by written list to ASM (administrative staff member) #1, the administrator for evidence of written notification provided to the responsible party for the transfer on 2/16/2022 for R81. On 4/6/2022 at 11:53 a.m., ASM #2, the director of nursing provided a copy of the transfer to hospital checklist for R81 dated 2/16/2022 and the progress notes documented above. The transfer to hospital checklist failed to evidence written notification provided to the responsible party for the transfer on 2/16/2022. On 4/6/2022 at 11:55 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that they had changed social workers, offices and that they had called the previous social worker but were not able to find any evidence of written notification provided to the responsible party. On 4/06/2022 at 1:40 p.m., an interview was conducted with OSM (other staff member) #9, the social services director. OSM #9 stated that they were new to the facility and had not taken over sending the written notification to the responsible	F 623		4/19/22

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F 623	Continued From page 14 party at that time. OSM #9 stated that in their previous experience at other facilities, the social services department had been responsible for sending out a notice of transfer/discharge to the responsible party and the ombudsman with hospital transfers. On 4/6/2022 at approximately 5:00 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 5. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/20/2022, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired for making daily decisions. The progress notes for R17 documented in part: "3/26/2022 16:45 (4:45 p.m.) Resident sent to ER (emergency room) with paper work, pertinent information, face sheet, H&P (history and physical), most recent MD (medical doctor) progress noted (sic), MD orders, pertinent lab and diagnostic reports, care plan and care plan goals, bed hold agreement, R.P. (responsible party) and resident notified of the bed hold notice, E.R. called and given report of the resident and is aware of the resident coming, resident is OOF (out of facility) to the E.R." "3/29/2022 13:25 (1:25 p.m.) Writer called (Name of hospital) and spoke with (Name of staff member) who stated resident was admitted for dx (diagnosis) Encephalopathy."	F 623		4/19/22

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F 623	Continued From page 15 The clinical record failed to evidence documentation of written notification provided to the responsible party for the transfer on 3/26/2022 for R17. On 4/6/2022 at approximately 10:00 a.m., a request was made by written list to ASM (administrative staff member) #1, the administrator for evidence of written notification provided to the responsible party for the transfer on 3/26/2022 for R17. On 4/6/2022 at 11:53 a.m., ASM #2, the director of nursing provided a copy of the transfer to hospital checklist for R17 dated 3/26/2022. The transfer to hospital checklist failed to evidence written notification provided to the responsible party for the transfer on 3/26/2022. On 4/6/2022 at 11:55 a.m., an interview was conducted with ASM #2, the director of nursing. ASM #2 stated that they had changed social workers, offices and that they had called the previous social worker but were not able to find any evidence of written notification provided to the responsible party. On 4/06/2022 at 1:40 p.m., an interview was conducted with OSM (other staff member) #9, the social services director. OSM #9 stated that they were new to the facility and had not taken over sending the written notification to the responsible party at that time. OSM #9 stated that in their previous experience at other facilities, the social services department had been responsible for sending out a notice of transfer/discharge to the responsible party and the ombudsman with hospital transfers.	F 623		4/19/22

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F 623	Continued From page 16 On 4/6/2022 at approximately 5:00 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 6. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/7/22, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. A review of R36's clinical record revealed a nurse's note dated 1/19/22 that documented the resident was transferred to the hospital for abnormal lab results. Further review of R36's clinical record failed to reveal evidence that written notice of the transfer was provided to R36'a representative. On 4/6/22 at 11:55 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated the facility changed social workers and moved offices. ASM #2 stated she would check on written resident representative notification for hospital transfers. On 4/6/22 at 5:07 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. According to the facility's "Transfer or Discharge Notice" policy, dated 3/21, which reveals, "Under the following circumstances, the notice is given as soon as it is practicable but before the transfer or discharge: An immediate transfer or discharge	F 623		4/19/22

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F 623	Continued From page 17 is required by the resident's urgent medical needs. The resident and representative are notified in writing of the following information: specific reason for the transfer or discharge, location to which the resident is being transferred or discharged and effective date of the transfer or discharge." No further information was presented prior to exit.	F 623		4/19/22
F 645 SS=E	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility;	F 645	F – 645 *The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated* It is the intended practice of the facility to establish and maintain residents clinical record to include preadmission screening and resident review documentation.	

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F 645	Continued From page 18 and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.	F 645	1. Upon notification from the surveyor on 4/6/22 that residents #11, #90, #81, #20, and #64 did not have a PASRR in their clinical record, social services and admissions were educated on the preadmission screening process. 2. Residents who admit to the facility have the potential to be affected. 3. Admin and/or designee will educate the administrative team on the preadmission screening process. 4. Admissions Director/Social Services Director and/or designee will audit new admissions within the facility for PASRRs 3 days a week x 4 weeks and then will audit 5 admissions monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be 5/12/2022.	4/19/22

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F 645	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview, the facility staff failed to evidence completion of a level 1 PASRR (preadmission screening and resident review) for 5 of 36 residents in the survey sample, Residents #11, #90, #81, #20, and #64. The findings include: 1. Resident #11 (R11) was admitted to the facility with diagnoses that included but were not limited to traumatic brain injury, post traumatic stress disorder, and schizoaffective disorder. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/10/2022, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired for making daily decisions. Review of R11's clinical record failed to evidence a level 1 PASRR. On 4/6/2022 at approximately 10:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the Level 1 PASRR for R11. On 4/6/2022 at 1:21 p.m., ASM #1 stated that they did not have a PASRR for R11 because they followed the rule that anyone admitted prior to 7/1/2019 did not need to have a PASRR completed. On 4/6/2022 at 1:40 p.m., an interview was conducted with OSM (other staff member) #9, the	F 645		4/19/22

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F 645	Continued From page 20 social services director. OSM #9 stated that they were new to the facility and had not started completing PASRR assessments in the facility at this time. OSM #9 stated that in their previous experience at other facilities they would complete the Level 1 PASRR for every resident admitted regardless of their payer source. OSM #9 stated that they were not sure how long the Level 1 PASRR assessment was a requirement and was not sure if there was a date that exempted residents from screening. OSM #9 stated that most residents arrived from the hospital with the Level 1 PASRR completed but at times they did it at the facility. OSM #9 stated that they would review Resident #11's record to see if they were able to locate a Level 1 PASRR. On 4/6/2022 at 2:19 p.m., OSM #9 stated that they had verified their process with ASM #1, the administrator and had spoken previously about the process from their former facility. OSM #9 stated that at this facility, the only residents who had Level 1 PASRR were Medicaid or Medicaid pending residents. On 4/6/2022 at 2:46 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that the level 1 PASRR was completed by the hospital, social services or admissions for Medicaid or Medicaid pending residents only. ASM #1 stated that residents who were admitted as skilled care or managed care would not have a PASRR completed. ASM #1 stated that they had a form that they completed which documented the effective date of 7/1/2019 and showed that R11 was exempted due to being admitted in 2011 and would provide that. On 4/6/2022 at 3:37 p.m., an interview was	F 645		4/19/22

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F 645	Continued From page 21 conducted with OSM #1, the business office manager. OSM #1 stated that R11 did not have a Level 1 PASRR because it was not required for anyone admitted prior to 7/1/2019. OSM #1 provided a copy of "Virginia Department of Medical Assistance Services Nursing Facility Admission, Discharge or Level of Care Change (DMAS-80)" dated 1/7/2021 for Resident #11. It documented regulatory special circumstance for residents admitted prior to July 1, 2019 for review of a completed Medicaid LTSS (Long-term Services and Supports) Screening Package that indicates the individual met Level of Care Criteria and was authorized for LTSS services. The document failed to evidence documentation that a PASRR Level 1 screening was not required for R11. According to Virginia's Medicaid Program document "Required Screening for Nursing Facility Placement and Use of the LTC (long term care) Portal dated 6/20/2019 it documented in part, "...Handling Special Circumstances...Be sure to complete Level 1 if special circumstance is met. NF (nursing facility) completes the DMAS-80 form and submit a copy to the plan Both Plan and NF retains a record to document the special circumstances...The Level one PASRR should have been completed upon admission by the NF for all Special Circumstances..." This information was obtained from the website: https://www.dmas.virginia.gov/media/1153/required-screening-for-nursing-facility-placement-and-use-of-the-ltc-portal.pdf The facility policy "Admission Criteria" dated "revised March 2019" documented in part, "...The facility conducts a Level 1 PASARR screen for all	F 645		4/19/22

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F 645	Continued From page 22 potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD (mental disorder), ID (intellectual disability), or RD (related disorders)..." On 4/6/2022 at approximately 5:00 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 2. Resident #90 (R90) was admitted to the facility with diagnoses that included but were not limited to bipolar disorder and schizoaffective disorder. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/21/2022, the resident scored 8 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately impaired for making daily decisions. Review of R90's clinical record failed to evidence a level 1 PASRR. On 4/6/2022 at approximately 10:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the Level 1 PASRR for R90. On 4/6/2022 at 1:21 p.m., ASM #1 provided a UAI (uniform assessment instrument) for R90 dated 8/27/2019. The document failed to evidence documentation of a Level 1 PASRR screening. On 4/6/2022 at 1:40 p.m., an interview was conducted with OSM (other staff member) #9, the social services director. OSM #9 stated that they were new to the facility and had not started	F 645		4/19/22

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F 645	Continued From page 23 completing PASRR assessments at this time. OSM #9 stated that in their previous experience at other facilities they would complete the Level 1 PASRR for every resident admitted regardless of their payer source. OSM #9 stated that they were not sure how long the Level 1 PASRR assessment was a requirement and was not sure if there was a date that exempted residents from screening. OSM #9 stated that most residents arrived from the hospital with the Level 1 PASRR completed but at times they did it. OSM #9 reviewed the UAI dated 8/27/2019 for R90 and stated that they did not see any documentation of a Level 1 PASRR in the document. On 4/6/2022 at 2:19 p.m., OSM #9 stated that they had verified their process with ASM #1, the administrator and had spoken previously about the process from their former facility. OSM #9 stated that at this facility, the only residents who had Level 1 PASRR were Medicaid or Medicaid pending residents. On 4/6/2022 at 2:46 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that the level 1 PASRR was completed by the hospital, social services or admissions for Medicaid or Medicaid pending residents. ASM #1 stated that residents who were admitted as skilled care or managed care would not have a PASRR completed. ASM #1 stated that they would check for another PASRR for R90. On 4/6/2022 at approximately 5:00 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit.	F 645		4/19/22

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F 645	Continued From page 24 3. Resident #81 (R81) was admitted to the facility with diagnoses that included but were not limited to schizoaffective disorder, anxiety disorder and major depressive disorder. On the most recent MDS (minimum data set), a five-day assessment with an ARD (assessment reference date) of 3/14/2022, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. Review of R81's clinical record failed to evidence a level 1 PASRR. On 4/6/2022 at approximately 10:00 a.m., a request was made to ASM (administrative staff member) #1, the administrator for the Level 1 PASRR for R81. On 4/6/2022 at 1:21 p.m., ASM #1 stated that they did not have a PASRR for R81 because they were were a Medicare resident and they did not complete them for those residents. On 4/6/2022 at 1:40 p.m., an interview was conducted with OSM (other staff member) #9, the social services director. OSM #9 stated that they were new to the facility and had not started completing PASRR assessments at this time. OSM #9 stated that in their previous experience at other facilities they would complete the Level 1 PASRR for every resident admitted regardless of their payer source. OSM #9 stated that they were not sure how long the Level 1 PASRR assessment was a requirement and was not sure if there was a date that exempted residents from screening. OSM #9 stated that most residents arrived from the hospital with the Level 1 PASRR	F 645		4/19/22

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F 645	Continued From page 25 completed but at times they did it. On 4/6/2022 at 2:19 p.m., OSM #9 stated that they had verified their process with ASM #1, the administrator and had spoken previously about the process from their former facility. OSM #9 stated that at this facility, the only residents who had Level 1 PASRR were Medicaid or Medicaid pending residents. On 4/6/2022 at 2:46 p.m., an interview was conducted with ASM #1, the administrator. ASM #1 stated that the level 1 PASRR was completed by the hospital, social services or admissions for Medicaid or Medicaid pending residents. ASM #1 stated that residents who were admitted as skilled care or managed care would not have a PASRR completed. ASM #1 stated that Resident #81 was admitted under Medicare and would not have been screened. On 4/6/2022 at approximately 5:00 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. 4. Resident #20 was admitted to the facility with diagnoses that included but were not limited to: metabolic encephalopathy, dementia and cerebral ischemia. Resident #20's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/18/22, coded the resident as scoring 02 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of Resident #20's clinical record failed	F 645		4/19/22

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F 645	Continued From page 26 to reveal evidence of completion of a Level 1 PASARR either prior to or on admission on 10/20/21. An interview was conducted on 4/6/22 at 1:40 PM, with OSM (other staff member) #9, the director of social services. When asked how long she had been employed at the facility, OSM #9 stated, I started here last Monday, 3/28/22. When asked what process she used to complete the PASARR, OSM #9 stated, at my previous facility, I would do the level I PASARR for residents admitted. I have not done any here yet. I believe the previous person is still doing them. I did every level I PASARR at my last facility. When asked if a level I PASAAR is to be done for every person admitted to the facility, OSM #9 stated, Yes, regardless of payer source. On 4/6/22 at 2:19 PM OSM #9 stated, I verified the PASARR information with my administrator (ASM #1), I told you the way I did it before was from my prior facility. At this facility, the patients who are Medicaid or Medicaid pending will have not the level 1 PASARR completed. On 4/6/2022 at 2:46 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that the level 1 PASARR was completed by the hospital, social services or admissions for Medicaid or Medicaid pending residents. ASM #1 stated that residents who were admitted as skilled care or managed care would not have a PASARR completed. On 4/6/22/22 at 5:00 PM, ASM #1, the	F 645		4/19/22

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F 645	Continued From page 27 administrator and ASM #2, the director of nursing, were informed of the above concern. According to the facility's "Admission Criteria" policy dated 3/19, which reveals, "All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. The facility conducts a Level 1 PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD." No further information was provided prior to exit. 5. On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/04/2022, Resident #64 scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. A review of (R64's) clinical record revealed they were admitted under Medicare. Further review of the clinical record failed to evidence a level 1 (one) PASARR was completed prior to admission on 08/22/2021. On 04/06/2022 at approximately 1:50 p.m., an interview was conducted with OSM (other staff member) # 1, business office manager. When asked about a level 1 PASARR for (R64) OSM # 1 stated that when (R64) was originally admitted to the facility it was for short term care but had a change in their level of care and a level 1 PASARR was not completed because it wasn't required.	F 645		4/19/22

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F 645	Continued From page 28 On 4/6/2022 at 2:46 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that the level 1 PASARR was completed by the hospital, social services or admissions for Medicaid or Medicaid pending residents. ASM #1 stated that residents who were admitted as skilled care or managed care would not have a PASRR completed. On 04/06/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 645		4/19/22
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, resident representative interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, the facility staff failed to provide adequate bathing for 2 of 36 residents in the survey sample, Residents #57 and #29. The findings include: 1. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/29/22, Resident	F 677	F – 677 *The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated* It is the intended practice of the facility for residents who are unable to carry out activities of daily living to receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	

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F 677	Continued From page 29 #57 (R57) scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. Section G coded R57 as requiring one person physical assistance with bathing. R57's comprehensive care plan dated 4/20/21 documented, "The resident has an ADL (activities of daily living) Performance Deficit...Provide the resident with a sponge bath when a full bath or shower cannot be tolerated." On 4/5/22 at 2:06 p.m., a telephone interview was conducted with R57's representative. The representative stated sometimes staff does not provide R57 with regular showers like they should but then the representative reminds them and they provide a shower. A review of R57's clinical record (including shower sheets, ADL records and nurses' notes for February 2022) failed to reveal documentation that R57 was offered or provided any type of bathing (including showers, a tub bath or a bed bath/sponge bath) on the following dates: 2/1/22, 2/3/22, 2/6/22, 2/8/22, 2/9/22, 2/10/22, 2/12/22, 2/13/22, 2/15/22, 2/17/22, 2/19/22, 2/20/22, 2/22/22, 2/24/22, 2/26/22 and 2/27/22. Further review of these documents failed to reveal documentation that R57 refused bathing on these dates. On 4/6/22 at 2:00 p.m., an interview was conducted with RN (registered nurse) #3, regarding resident bathing. RN #3 stated the CNAs (certified nursing assistants) provide showers according to a shower schedule but she was not sure how the schedule goes.	F 677	1. Resident #29 received a shower on 4/7/22. Resident #57 was offered a shower on 4/6/22 and 4/7/22 and refused. 2. Residents who reside in the facility, who are unable to carry out ADLs, have the potential to be affected. 3. DON and/or designee will educate nursing staff on proper ADL services and documentation. 4. DON and/or designee will audit 3 residents who are unable to carry out ADLs for shower or bed bath documentation 3 days a week x 4 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be 5/12/2022.	4/19/22

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F 677	Continued From page 30 On 4/6/22 at 2:19 p.m., an interview was conducted with CNA #6. CNA #6 stated residents are supposed to receive a shower or whirlpool tub bath twice a week and receive a bed bath on all other days. On 4/7/22 at 8:02 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Bath, Shower/Tub" documented, "The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin." The policy did not document how often residents should receive bathing. No further information was presented prior to exit. COMPLAINT DEFICIENCY 2. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/03/2022, Resident # 29 scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. Section G0120 coded (R29) as requiring "Physical help in part of bathing activity" of one staff member. Section G0400 "Functional Limitation in Range of Motion' coded (R29) as having impairment one side of upper and lower extremities requiring a walker or wheelchair. On 04/05/22 at approximately 1:31 p.m., during an interview with R29 they stated that they had not received a bath in three weeks. When asked how often they were to receive a bath or shower,	F 677		4/19/22

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F 677	Continued From page 31 R29 stated they were to get a bath or shower twice a week. The comprehensive care plan for R29 documented in part, "Focus: The resident has an ADL Self Care Performance Deficit r/t Decreased mobility, function, and weakness, Impaired balance ... Date Initiated: 01/06/2022." Under "interventions" it documented in part, "Provide the resident with a sponge bath when a full bath or shower cannot be tolerated. Date Initiated: 01/06/2022" The facility's document entitled "Documentation Survey Report V2" for ADLs (activities of daily living) dated 03/01/2022 through 03/31/2022 documented in part, "ADL - Shower or whirlpool." Review of the form revealed R29 received a bed bath on 03/05/2022, 03/16/2022 and on 03/23/2022. Further review failed to evidence of documentation that R29 received a shower or whirlpool bath from 03/01/2022 through 03/31/2022. The progress notes for (R29) dated 03/01/2022 through 03/31/2022 failed to evidence that R29 received a shower or whirlpool bath from 03/01/2022 through 03/31/2022. Further review of the progress notes failed to evidence documentation that R29 refused a shower or whirlpool from 03/01/2022 through 03/31/2022. Review of the facility's resident's shower sheets from 03/01/2022 through 03/31/2022 failed to evidence that R29 refused or was offered a shower or whirlpool. On 04/06/2022 at approximately 1:50 p.m., an interview was conducted with LPN (licensed	F 677		4/19/22

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F 677	Continued From page 32 practical nurse) # 1. When asked how often a resident is provided a shower or bath LPN # 1 stated that a resident is scheduled for a bath or shower twice a week unless they refuse and that they are offered a bed bath. After reviewing the ADL sheet and the bath/shower sheets for (R29) LPN # 1 stated that (R29) received three bed baths and was not offered or given a shower or bath during March 2022. When asked why (R29) was not offered or received a bath or shower during March LPN # 1 stated that it may have been due to not having enough staff for shower aides. On 04/06/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 677		4/19/22
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to provide respiratory care and services for 1 of 36 residents in the survey	F 695	F-695 *The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated* It is the intended practice of the facility to establish and maintain an adequate program to meet the needs of respiratory care, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	

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F 695	Continued From page 33 sample, Resident #191. The facility staff failed to administer oxygen to Resident #191 (R191) per the physician prescribed rate of two liters per minute. The findings include: R191's diagnoses included but were not limited to shortness of breath. R191's admission minimum data set assessment was not complete. R191's admission nursing assessment dated 3/28/22 documented the resident was alert but not oriented to person, place, time or situation. A review of R191's clinical record revealed a baseline care plan dated 3/28/22 that documented, "Pulmonary management. Provide treatments per orders..." R191's April 2022 physician's order sheet documented a physician's order dated 4/1/22 for oxygen at two liters per minute as needed for shortness of breath or an oxygen saturation level below 90%. On 4/5/22 at 11:45 a.m., 4/5/22 at 4:10 p.m. and 4/6/22 at 7:59 a.m., R191 was observed in bed, receiving oxygen at one and a half liters per minute. On 4/6/22 at 2:00 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated nurses should look at residents' physician's orders to verify oxygen orders. RN #3 stated the two liter line in the oxygen concentrator flowmeter should run through the middle of the ball in the flowmeter if the physician's order is for two liters.	F 695	1. Upon notification of surveyor on 4/6/22 regarding resident #191 concentrator not reading at 2 liters per minute, facility staff replaced the concentrator for a new one to check the functionality of the previous concentrator. 2. Residents who reside in the facility who have oxygen concentrators have the potential to be affected. 3. DON and/or designee will educate nursing staff on the proper administration of oxygen per physician orders. 4. DON and/or designee will audit 3 residents within the facility, who have oxygen concentrators, 3 days a week x 4 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be 5/12/2022.	4/19/22

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F 695	Continued From page 34 On 4/6/22 at 5:07 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 4/7/22 at 8:32 a.m., ASM #2 stated she thought something was wrong with R191's oxygen concentrator and it was taken out of service. ASM #2 stated nurses should check residents' oxygen concentrators every shift. The oxygen concentrator manufacturer's instructions documented, "NOTE: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed." The facility policy titled, "Oxygen Administration" documented, "1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration." No further information was presented prior to exit.	F 695		4/19/22
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed	F 698	Past noncompliance: no plan of correction required.	

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STREET ADDRESS, CITY, STATE, ZIP CODE
8830 VIRGINIA STREET
AMELIA, VA 23002

(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 698	Continued From page 35 to provide care and service for a complete dialysis program for one of 36 residents in the survey sample, Resident # 59 (R59). The facility staff failed to provide dialysis communication forms for R59 and the dialysis center on 03/02/2022, 03/04/2022, 03/07/2022, 03/09/2022, 03/11/2022, 03/14/2022, 03/16/2022, 03/18/2022 and on 03/21/2022. The findings include: R59 was admitted to the facility with diagnoses included but were not limited to: end stage renal disease. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/24/2022, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition intact for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded R59 for "Dialysis" while a resident. The physician's order for R59 documented in part, "(Name of Dialysis Center with Name of Physician and Phone Number) on MON-WED-FRI (Monday, Tuesday and Friday). Order Date: 12/29/2021." On 04/06/2022 at approximately 10:02 a.m., ASM (administrative staff member) # 2, director of nursing, provided copies of the facility's dialysis communication forms for R59 dated 03/23/2022, 03/25/2022, 03/28/2022, 03/30/2022, 04/01/2022 and 04/04/2022. When asked about the dialysis communication forms for 03/02/2022, 03/04/2022, 03/07/2022, 03/09/2022, 03/11/2022,	F 698		4/19/22

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	495358		C 04/07/2022

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F 698	Continued From page 36 03/14/2022, 03/16/2022, 03/18/2022 and on 03/21/2022, ASM # 2 stated they recognized that the dialysis communication form were not being completed and that they put a plan of correction (POC) in place. The facility's POC for dialysis communication forms documented, "1) No communication forms to be sent with resident to dialysis for treatments. Identified on 3/15/2022. 2) Dialysis communication form implemented on 3/22/2022. 3) Nurses updated on use of new sheets. New forms placed in communication book. 4) Communication sheets/handoff from dialysis center monitored once return from dialysis. 5) Day of Compliance 4/1/2022." On 04/06/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 698		4/19/22
F 732 SS=C	Past Noncompliance Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 732	F – 732 *The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated* It is the intended practice of the facility to establish and maintain a process that meets the posting requirements of the nurse staffing data daily at the beginning of each shift.	

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F 732	Continued From page 37 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, the facility staff failed to post daily staffing for one of three days reviewed. The findings include: A review of the daily staffing evidenced the following: On 4/5/22 at 10:30 AM, upon entry into the	F 732	1. Upon notification from surveyor on 4/6/22 that the daily staffing was not posted for one of three days reviewed, the staffing coordinator was educated on the posting requirements. 2. Residents who reside in the facility have the potential to be affected. 3. Admin and/or designee will educate administrative staff on nurse posting requirements. 4. Admin and/or designee will audit the nurse staff posting within the facility 3 days a week x 4 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be 5/12/22.	4/19/22

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F 732	Continued From page 38 facility, the staff posting was not observed in front lobby, outside of the director of nursing office, on the north nursing unit, and on the south nursing unit. Additional observation of these areas was conducted at 12:30 PM, 2:30 PM and 4:30 PM, and staffing was not posted. On 4/6/22 at 8:00 AM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. When asked who was responsible for posting the daily staffing, ASM #2, stated the staffing person was responsible. When asked who posted the daily staffing on 4/5/22, ASM #2 stated, "It was not posted. The staffing person was not here yesterday." When asked who was responsible for posting daily staffing if the staffing person is on vacation, off or sick, ASM #2 stated, "That is a great question, I will have to get back to you on that." On 4/6/22 at 8:20 AM, ASM #2 brought in copy of the 4/6/22 daily staff posting. ASM #2 stated, "The staffing person does not work the weekends, so she posts the weekend staffing sheets before she leaves on Friday." When asked who posts daily staffing if the staffing person is on vacation, ASM #2 stated, "I do not know. I should keep up with this but I have not been." On 4/6/22/22 at 5:00 PM, ASM #1, the administrator and ASM #2, the director of nursing, were informed of the above concern. According to the facility's "Posting Direct Care Daily Staffing Numbers" policy dated 7/16, which reveals, "Our facility will post, on a daily basis for each shift, the number of nursing personnel	F 732		4/19/22

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F 732	Continued From page 39 responsible for providing direct care to residents. Within two hours of the beginning of each shift the number of licenses nurses and the number of unlicensed nursing personnel directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format." No further information was provided prior to exit.	F 732		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to store and prepare food in a sanitary manner in one of one facility kitchens, and on one nursing unit.	F 812	F – 812 *The statements made on this plan of correction are not an admission to and do not constitute an agreement within the alleged deficiencies cited herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated* **It is the intended practice of the facility to store, prepare, distribute, and serve food in accordance with professional standards for food service safety.**	

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F 812	Continued From page 40 The findings include: On 04/05/2022 at approximately 10:50 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) # 2, a cook. Observation of the meat slicer located in the facility's kitchen on a food preparation table was conducted with OSM # 2. When asked if the meat slicer was cleaned and ready for use OSM # 2 stated yes. An observation of the meat slicer revealed food debris on the surface of the base under the gauge plate and on the knife cover. When asked if the mixer was clean OSM # 2 stated no. When asked how often the meat slicer is cleaned OSM # 2 stated that it should be cleaned after every use. An observation of the inside of the facility's walk-in refrigerator revealed a three quart container with approximately 12 slices of ham with a use-by-date of 04/01/2022, available for use. When asked if the ham should be available for use OSM # 2 stated no and immediately removed the container from the walk-in refrigerator and discarded the ham. On 04/06/2022 at approximately 9:25 a.m., an observation of the south unit refrigerator/ freezer revealed a half bottle of salad dressing without a name or date in the refrigerator. Further observation revealed one frozen pot pie and two half gallons of ice cream without a name or date in the freezer. On 04/06/2022 at approximately 9:28 a.m., an observation of the north unit refrigerator/ freezer revealed two frozen dinners without a name or date.	F 812	1. Upon notification from surveyor on 4/6/22, the food that was not stored in a sanitary manner in the facility kitchen and the on the nursing unit was discarded; The meat slicer that was found to have debris on it was properly cleaned; The ham in the walk-in refrigerator that was past its use-by-date was immediately discarded. 2. Residents who reside in the facility have the potential to be affected. 3. Food Service Director will educate dietary staff on storing, preparing, distributing, and serving food in accordance with professional standards for food service safety. 4. Food Service Director and/or designee will audit all refrigerators and freezers to ensure all food items are labeled and dated appropriately 3 days a week x 4 weeks and then monthly x 2 months. The Food Service Director will audit the meat slicer in the kitchen to ensure it is cleaned and ready for use 3 days a week x 4 weeks and then monthly x 2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be 5/12/2022.	4/19/22

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F 812	Continued From page 41 On 04/06/2022 at approximately 1:40 p.m., an interview and observation of the refrigerators and freezers on the north and south units with OSM # 8, cook. When asked to describe the procedure for the use of the unit refrigerator/freezers OSM # 8 stated that they were used for the residents food and that their name should be on the items and the date when it was put in the refrigerator or freezer. When asked who was responsible for checking them and how often it was done OSM # 8 stated that the kitchen staff on the night shift was responsible for checking them every night. After observing the two frozen dinners in the north unit freezer OSM # 8 stated that they did not have a name of a resident or a date of when they were placed in the freezer and immediately discarded the items. After observing the two half gallons of ice cream, frozen pot pie in the freezer and the bottle of salad dressing in the refrigerator on the south unit, OSM # 8 stated that they did not have a name of a resident or a date of when they were placed in the refrigerator or the freezer and immediately discarded the items. The facility's policy "Food Receiving and Storage" documented in part, "14. Food items and snacks kept on the nursing units must be maintained as indicated below: ...b. All foods belonging to residents must be labeled with the resident's name, the item and the "use-by" date." The facility's policy "Food Preparation and Service" documented in part, "Food Preparation Area. 4d. Cleaning and sanitizing work services (including cutting boards) and food-contact equipment between uses, following food code guidelines."	F 812		4/19/22

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F 812	Continued From page 42 On 04/06/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.	F 812		4/19/22