STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 An unannounced Emergency Preparedness survey was conducted 4/24/22 through 4/26/22. The facility was in compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 4/24/22 through 4/26/22. Two complaints were investigated during the survey (VA00051522 - unsubstantiated; VA00054305 - unsubstantiated). 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 bed facility was 98 at the time of the survey. The survey sample consisted of 35 current resident reviews and 15 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		6/6/22

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

Electronically Signed | 05/12/2022

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to serve meals in a manner to promote resident dignity for two of 50 residents in the survey sample, Residents #32 and #95; and during the evening meal on 4/24/22 in two of two dining rooms. The findings include: 1. At dinner on 4/24/22, Resident #32 (R32) and Resident #95 (R95) had to wait 23 minutes for	F 550	CORRECTVE ACTION: In order to immediately correct the cited deficiency for failing to serve meals in a manner to promote resident dignity, the RN Unit Manager re-educated the CNA on serving meals to residents with dignity and respect. In order to immediately correct the cited deficiency for failing to provide dining services in a dignified manner, the Director of Food Service stopped using	

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F 550	Continued From page 2	F 550		

their meal to be served. While they waited at the table with Resident #34 (R34), R 34 was served her meal and finished eating her meal before R32 and R95 were ever served.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/5/22, R34 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status).

On the most recent MDS, a significant change assessment with an ARD of 2/24/22, R32 was coded as being severely cognitively impaired for making daily decisions, having scored two out of 15 on the BIMS.

On the most recent MDS, a quarterly assessment with an ARD of 2/12/22, R95 was coded as being severely cognitively impaired for making daily decisions, having scored one out of 10 on the BIMS.

On 4/24/22 at 5:00 p.m., R32, R34, and R95 sat at a table in the dining room. CNA (certified nursing assistant) #1 placed R34's meal tray in front of the resident. Neither R32 nor R95 was served food or beverage. R34 began to eat. As R34 ate, R32 and R95 stared at R34. None of the residents spoke to each other. R34 ate all the meal and pushed back from the table at 5:21 p.m. R34 stated: "I am finished." At 5:23 p.m., CNA #1 put R32's in front of the resident, returned to the tray cart, obtained R95's tray, and served R95. Both residents began eating immediately.

On 2/24/22 at 5:34 p.m., CNA #1 was interviewed. When asked why it took so long for Styrofoam during meal service. 4/25/22

OTHER POTENTIAL RESIDENTS:

All residents who eat in the second-floor dining room are potentially affected by the cited deficiency. However, no other observations of non-compliance of cited deficiency were identified.
All residents who receive meal trays are potentially affected by the cited deficiency. However, no other observations of non-compliance of cited deficiency were identified. 4/25/22

SYSTEMATIC CHANGES:

The facility policy Dignity, Respect, and Privacy will be revised to specifically address serving meals in a manner to promote dignity and to address the use of dishware during meal service. All nursing staff will be re-educated by the Geriatric Education Coordinator on the revised facility policy, Dignity, Respect, and Privacy and serving meals to residents to promote dignity. The nursing staff will sign-off once they attend the training and documentation of attendance will be placed in their training files.
All Food Service staff will be re-educated by the Director of Food Services on the revised facility policy, Dignity, Respect, and Privacy and serving meals in a dignified manner with proper dishware. The food service staff will sign-off once they attend the training and documentation of attendance will be placed in their training files. 6/6/22

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F 550	Continued From page 3 R32 and R95 to receive their meals after their tablemate had been served, CNA #1 stated sometimes there is more staff to assist with meal service. CNA #1 also stated the order in which residents are served depends on which carts arrive first from the kitchen downstairs. She stated: "When the cart gets here, we try to serve." She stated if there is only one staff person to serve, it can take a longer amount of time than usual. She stated the nursing staff members have asked the kitchen to send all carts at one time, but that has not started happening. CNA #1 stated residents also switch preferences from eating in the dining room to eating in their bedrooms from time to time. When asked if there were any concerns with a resident being served a meal 23 minutes before the tablemates, and completing the meal before tablemates were even served, CNA #1 stated she would not like it if that happened to her. CNA #1 stated it would be hard to be the resident who had to watch another resident eat, especially if she were hungry. On 4/25/22 at 1:55 p.m., OSM (other staff member) #1, the director of food services, was interviewed. He stated carts are loaded in the kitchen according to their final destination. He stated each cart holds 16 trays. He stated the nursing staff is responsible for the order in which the trays are served. He stated he was not working on 4/24/22 for the evening meal. He stated there is normally one cart which contains the trays for all residents who are eating the meal in the dining room. He stated if a resident changes a preference from dining room to bedroom or vice versa, the nursing staff should notify the dining staff. When informed of the observations of the delay in serving the evening meal to R32 and R95 the night before, he stated	F 550	MONITORING: The RN Unit Manager will audit 10% of all residents who eat meals in the dining room weekly for six (6) weeks. Where non-compliance is reported, responsible staff will be re-educated immediately, and corrective action taken. The results of the weekly audit will be reported to the Director of Nursing for analysis of trends and patterns. The Director of Nursing will present audit results to ILNRC□s Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will review a summary analysis of the weekly audits and provide additional recommendations including the frequency of continued audits. The Assistant Food Service Director or designee will audit 10% of all resident trays weekly for six (6) weeks to ensure that no Styrofoam has been used during meal service. Where non-compliance is reported, responsible staff will be re-educated immediately, and corrective action taken. The results of the weekly audit will be reported to the Food Service Director to ensure compliance. Any non-compliance will be immediately addressed. The Food Service Director will present audit results to ILNRC□s Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will review a summary analysis of weekly audits and provide additional recommendations in the frequency of continued audits. 6/6/22	

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F 550	Continued From page 4	F 550		

such a delay could cause inconvenience, and perhaps even conflict between residents. He stated it is a matter of dignity if a resident is forced to watch another resident eat a meal at the same table, without having their own meal to enjoy at the same time.

On 4/25/22 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

A review of the facility policy, "Dignity, Respect, and Privacy," revealed, in part: "All residents in our facility must be treated with kindness, dignity, and respect whenever talked with, cared for, or talked about."

No further information was provided prior to exit.

2. The facility staff failed to provide dining services in a dignified manner on 2 of 2 nursing units, 1st floor and 2nd floor.

On 4/24/22 at 2:40 PM an inspection of the kitchen was conducted with OSM #3 (Other Staff Member) the Assistant Dietary Manager. During this inspection, staff were noted to be in the midst of preparing for the dinner service. Quantities of styrofoam trays, plates, etc., were noted to be out and ready for use. OSM #3 stated that the dietary department is short staffed on the weekends so they use styrofoam on the weekends and use standard dishware during the week.

On 4/24/22 at 4:58 PM, The survey team observed residents on the two nursing units being served the dinner meal. All residents were noted

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F 550	Continued From page 5	F 550		

to being served their meals on styrofoam trays with styrofoam plates with a plastic cover, plastic and/or styrofoam bowls, plastic cups, and plastic utensils. CNA #1 (Certified Nursing Assistant), who was serving residents, was asked how long residents have been served on styrofoam and plastic. They stated that it had been about a week and that they thought there might be something broken in the kitchen.

On 4/25/22 at 8:45 AM an interview was conducted with OSM #1, the Director of Food Services. When asked if the dishwasher was broken, they stated it was not, and that a new one was installed within the last 2 months. When asked if the dishwasher was working on Sunday 4/24/22, they stated it was. When asked why were residents served on styrofoam on Sunday 4/24/22 if the dishwasher was not broken, there was no infection outbreaks in the facility, and there was no emergency events interfering with meal service, they stated that the facility did not have adequate staff in the kitchen on Sunday, 4/24/22. They stated that it "comes down to staffing." When asked if the use of styrofoam and plastic was for staff convenience, they stated that it was. When asked about the statement from CNA #1 that the residents had been served on styrofoam about a week and that the unit staff thought there might be something broken in the kitchen, they stated that was not accurate, and that it was an infrequent occurrence. A policy regarding dining and dishware was requested.

A review of the facility document provided, "Labor Management" was conducted. This policy documented, "Staffing is sufficient to carry out the functions of department in a timely and appropriate manner...Staffing is designed and

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F 550	Continued From page 6 planned to meet the needs of the account..." This policy did not address residents rights and dignity to be served on standard dishware in absence of an infection outbreak in the facility, dishwashing equipment failure, or an emergency event that interferes with normal meal and dining service (of which staffing concerns do not qualify as an emergency). A review of the facility policy, "Dignity, Respect and Privacy" was conducted. This policy documented, "All residents in our facility must be treated with kindness, dignity and respect whenever talked with, cared for, or talked about." The policy did not address the use of dishware during meal service. On 4/25/22 at 5:40 PM an end-of-day meeting was conducted with ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively. They were notified of this concern. ASM #1 stated that they were not aware that dietary staff had been using styrofoam and plastic on the weekend and that it should not be happening. No further information was provided by the end of the survey.	F 550		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622		6/6/22

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F 622	Continued From page 7	F 622		

because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's

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F 622	Continued From page 8	F 622		

medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-
(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and
(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.
(iii) Information provided to the receiving provider must include a minimum of the following:
(A) Contact information of the practitioner responsible for the care of the resident.
(B) Resident representative information including contact information
(C) Advance Directive information
(D) All special instructions or precautions for ongoing care, as appropriate.
(E) Comprehensive care plan goals;
(F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility document review, it was determined

CORRECTIVE ACTION:

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F 622	Continued From page 9 the facility staff failed to provide a resident's comprehensive care plan goals to the receiving facility at the time of discharge for one of 50 residents in the survey sample, Resident #32. The facility failed to evidence that Resident #32's (R32's) care plan goals were sent to the hospital when the resident was discharged on 2/6/22. The findings include: On the most recent MDS, a significant change assessment with an ARD of 2/24/22, R32 was coded as being severely cognitively impaired for making daily decisions, having scored two out of 15 on the BIMS. A review of R32's clinical record revealed a rapid response assessment form dated 2/6/22. The form stated R32 had experienced a decrease in oxygenation due to COVID-19, and was transferred to the hospital via ambulance. The form contained a check list where staff had placed a check mark beside documents sent with the resident to the hospital. There was no check mark indicating comprehensive care plan goals had been sent to the hospital. On 4/25/22 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing) were informed of these concerns. On 4/26/22 at 9:35 a.m., ASM #2 stated the facility could not locate any evidence that the care plan goals were sent to the hospital with R32 on 2/6/22. On 4/26/22 at 12:53 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked what	F 622	In order to immediately correct the cited deficiency for Resident # 32 where facility staff failed to provide comprehensive care plan goals to the receiving facility at the time of discharge, a meeting with the nurses was conducted by the Director of Nursing and the RN Unit Managers to review the cited deficiency. In addition, the resident transfer checklist was reviewed with the nurses to ensure compliance of all required information that must be sent to the hospital at discharge. Resident # 32 is no longer in the hospital. 5/4/22 OTHER POTENTIAL RESIDENTS: All residents who have been transferred to the hospital are potentially affected by the cited deficiency however, no other inaccuracies were found. 5/4/22 SYSTEMIC CHANGES: The nursing staff will be re-educated by the Geriatric Education Coordinator on the Transfer to Emergency Room policy to provide resident comprehensive care plan goals to hospital staff when the resident is transferred to the hospital. In addition, the nurses will be re-educated on the resident transfer checklist to be used on all resident discharges. 6/6/22 MONITORING: The Medical Records Manager/designee will track and monitor residents who are transferred to the hospital. The Medical Records Manager/designee will audit	

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F 622	Continued From page 10 paperwork is sent to the hospital when a resident is discharged, she stated the do not resuscitate form, a face sheet, a copy of medications, recent laboratory results, and the comprehensive care plan goals should be sent. She stated there is a checklist on the back of the transfer form where a nurse places a check beside all documents he/she send with the resident. LPN #1 stated it is important for care plan goals to be sent so the hospital staff can take better care of the resident by knowing the resident's particular needs, including with which activities of daily living a resident needs assistance. A review of the facility policy, "Emergency Transfer to the Emergency Room," revealed, in part: "Copy any pertinent physician order sheets, current MAR (medication administration record, past 24 hours nurses' notes, pertinent lab work, x-rays ...to send with the Rapid Response Form ...Comprehensive Care Plan Goals." No further information was provided prior to exit.	F 622	100% of resident medical records who were transferred to the hospital for documentation of written comprehensive care plan goals. A weekly audit for 4 weeks will be conducted by the Medical Records Manager for compliance. After 4 weeks, a monthly audit will be conducted. Any discrepancies will be immediately corrected and brought to the attention of the Director of Nursing. The ILNRC Performance Improvement committee (QAPI) will review a summary analysis of the monthly audits and provide additional recommendations, including the frequency of the continued audits. 6/6/22	
F 640 SS=B	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 640		5/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 640	Continued From page 11 (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed	F 640	CORRECTIVE ACTION:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 640	Continued From page 12 to transmit MDS (minimum data set) OBRA (Omnibus Budget Reconciliation Act) tracking records and assessments to CMS (the Centers for Medicare and Medicaid Services) for 6 of 50 residents in the survey sample, Residents #6, #8, #9, #10, #11 and #12. The findings include: 1. The facility staff failed to transmit Resident #6's (R6) discharge- return not anticipated assessment dated 11/29/21. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/1/21, the resident scored 12 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions. Review of R6's clinical record revealed a discharge- return not anticipated assessment dated 11/29/21 was completed but not transmitted to CMS. On 4/25/22 at 3:10 p.m., an interview was conducted with RN (registered nurse) #1 (MDS coordinator). RN #1 stated R6's discharge-return not anticipated assessment was not transmitted because the resident's payer source was a private insurance company. On 4/25/22 at 4:25 p.m., RN #1 stated it was a mistake to not transmit R6's assessment and it should have been sent. RN #1 stated she references the CMS RAI (resident assessment instrument) manual in regards to transmitting MDS assessments. On 4/25/22 at 5:44 p.m., ASM (administrative	F 640	In order to immediately correct the cited deficiency for Residents #6, #8, #9, #10, #11 and #12 where facility staff failed to transmit MDS OBRA tracking records and assessments to CMS, the Lead MDS Coordinator transmitted MDS OBRA tracking records and assessments to CMS for all six residents. 4/27/22 OTHER POTENTIAL RESIDENTS: All residents are potentially affected by the cited deficiency. A review of all residents in the last seven months was conducted to identify any further MDS OBRA tracking records and assessments not transmitted as required. Any non-compliance found was corrected by transmitting MDS OBRA tracking records and assessments to CMS. 4/27/22 SYSTEMIC CHANGES: Re-education of MDS Coordinators will be conducted by the Lead MDS Coordinator on transmission requirements Nursing Homes are required to submit OBRA MDS records for all residents in Medicare or Medicaid certified beds regardless of the payor source. 5/31/22 MONITORING: The Lead MDS Coordinator will audit all completed MDSs prior to submission for 4 weeks and then monthly for 5 months. Where non-compliance is reported, responsible staff will be re-educated immediately, and corrective action taken.	

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F 640	Continued From page 13 staff member) #1 (the administrator) and ASM #2 (the director of nursing were made aware of the above concern. The facility policy titled, "CARE PLANNING- MDS SUBMISSION AND CORRECTION" documented, "All Medicare and/or Medicaid- certified nursing facilities or agents of those facilities must transmit required MDS data records to CMS QIES (Quality Improvement and Evaluation System) Assessment Submission and Processing (ASAP) system...(Refer to Chapter 5 of the CMS Long-Term Care Resident Assessment Instrument User's 3.0 Manual)." The CMS RAI manual documents the following: "CHAPTER 2: ASSESSMENTS FOR THE RESIDENT ASSESSMENT INSTRUMENT (RAI) OBRA-Required Tracking Records and Assessments are Federally mandated, and therefore, must be performed for all residents of Medicare and/or Medicaid certified nursing homes. These assessments are coded on the MDS 3.0 in items A0310A (Federal OBRA Reason for Assessment) and A0310F (Entry/discharge reporting). They include: Tracking records ·Entry ·Death in facility Assessments ·Admission (comprehensive) ·Quarterly ·Annual (comprehensive) ·SCSA (comprehensive) ·SCPA (comprehensive) ·SCQA ·Discharge (return not anticipated or return anticipated). CHAPTER 5: SUBMISSION AND CORRECTION	F 640	The results of the weekly audit will be reported to the Director of Nursing for analysis of trends and patterns. The Director of Nursing will present audit results to LNRC□s Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will review a summary analysis of the audits and provide additional recommendations including the frequency of continued audits. 5/31/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 640	Continued From page 14	F 640		

OF THE MDS ASSESSMENTS
Nursing homes are required to submit Omnibus Budget Reconciliation Act (OBRA) required Minimum Data Set (MDS) records for all residents in Medicare- or Medicaid-certified beds regardless of the pay source."

No further information was presented prior to exit.

2. The facility staff failed to transmit Resident #8's (R8) entry tracking record dated 11/4/21 and discharge- return not anticipated assessment dated 12/4/21.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/10/21, the resident scored 14 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions.

Review of R8's clinical record revealed an entry tracking record dated 11/4/21 and a discharge-return not anticipated assessment dated 12/4/21 was completed but not transmitted to CMS.

On 4/25/22 at 3:10 p.m., an interview was conducted with RN (registered nurse) #1 (MDS coordinator). RN #1 stated R8's entry tracking record and discharge-return not anticipated assessment was not transmitted because the resident's payer source was a private insurance company. On 4/25/22 at 4:25 p.m., RN #1 stated it was a mistake to not transmit R8's tracking record and assessment and they should have been sent.

On 4/25/22 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 640	Continued From page 15	F 640		

(the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to transmit Resident #9's (R9) entry tracking record dated 11/3/21 and discharge- return not anticipated assessment dated 1/22/22.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/9/21, the resident scored 0 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions.

Review of R9's clinical record revealed an entry tracking record dated 11/3/21 and a discharge-return not anticipated assessment dated 1/22/22 was completed but not transmitted to CMS.

On 4/25/22 at 3:10 p.m., an interview was conducted with RN (registered nurse) #1 (MDS coordinator). RN #1 stated R9's entry tracking record and discharge-return not anticipated assessment was not transmitted because the resident's payer source was a private insurance company. On 4/25/22 at 4:25 p.m., RN #1 stated it was a mistake to not transmit R9's tracking record and assessment and they should have been sent.

On 4/25/22 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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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 640	Continued From page 16	F 640		

4. The facility staff failed to transmit Resident #10's (R10) entry tracking record dated 11/8/21 and discharge- return not anticipated assessment dated 12/10/21.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/14/21, the resident scored 8 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions.

Review of R10's clinical record revealed an entry tracking record dated 11/8/21 and a discharge-return not anticipated assessment dated 12/10/21 was completed but not transmitted to CMS.

On 4/25/22 at 3:10 p.m., an interview was conducted with RN (registered nurse) #1 (MDS coordinator). RN #1 stated R10's entry tracking record and discharge-return not anticipated assessment was not transmitted because the resident's payer source was a private insurance company. On 4/25/22 at 4:25 p.m., RN #1 stated it was a mistake to not transmit R10's tracking record and assessment and they should have been sent.

On 4/25/22 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

5. The facility staff failed to transmit Resident #11's (R11) discharge- return anticipated assessment dated 2/24/22, entry tracking record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 640	Continued From page 17	F 640		

dated 2/26/22 and annual assessment dated 3/8/22.

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/8/22, the resident scored 11 out of 15 on the BIMS (brief interview for mental status), indicating the resident is moderately cognitively impaired for making daily decisions.

Review of R11's clinical record revealed a discharge- return anticipated assessment dated 2/24/22, an entry tracking record dated 2/26/22 and an annual assessment dated 3/8/22 was completed but not transmitted to CMS.

On 4/25/22 at 3:10 p.m., an interview was conducted with RN (registered nurse) #1 (MDS coordinator). RN #1 stated R11's discharge-return anticipated assessment, entry tracking record and annual assessment was not transmitted because the resident's payer source was private pay. On 4/25/22 at 4:25 p.m., RN #1 stated it was a mistake to not transmit R11's tracking record and assessments and they should have been sent.

On 4/25/22 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing were made aware of the above concern.

No further information was presented prior to exit.

6. The facility staff failed to transmit Resident #12's (R12) discharge- return not anticipated assessment dated 1/11/22.

On the most recent MDS (minimum data set), an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 640	Continued From page 18 admission assessment with an ARD (assessment reference date) of 12/21/21, the resident scored 0 out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely cognitively impaired for making daily decisions. Review of R12's clinical record revealed a discharge- return not anticipated assessment dated 1/11/22 was completed but not transmitted to CMS. On 4/25/22 at 3:10 p.m., an interview was conducted with RN (registered nurse) #1 (MDS coordinator). RN #1 stated R12's discharge-return not anticipated assessment was not transmitted because the resident's payer source was a private insurance company. On 4/25/22 at 4:25 p.m., RN #1 stated it was a mistake to not transmit R12's assessment and it should have been sent. On 4/25/22 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 640		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review, and clinical record review, it was determined the facility failed	F 641	ORRECTIVE ACTION: In order to immediately correct the cited	6/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 641	Continued From page 19	F 641		

to complete an accurate MDS (minimum data set) for four of 50 residents in the survey sample, Residents #108, #105, #23, and #83.

The findings include:

1. For Resident #108 (R108) the facility inaccurately coded the discharge location on the 2/28/22 MDS.

On the most recent MDS, an admission assessment with an ARD (assessment reference date) of 2/16/22, R108 was coded as being severely cognitively impaired for making daily decisions, having scored zero out of 15 on the BIMS (brief interview for mental status).

A review of R108's clinical record revealed the following from the discharge summary dated 2/28/22: "[R108] discharged home with all belongings. Family supportive of care."

A review of the discharge MDS dated 2/16/22 revealed R108 was coded as having been discharged to the hospital. Box A2100, Discharge Status, was coded as a "3," indicating R108 was discharged to the hospital.

On 4/25/22 at 2:59 p.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. When asked what reference she uses to complete the MDS, she stated she uses the RAI (Resident Assessment Instrument) manual.

On 4/25/22 at 4:32 p.m., ASM (administrative staff member) #1, the administrator, was informed of this concern. She stated R108 had not been discharged to the hospital, but instead had been discharged home. She stated the

deficiency for Resident C#108, #105, #23, and #83 where facility staff failed to complete an accurate MDS, all MDS assessments were modified to correct the coding error for these four residents. 4/27/22

OTHER POTENTIAL RESIDENTS:

All residents are potentially affected; however, an audit of the most recent MDS assessments in the last month submitted for all residents were reviewed/audited to ensure the assessments accurately reflects the resident status. Any MDS found to be affected were modified to correct the error. 5/20/22

SYSTEMIC CHANGES:

The Lead MDS Coordinator will conduct training for all MDS Coordinators for ensuring MDS assessments accurately reflect the resident status based on the RAI Manual. Utilization of EMR quality reporting to review for accuracy. 6/6/22

MONITORING:

The MDS Coordinator will audit 15% of MDS assessments ready for submission for coding accuracy for 4 weeks and then monthly for 5 months to ensure compliance. Any non-compliance will be immediately corrected. The results will be reported to the Director of Nursing for analysis and trends and patterns. A summary report of the audits will be provided to the Quality Assurance and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 20 2/16/22 MDS was coded in error. No further information was provided prior to exit. According to the MDS RAI Manual, v1 17.1 October, 2019, at A2100: "Coding Instructions Select the 2-digit code that corresponds to the resident's discharge status. · Code 01, community (private home/apt., board/care, assisted living, group home): if discharge location is a private home, apartment, board and care, assisted living facility, or group home. · Code 02, another nursing home or swing bed: if discharge location is an institution (or a distinct part of an institution) that is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for injured, disabled, or sick persons. Includes swing beds. · Code 03, acute hospital: if discharge location is an institution that is engaged in providing, by or under the supervision of physicians for inpatients, diagnostic services, therapeutic services for medical diagnosis, and the treatment and care of injured, disabled, or sick persons." 2. For Resident #105 (R105), the facility staff failed to correctly code the resident's ADL (activities of daily living) performance status on the 11/25/22 MDS. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/25/22, R105 was coded as being severely cognitively impaired for making daily decisions, having scored zero out of 15 on	F 641	Performance Improvement Committee (QAPI) for additional review and recommendations. 6/6/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 641	Continued From page 21	F 641		

the BIMS (brief interview for mental status).

In a comparison between R105's quarterly MDS with an ARD of 2/25/22, and the previous quarterly assessment with an ARD of 11/25/22, R105 was coded to have declined in ability to perform the ADLs of bed mobility, transferring, and eating. In each category, she was coded as going from a "3," meaning she required the extensive assistance of staff, to a "4," meaning she was completely dependent on staff.

On 4/25/22 at 2:59 p.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. She was asked about the reason for the decline. RN #1 stated R105 was completely dependent in all ADLs at the time of both assessments. She stated R105 was completely dependent on staff for all ADLs for as long as the resident has lived at the facility. She stated the ADL coding on the 11/25/22 MDS for bed mobility, transferring, and eating, was incorrect. RN #1 provided credible evidence from CNA (certified nursing assistant) daily records to verify this statement.

On 4/25/22 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

According to the MDS RAI Manual, v1 17.1 October, 2019, at Section G: "Coding Instructions For each ADL activity:
- Consider all episodes of the activity that occur over a 24-hour period during each day of the 7-day look-back period, as a resident ' s ADL self-performance and the support required may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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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 641	Continued From page 22	F 641		

vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations to occur, including but not limited to, mood, medical condition, relationship issues (e.g., willing to perform for a nursing assistant that he or she likes), and medications. The responsibility of the person completing the assessment, therefore, is to capture the total picture of the resident 's ADL self-performance over the 7-day period, 24 hours a day (i.e., not only how the evaluating clinician sees the resident, but how the resident performs on other shifts as well)."

3. For Resident #23 (R23), the facility incorrectly coded the resident as having restraints on the 2/9/22 MDS (minimum data set).

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/9/22, R23 was coded as being moderately cognitively impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). R23 was coded as having restraints in section P.

4/24/22 at 2:41 p.m., R23 was observed sitting up in bed. Both side rails were up. R23 was asked if they used the side rails. R23 stated they used them "all the time" for turning over in bed, and for getting in and out of bed. When asked if the side rails prevented their movement in any way, R23 stated the side rails did not.

On 4/25/22 at 2:59 p.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. When asked if R23 uses restraints, she stated: "No." After reviewing section P of the 2/9/22 MDS, she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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 641	Continued From page 23	F 641		

stated the MDS incorrectly coded R23 as having restraints. She stated the MDS coding in section P was a mistake. She stated instead of a "1," R23 should have been coded as a zero.

On 4/25/22 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns.

No further information was provided prior to exit.

According to the MDS RAI Manual, v1 17.1 October, 2019, at Section P: "Coding Instructions Identify all physical restraints that were used at any time (day or night) during the 7-day look-back period. After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use:
o Code 0, not used: if the item was not used during the 7-day look-back or it was used but did not meet the definition.
o Code 1, used less than daily: if the item met the definition and was used less than daily.
o Code 2, used daily: if the item met the definition and was used on a daily basis during the look-back period."

4. Facility staff failed to complete an accurate MDS (Minimum Data Set) assessment for Resident #83. The annual assessment with an ARD (Assessment Reference Date) of 4/10/22 was erroneously coded for the use of anticoagulant medication when the resident was not on any.

On the most recent MDS, an annual assessment with an ARD of 4/10/22, Resident #83 scored 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 641	Continued From page 24	F 641		

out of 15 on the BIMS (brief interview for mental status), indicating the resident was not cognitively impaired for making daily decisions. The resident was coded as being independent for eating; required limited assistance for transfers, dressing, toileting and hygiene; and extensive assistance for bathing.

A review of the above MDS revealed Section N "Medications" the question "Indicate the number of DAYS the resident received the following medications during the last 7 days or since admission/entry or reentry if less than 7 days." There were 8 medication types listed, one which was anticoagulants. The MDS was coded as the resident having been administered anticoagulants for 7 out of 7 days prior to the MDS date.

A review of the clinical record failed to reveal any evidence that the resident had been on any anticoagulant medication in the time period of the above MDS.

On 4/25/22 at 3:10 PM, an interview was conducted with RN #1 (Registered Nurse) the MDS nurse. When asked about the coding for anticoagulants and that none was identified in the clinical record, they reviewed the record. They stated that the resident was on an anticoagulant medication which had been discontinued in May of 2020 and was not currently on any. They stated that it was a coding error for the use of anticoagulant medication. When asked what procedures are used to complete the MDS, they stated the RAI manual (Resident Assessment Instrument).

A review of the RAI manual, Version 1.17.1, October 2019, documented:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 641	Continued From page 25	F 641		

"Medications are an integral part of the care provided to residents of nursing homes. They are administered to try to achieve various outcomes, such as curing an illness, diagnosing a disease or condition, arresting or slowing a disease's progress, reducing or eliminating symptoms, or preventing a disease or symptom....
·Residents taking medications in these medication categories and pharmacologic classes are at risk of side effects that can adversely affect health, safety, and quality of life.
·While assuring that only those medications required to treat the resident's assessed condition are being used, it is important to assess the need to reduce these medications wherever possible and ensure that the medication is the most effective for the resident's assessed condition.
·As part of all medication management, it is important for the interdisciplinary team to consider non-pharmacological approaches. Educating the nursing home staff and providers about non-pharmacological approaches in addition to and/or in conjunction with the use of medication may minimize the need for medications or reduce the dose and duration of those medications...
Steps for Assessment:
1. Review the resident's medical record for documentation that any of these medications were received by the resident during the 7-day look-back period (or since admission/entry or reentry if less than 7 days)....
Anticoagulant (e.g., warfarin, heparin, or low-molecular weight heparin): Record the number of days an anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/entry or reentry if less than 7 days). Do not code antiplatelet medications such as aspirin/extended

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 641	Continued From page 26 release, dipyridamole, or clopidogrel here." On 4/25/22 5:40 PM an end-of-day meeting was conducted with ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively. They were notified of this concern. No further information was provided by the end of the survey.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		6/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 657	Continued From page 27 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 review and revise the comprehensive care plan for 1 of 50 residents in the survey sample, Resident #55. The facility staff failed to review and revise Resident #55's (R55) comprehensive care plan for the use of side rails. The findings include: On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/20/22, the resident scored 0 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 R55's clinical record revealed a physician's order dated 3/16/22 for two upper side rails in bed. R55's comprehensive care plan dated 3/21/22 failed to document information regarding side rails. On 4/24/22 at 3:36 p.m. and 4/25/22 at 8:52 a.m., R55 was observed lying in bed with two upper side rails in the upright position. On 4/25/22 at 3:15 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated the purpose of the care plan is for everyone to know how to take care of the patients. RN #1 stated side rails are not used as restraints and are used as enablers for bed mobility and transfers but a former director of nursing told staff side rails need to be	F 657	CORRECTIVE ACTION: In order to correct the cited deficiency for facility staff failing to review and revise the comprehensive care plan for use of side rails, Resident #55 comprehensive care plan was reviewed and revised to accurately reflect the use of side rails. 4/27/22 OTHER POTENTIAL RESIDENTS: All residents who use side rails are potentially affected, however, an audit of comprehensive care plans was conducted on all residents who use side rails, and no other non-compliance was found. 5/10/22 SYSTEMIC CHANGES: Re-education of nursing staff and MDS Coordinators will be conducted by the Geriatric Education Coordinator on the facility policy titled, Care Planning MDS-Resident Plan of Care to ensure the Plan of Care is updated with new orders, occurrences or changes that affect the resident within a reasonable amount of time. 6/6/22 MONITORING: The MDS Coordinator will audit 15% of Care Plans for side rail use weekly for 4 weeks and then monthly for 5 months to ensure the comprehensive care plans reflects it has been reviewed and revised	

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	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 657	Continued From page 28 documented on residents' care plans. RN #1 reviewed R55's care plan and stated she did not see the use of side rails documented on the care plan. On 4/25/22 at 5:44 p.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, "CARE PLANNING MDS-RESIDENT PLAN OF CARE" documented, "5. The Plan of Care is updated with new orders, occurrences or changes that affect the resident within a reasonable amount of time." No further information was presented prior to exit.	F 657	accurately. A summary analysis of the audit results will be presented to the Quality Assurance and Performance Improvement Committee (QAPI) for additional recommendations including frequency of continued audits. 6/6/22	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to follow professional standards of practice for 2 of 50 residents in the survey sample; Residents #317 and #98. The findings include: 1. The facility staff failed to transcribe and sign out for a medication as ordered and	F 658	CORRECTIVE ACTION: To immediately correct the cited deficiency for facility staff failing to follow professional standards of practice for Resident #317 and #98, LPN #5 was re-educated on the facility policy titled Medication and Treatment Administration Records to transcribe all verbal and written orders and to not borrow medication. In addition, the Director of	6/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 658	Continued From page 29 administered; and failed to ensure the medication that was administered was designated for the resident that received it. Resident #317 was admitted to the facility on 1/28/22 and discharged on 2/22/22. On the admission MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/1/22, Resident #317 scored 7 out of 15 on the BIMS (brief interview for mental status, indicating the resident was cognitively impaired for making daily decisions. The resident was coded as requiring extensive to total care for all areas of activities of daily living. A review of the clinical record revealed a nurse's note dated 2/15/22 that documented, "...Sat in nurses station all shift. Not compliant with getting up by himself. This AM (morning) patient had a mental status change. MD (medical doctor) ordered Haldol (1) one time dose and not effective..." A review of the clinical record revealed a nurse's note dated 2/18/22 that documented, "Patient started the morning in good mood. Then about 0945 patient got very combative, kicking, hitting, trying to get out of the chair. 5 staff members were struggling to keep (the resident) safe. This nurse called director of nursing in to help. MD (medical doctor) was called and IM (intramuscular) one time dose of Haldol was ordered. That was effective. [Family member] was called to make family aware. Will continue to monitor." A review of the physician's orders and the February 2022 eMAR (electronic medication administration record) failed to reveal any	F 658	Nursing revised the policy to include direction regarding ensuring medications administered are for the resident it is being administered to and not borrowing medications from other residents. 4/27/22 To immediately correct the cited deficiency for facility staff failing to follow medication administration standards of practice during the medication administration observation, LPN #4 was educated on cleaning a pill cutter between uses. The Director of Nursing revised the policy, Tablet splitting Guidance for Patient Safety to reflect proper cleaning between uses of the pill splitter. 4/27/22 OTHER POTENTIAL RESIDENTS: All residents who receive medications by LPN #5 and LPN #4 are potentially affected by the cited deficiency. However, no other observations of non-compliance of cited deficiency were identified. 4/27/22 SYSTEMIC CHANGES: All nurses will be re-educated by the Geriatric Education Coordinator on the revised Medication and Treatment Administration Records policy and revised Tablet splitting Guidance for Patient Safety policy focusing on transcribing all verbal and written orders, not borrowing medications from other residents, and cleaning the pill splitter between uses. The nurses will sign off once they attend the in-service training and the documentation will be placed in their	

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F 658	Continued From page 30 evidence that this medication order was transcribed and initialed as being given on these 2 dates. On 4/26/22 at 10:45 AM, LPN #5 was interviewed. They stated that they could not recall if they transcribed the order and signed it out or not as it was a while ago. On 4/26/22 at 11:28 AM, ASM #1 and ASM #2 (Administrative Staff Member) the Administrator and the Director of Nursing, respectively, were notified of the concern. ASM #1 stated that this medication was maintained in a locked cabinet system that required the pharmacy to provide a code in order to access the cabinet and obtain the medication. ASM #1 stated that it requires an order for the medication that has to be provided to the pharmacy before they will provide access to the cabinet. On 4/26/22 at 12:30 PM an observation was made of the locked cabinet system, with RN #5 (Registered Nurse) the unit manager, and ASM #2. RN #5 described the system, pointing to a sign posted on the wall above the cabinet with the pharmacy number and instructions. RN #5 stated that staff call the number and provide the pharmacy with the physician's order and the pharmacy then uses a code to provide access to the cabinet drawer that the medication is in. At this time, ASM #2 called the Director of Pharmacy (OSM #4 - Other Staff Member) on the phone and inquired if there was evidence that on 2/15/22 and 2/18/22, that the pharmacy received an order for the Haldol and provided access to the cabinet to pull the Haldol. OSM #4 stated that the system had not been accessed on those dates for that medication for this resident.	F 658	training file. 6/6/22 MONITORING: The RN Unit Managers or designee will audit 15% of medication administrations once a week for 4 weeks and then monthly for 3 months to ensure facility staff follow professional standards of practice and follow medication administration standards of practice. Where non-compliance is reported, responsible staff will be re-educated immediately, and corrective action taken. The results of the audits will be reported to the Director of Nursing and to LNRC□s Quality Assurance and Performance Improvement Committee (QAPI). The QAPI Committee will review a summary analysis of the audits and provide recommendations including the frequency of continued audits. 6/6/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 658	Continued From page 31	F 658		

On 4/26/22 at 12:40 PM, ASM #2, RN #5, and LPN #5 met to discuss how and where the medication was obtained as the pharmacy had not provided it from the locked system and the order had not been transcribed in the clinical record and sent to the pharmacy, and the medication was not on the eMAR and signed out for. LPN #5 stated that they obtained it from another nurse's medication cart from a resident who had been discharged.

A review of the facility policy, "Medication and Treatment Administration Records" was conducted. This policy documented, "A complete record of medications and treatments will be provided for each resident for the use in preparing, administering and documenting...All medications and treatments will be transcribed exactly as written by the Physician/Nurse Practitioner..."

This policy did not include direction regarding ensuring medications administered are for the resident it is being administered to and not borrowing medications from other residents.

No further information was provided by the end of the survey.

COMPLAINT RELATED DEFICIENCY

Lippincott, Williams and Wilkins, Fundamentals of Nursing, 2007, Ambler, PA, page 181 documented "Nurses carry a great deal of responsibility for making sure that patients get the right drugs at the right time, in the right dose and by the right routes...this includes accurate documentation and explanation..." Page 165

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 32	F 658		

documented, "After administering a tablet or capsule, be sure to record: drug given, dose given, date and time of administration, signing out the drug on the patients medication record..."

The phrase, "Neither a borrower nor a lender be,"originated from Shakespeare's famous play, Hamlet (1603),....when it comes to medication safety, Shakespeare's advice is timeless; medications should never be borrowed from or lent to others. Cohen H, Shastay AD. Nursing 2008 survey report: getting to the root of medication errors. Nursing 2008 December 2008;38(12):39-47. From the November 19, 2009 Nursing 2009 issue.

(1) Haldol - Is used to treat psychotic disorders. It is also used to treat severe behavioral problems such as explosive, aggressive behavior. Information obtained from https://medlineplus.gov/druginfo/meds/a682180.html

2. The facility staff failed to follow medication administration standards of practice during the medication administration observation on 4/25/2022. A pill cutter was used for medication prepared for Resident #33 (R33) and Resident #98 (R98) consecutively without cleaning between cutting R33's medication and R98's medication.

On 4/25/2022 at approximately 8:01 a.m., an observation was conducted of LPN (licensed practical nurse) #4 administering medications. LPN #4 was observed preparing medications for R33 which included 11 tablets. LPN #4 was observed using a pill cutter to cut 4 of the tablets in half at R33's request. LPN #4 was observed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 33	F 658		

place the pill cutter inside of the medication cart after cutting the tablets. LPN #4 failed to clean the pill cutter after use prior to returning it to the medication cart. LPN #4 administered the medications to R33 and proceeded to prepare medications for R98. LPN #4 prepared 12 tablets for R98 and was observed removing the pill cutter from the medication cart to cut 2 of the tablets in half. LPN #4 was observed to place the pill cutter back into the medication cart after cutting the tablets without cleaning it.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/26/2022, R33 scored 7 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is moderately impaired for making daily decisions.

On the most recent MDS, an admission assessment with an ARD of 4/15/2022, R98 scored 14 out of 15 on the BIMS assessment, indicating the resident is not cognitively impaired for making daily decisions.

On 4/25/2022 at 8:57 a.m., an interview was conducted with LPN #4. LPN #4 stated that they cleaned the pill cutter with alcohol prep pads kept on the medication cart. LPN #4 stated that they normally cleaned the pill cutter between every three resident medication passes.

On 4/25/2022 at 3:29 p.m., an interview was conducted with LPN #1. LPN #1 stated that they did not use the pill cutter often but they would wash it with soap and water between uses and let it air dry. LPN #1 stated that they would do this to keep it clean and to keep the next resident from getting any residue from the previous medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 34 on the cutter. On 4/25/2022 at 3:45 p.m., an interview was conducted with LPN #2. LPN #2 stated that they cleaned the pill cutter after each use with an alcohol wipe and let it air dry prior to storing it on the medication cart. LPN #2 stated that they cleaned it because the medication could linger on the pill cutter and could potentially get to the next resident. LPN #2 stated that the next resident could be allergic to any medication left on the pill cutter. The facility policy, "Tablet splitting Guidance for Patient Safety" failed to evidence guidance on cleaning the pill cutter between uses. On 4/25/2022 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was presented prior to exit.	F 658		
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, resident interview, staff	F 695	CORRECTIVE ACTION:	6/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 695	Continued From page 35 interview, facility document review and clinical record review, the facility staff failed to ensure respiratory care and services were provided in a sanitary manner for 2 of 50 residents in the survey sample, Residents #209 and #59. The findings include: 1. The facility staff failed to store Resident #209's (R209) incentive spirometer in a sanitary manner. R209's diagnoses included but were not limited to pneumonia. On the most recent MDS (minimum data set), a 5 day Medicare assessment with an ARD (assessment reference date) of 4/19/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not cognitively impaired for making daily decisions. A review of R209's clinical record revealed a physician's order dated 4/15/22 for an incentive spirometer. R209's comprehensive care plan dated 4/20/22 documented, "Resident has potential for difficulty in breathing related to -Pna (pneumonia) -pulmonary masses." The care plan failed to document information regarding the storage of R209's incentive spirometer. On 4/24/22 at 3:51 p.m., R209 was observed in bed. An incentive spirometer was on the resident's over bed table. The incentive spirometer (including a mouth piece) was uncovered and exposed to air. At this time, an interview was conducted with the resident. R209 stated staff has never provided a cover for the incentive spirometer. On 4/25/22 at 8:45 a.m., the incentive spirometer remained uncovered on the over bed table.	F 695	In order to immediately correct the cited deficiency, Resident #209 incentive spirometer was changed and stored in a sanitary manner. 4/25/22 In order to immediately correct the cited deficiency, Resident #59 incentive spirometer and nebulizer mask was changed and stored in a sanitary manner. In addition, a physician order was obtained for use of an incentive spirometer. 4/25/22 OTHER POTENTIAL RESIDENTS: All residents with incentive spirometers or nebulizer masks are potentially affected. However, no other observations of non-compliance were observed by our Infection Preventionist. 4/25/22 SYSTEMIC CHANGES: The facility policy Nebulizer Treatments will be revised to include incentive spirometer care and proper storage. Re-education of nursing staff via in-services will be conducted by the Geriatric Education Coordinator on the revised policy for storing respiratory equipment in a sanitary manner. 6/6/22 MONITORING: The Facility Compliance Monitoring tool will be revised to include observation of incentive spirometers and nebulizer masks being stored in a sanitary manner. A random sample of 10% of residents with	

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F 695	Continued From page 36 On 4/25/22 at 3:29 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated an incentive spirometer should be stored in a plastic Ziploc bag to keep the device clean and prevent organisms. On 4/25/22 at 5:44 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing were made aware of the above concern. On 4/26/22 at 3:29 p.m., ASM #1 stated the facility did not have a policy regarding incentive spirometers. No further information was presented prior to exit. 2. The facility staff failed to store an incentive spirometer and a nebulizer mask in a sanitary manner and obtain an order for use of an incentive spirometer for Resident #59 (R59). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/27/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is not cognitively impaired for making daily decisions. On 4/24/2022 at approximately 2:15 p.m., an observation was made of R59 in their room. An incentive spirometer was observed on the overbed table in R59's room uncovered. A nebulizer machine was observed on the nightstand to the left of R59's bed with a mask attached to the nebulizer medication delivery device. The nebulizer mask was observed to be lying on top of the machine uncovered. At this	F 695	incentive spirometers and nebulizer masks will be monitored weekly for four (4) weeks to ensure they are stored in a sanitary manner. As a second step, residents in the audit who have an incentive spirometer will be verified a physician order is in place. Where non-compliance is reported, responsible staff will be re-educated immediately, and corrective action taken. The results of the weekly audit will be reported to the Director of Nursing for analysis of trends and patterns. The Quality Assurance and Performance Improvement Committee (QAPI) will review a summary analysis of the weekly audits and provide additional recommendations including the frequency of continued audits. 6/6/22	

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F 695	Continued From page 37	F 695		

time an interview was conducted with R59. R59 stated that they used the incentive spirometer "sometimes" to help their breathing and they received medication through the nebulizer. When asked about storage of both, R59 stated that the incentive spirometer stayed on the bedside table and was not ever covered and the nebulizer was sometimes put in the nightstand drawer.

Additional observations of R59's room on 4/24/2022 at 2:57 p.m., and 4/24/2022 at 5:41 p.m. revealed the findings above. On 4/25/2022 at 8:45 a.m., the incentive spirometer remained on the overbed table uncovered and the nebulizer mask was observed to be on the nightstand in a plastic bag dated 4/25/2022.

The physician's orders for R59 documented,
- "DuoNeb (Ipratropium-Albuterol) Inhalation Solution 0.5-2.5 (3) MG (milligram)/3ML (milliliter), every 6 hours. 2AM, 8AM, 2PM, 8PM 03/22/2022-05/30/2022, Diagnosis: Chronic Obstructive pulmonary disease, unspecified."

The physician orders failed to evidence an order for the incentive spirometer.

The MAR (medication administration record) dated 4/1/2022-4/30/2022 for R59 documented in part, "DuoNeb (Ipratropium-Albuterol) Inhalation Solution 0.5-2.5 (3) MG (milligram)/3ML (milliliter), every 6 hours. 2AM, 8AM, 2PM, 8PM 03/22/2022-05/30/2022, Instructions: none. Diagnosis: Chronic Obstructive pulmonary disease, unspecified." The MAR documented R59 receiving the nebulizer each day at the scheduled times through 4/25/2022.

The comprehensive care plan for R59 dated

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F 695	Continued From page 38	F 695		

3/25/2022 documented in part, "Resident has potential for difficulty in breathing related to: COPD (chronic obstructive pulmonary disease), CHF (congestive heart failure)..."

On 4/25/2022 at 3:29 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that incentive spirometers should be stored in plastic Ziploc bags when not in use. LPN #1 stated that they were stored in bags to keep them clean. LPN #1 stated that nebulizer masks should also be kept in Ziploc bags and should be labeled. LPN #1 stated that the bags should be labeled with residents name and room number.

On 4/25/2022 at 3:45 p.m., an interview was conducted with LPN #2. LPN #2 stated that incentive spirometers were stored in bags with residents names on the bag and the room numbers. LPN #2 stated that they were kept in bags for identification purposes and for infection control purposes. LPN #2 stated that nebulizer masks were washed out after each use and dried at the sink prior to being placed in a storage bag. LPN #2 stated that the nebulizer mask was stored in the bag for infection control purposes. LPN #2 stated that there should be an order for incentive spirometer use. LPN #2 stated that the nursing staff assisted residents in the use of the incentive spirometer and the order advised them how often the resident was to use it.

On 4/25/2022 at approximately 4:00 p.m., LPN #2 observed the uncovered incentive spirometer in R59's room on the overbed table and was made aware of the observations of the uncovered nebulizer mask on 4/24/2022. LPN #2 stated that the nebulizer mask was now in a bag dated

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F 695	Continued From page 39	F 695		

4/25/2022 and the night shift must have placed it in the bag. LPN #2 stated that they would check to see if there was an order for the incentive spirometer for R59.

On 4/25/2022 at approximately 2:00 p.m., ASM (administrative staff member) #1, the administrator provided written documentation of the facility nursing standard of practice as following the Lippincott Manual of Nursing Practice and the Long Term Care Nursing assistants textbook.

According to The Lippincott Manual of Nursing Practice 10th Edition, 2014, page 236, Procedure Guidelines 10-11 documented in part, "Follow-up phase 1. Record medication used and description of secretions. 2. Disassemble and clean nebulizer after each use. Keep this equipment in the patient's room. The equipment is changed according to facility policy. Each patient has own breathing circuit (nebulizer, tubing and mouthpiece). Through proper cleaning, sterilization, and storage of equipment, organisms can be prevented from entering the lungs."

The facility policy, "Nebulizer Treatments" documented in part, "...Store dry equipment in a clean, closed container changing weekly (plastic bags are easily changed weekly- do not use Tupperware containers)..."

On 4/25/2022 at approximately 5:30 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.

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F 756	Continued From page 40	F 756		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §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	F 756		6/6/22

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F 756	Continued From page 41 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review it was determined that the facility staff failed to act in a timely manner on the pharmacy medication regimen review for one of 50 residents in the survey sample, Resident #47 (R47). R47's medication regimen review was completed on 1/13/2022 with recommendations for a gradual dose reduction of the antipsychotic medication which were not addressed by the facility physician until after 3/9/2022. The findings include: On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/8/2022, the resident scored a 2 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is severely impaired for making daily decisions. Section N documented R47 receiving antidepressant and antipsychotic medications. Review of R47's clinical record contained a medication regimen review form which documented reviews completed on 4/14/21, 5/13/21, 6/9/21, 7/14/21, 8/11/21, 9/9/21, 10/13/21 and 12/8/21. On 4/26/2022 at 9:13 a.m., an interview was conducted with RN (registered nurse) #4, unit manager. RN #4 stated that the pharmacist came in monthly and documented the medication regimen review on the form in the clinical record. RN #4 reviewed R47's chart and stated that they would try to find the medication regimen reviews	F 756	CORRECTIVE ACTION: To immediately correct the cited deficiency for failing to act in a timely manner on the pharmacy medication regimen review for Resident #47, the Physician and RN #4 were re-educated on the policy, Monthly Drug Medication Regimen Reviews to be addressed each month by the physician in his next visit where a progress note is written and if the physician does not respond in a timely manner (45 days) the Medical Director will be notified. The physician had addressed for Resident #47 the gradual dose reduction of the antipsychotic medication on 3/9/22. 4/27/22 OTHER POTENTIAL RESIDENTS: All residents require monthly drug regimen reviews and therefore are potentially affected. An audit was conducted of 15% of resident charts to ensure medication regimen reviews were acted on in a timely manner and there was no other non-compliance identified. 4/27/22 SYSTEMIC CHANGES: Re-education of all physicians and the RN Unit Managers will be conducted by the Director of Nursing on the Monthly Drug	

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F 756	Continued From page 42 for 11/21, 1/22 and 2/22. On 4/26/2022 at 11:56 a.m., ASM (administrative staff member) #1, the administrator provided evidence of the pharmacist medication regimen review completed for 11/21 and 2/22. ASM #1 provided a blank copy of the physician recommendations from the medication regimen review dated 1/13/2022 which documented recommendations from the pharmacist for the physician to consider a gradual dose reduction of the antipsychotic medication Quetiapine 75 mg. At this time a request was made to ASM #1 for the physician response to the recommendations made on 1/13/2022. On 4/26/2022 at 10:00 a.m., an interview was conducted with ASM #3, medical doctor. ASM #3 stated that they had joined in on R47's care about 3 months ago and at their last evaluation had chosen to continue their current psychiatric medications. ASM #3 stated that their plan for R47 was for continued psychiatric evaluation and medication management. On 4/26/2022 at 12:33 p.m., ASM #1 provided a copy of the document, "Recommendations with no response" dated "For Outcomes Entered Between 3/1/2022-3/9/2022" for R47. It documented in part, "...Recommendation Status, No response...Priority: Normal MRR (medication regimen review) Date: 1/13/2022. Recommendation: This resident has been taking the antipsychotic Quetiapine 75mg (milligram) by mouth 2 times daily since 7/2021. Please evaluate the current dose and consider a dose reduction..." A mark was observed in the area documenting, "Resident with good response, maintain the current dose..." The document was	F 756	Medication Regimen Review policy. In addition, RN Unit Managers will add a monthly reminder to their Outlook calendars to audit all resident charts for a monthly drug medication regimen review and notify the physician to address them in their progress notes. 6/6/22 MONITORING: The RN Unit Managers will audit 15% of resident charts each month for 6 months to ensure a monthly drug medication regimen review has been completed and the physician has addressed all recommendations timely from the pharmacist. If the physician does not respond to the Regimen review in a timely manner (45 days), then the Medical Director will be notified. A summary analysis of the audit results will be presented to the Quality Assurance and Performance Improvement Committee (QAPI) for additional recommendations including frequency of continued audits. 6/6/22	

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F 756	Continued From page 43	F 756		

signed by ASM #3, there was no date observed with the signature.

On 4/26/2022 at 1:40 p.m., an interview was conducted with RN #4, unit manager. RN #4 stated that the medication regimen reviews were faxed to them and they left them in a box in the nurses station area for the physicians to review. RN #4 stated that after the physician reviewed the MRR's, they made sure any orders were completed and faxed them to the pharmacy. RN #4 stated they were not sure if there was a timeframe for the physician to respond to the MRR or not. RN #4 stated that they had never had to contact a physician regarding completing the MRR because they were good about checking the box and completing them. RN #4 reviewed the document, "Recommendations with no response" for R47 and stated that it appeared that the document was sent from the pharmacy because the physician at that time did not respond to the MRR recommendations from 1/13/2022.

The facility policy, "Monthly Drug Medication Regimen Reviews" documented in part, "...Reviews should be addressed by the physician upon his next visit where a progress note is written...If the attending physician does not respond to the Medication Regimen Review in a timely manner (45 days) the Medical Director is to be notified..."

On 4/26/2022 at approximately 1:53 p.m., ASM #1, the administrator was made aware of the findings.

No further information was provided prior to exit.

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F 758	Continued From page 44	F 758		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		6/6/22

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F 758	Continued From page 45 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide services to prevent a resident from receiving unnecessary psychoactive medications for two of 50 residents in the survey sample, Residents #91 and #23. The findings include: 1. For Resident #91 (R91), the facility staff failed to evaluate the use of, and document a reason for use beyond two weeks for, two psychoactive medications which were prescribed on a prn (as-needed) basis. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/7/22, R91 was coded as being severely cognitively impaired for making daily decisions, experiencing both short term and long term memory problems. R91 was coded as receiving an antipsychotic, antidepressant, and anti-anxiety medication on all seven days of the look back period.	F 758	CORRECTIVE ACTION: To immediately correct the deficiency for failing to evaluate the use of and document a reason for use beyond two weeks for two psychoactive medications which were prescribed on a prn basis for Resident #91, the attending physician discontinued the PRN Lorazepam and reordered the continued use of the PRN Trazadone for another 14 days with documented reasons. 4/28/22 To immediately correct the deficiency for failing to perform two gradual dose reductions for an antidepressant during the first year of its use for Resident #23, the consultant pharmacist was re-educated on the policy of Psychoactive Drug use and GDR/Tapering considerations with attempts to discontinue or reduce the dosage of a psychotropic drug for those residents who do receive them and facility must within the first year of therapy attempt a GDR in two separate quarters (with at least one month between the attempts) unless	

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F 758	Continued From page 46 On 4/24/22 at 2:31 p.m., R91 was observed standing in the doorway between their bedroom and the hallway. R91 slapped themselves on the right cheek hard with the right hand four times in succession. R91 then walked back and sat on the side of the bed. A review of R91's clinical record revealed the following physician order: "Lorazepam (1) oral tablet 0.5 mg (milligrams) po (by moth) prn (as needed) bedtime (Behavior - insomnia). Instructions Ativan 0.25 mg po prn nightly." This order was dated 2/25/22. A review of R91's MAR (medication administration record) for April 2022 revealed R91 received as-needed Lorazepam six times between 4/1/22 and 4/24/22. The MAR contained consistent documentation of the behaviors R91 demonstrated at the time of administration. Further review of the clinical record revealed the following physician order: "Trazodone HCl (2) Oral Tablet 100 mg 1 tablet PO prn Every 6 hours prn (Behavior - anxiety...biting...combative...continuous crying out...screaming...continuous pacing...insomnia.)" This order was dated 4/18/21. A review of R91's April 2022 MAR revealed R 91 received as-needed Trazodone six times between 4/1/22 and 4/24/22. The MAR contained consistent documentation of the behaviors R91 demonstrated at the time of administration. A review of R91's care plan dated 2/21/21 and updated 5/10/22 revealed no information related to the extended use for an as-needed psychoactive medication.	F 758	clinically contraindicated. 4/28/22 OTHER POTENTIAL RESIDENTS: All residents who are prescribed psychotropic drug therapy are potentially affected. An audit of all current residents on psychotropic drug therapy revealed there was no other non-compliance identified. 4/28/22 SYSTEMIC CHANGES: Re-education of the Pharmacist, attending physicians, and RN Unit Managers will be conducted by the Director of Nursing on the facility policy Psychotropic Drug Use to ensure PRN psychotropic drugs are limited to 14 days without an additional rationale documentation and the facility must attempt a GDR in two separate quarters unless clinically contraindicated. 6/6/22 MONITORING: The RN Unit Managers will audit 15% of clinical records monthly for 6 months for residents receiving Psychotropic drug therapy to ensure compliance with limiting PRN psychotropic drug to 14 days without an additional rationale documented and GDR attempts in two separate quarters unless contraindicated. A summary analysis of the audits will be presented to the Quality Assurance and Performance Improvement Committee (QAPI) for additional recommendations including frequency of continued audits. 6/6/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

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F 758	Continued From page 47	F 758		

Further review of the clinical record failed to reveal evidence that the prn orders for Lorazepam and Trazodone were evaluated by the physician or pharmacist beyond 14 days of use. A review of a consult report from an outside psychiatrist dated 4/15/22 failed to reveal evidence of a review of the prn orders for Ativan and Trazodone for use beyond 14 days.

On 4/25/22 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing) were informed of these concerns. Evidence of the review of these two psychoactive medications for use beyond 14 days on an as-needed basis was requested.

On 4/26/22 at 9:35 a.m., ASM #2 stated she had not been able to locate any documentation from a provider for use of the as-needed Lorazepam or Trazodone beyond 14 days.

On 4/26/22 at 10:21 a.m., ASM #3, the attending physician, was interviewed. He stated he had only assumed care of R91 three or four months ago. He stated the resident has had episodes of severe behaviors, and needs psychoactive medications for safety. ASM #3 stated he plans to evaluate R91 the next time he is in the building (in two or three days).

On 4/26/22 at 11:58 a.m., ASM #4, the consultant pharmacist, was interviewed. When asked if she has a role in evaluating prn psychoactive medications for use beyond 14 days, she stated she looks for behaviors as indications for use of the medications, as well as the frequency a prn medication is used. She stated the provider "usually" writes an order that states he/she is evaluating and recommending the usage of a prn

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 758	Continued From page 48	F 758		

medication beyond 14 days, and gives the basis for this recommendation. She stated she was not aware of such an order for R91. She stated she knows R91 is being followed by a psychiatrist, and she relies on the psychiatrist to address the usage of prn psychoactive medications beyond 14 days.

On 4/26/22 at 2:07 p.m., ASM #1 and ASM #2 were informed of these concerns.

A review of the facility policy, "Psychotropic Drug Use," revealed, in part: "PRN psychotropic drugs are limited to 14 days without an additional rationale documentation."

No further information was provided prior to exit.

REFERENCES
(1) "Lorazepam (brand name Ativan) is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682053.html.

(2) "Trazodone is used to treat depression. Trazodone is in a class of medications called serotonin modulators. It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681038.html.

2. For Resident #23 (R23), the facility staff failed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 758	Continued From page 49	F 758		

to two gradual dose reductions (GDRs) for an antidepressant during the first year of its use.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/9/22, R23 was coded as being moderately cognitively impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). R23 was coded as receiving an antidepressant on all seven days of the look back period.

A review of R23's clinical record revealed the following physician order, dated 8/14/20 when R23 was admitted to the facility: "Lexapro (Escitalopram) (1) oral tablet 10 mg (milligrams) 1 tablet po (by mouth) at bedtime...diagnosis: Major depressive disorder." A review of the MARs (medication administration records) for R23 between 8/14/20 and 8/14/21 revealed R23 had received the medication as ordered.

A review of R23's monthly medication regimen reviews revealed an attempt at a gradual dose reduction for Lexapro on 2/9/21. The review did not reveal a second GDR attempt during the 12 months between 8/14/20 and 8/14/21.

On 4/26/22 at 11:58 a.m., ASM (administrative staff member) #4, the consultant pharmacist, was interviewed. When asked why a second GDR had not been attempted for R23's Lexapro during the first 12 months R23 took the medication, ASM #4 stated she did not like to rush the antidepressant GDRs. She stated: "I like to give it a little more time." She stated she could not find evidence of a second GDR for R23's Lexapro.

On 4/26/22 at 2:07 p.m., ASM #1 and ASM #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 758	Continued From page 50 were informed of these concerns. A review of the facility policy, "Psychotropic Drug Use," revealed, in part: "GDR/Tapering considerations... [name of facility] attempts to discontinue or reduce the dosage of a psychotropic drug for those residents who do receive them...Within the first year: Facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated." No further information was provided prior to exit. REFERENCES (1) "Escitalopram is used to treat depression in adults and children and teenagers 12 years old or older. Escitalopram is also used to treat generalized anxiety disorder (GAD; excessive worry and tension that disrupts daily life and lasts for 6 months or longer) in adults. Escitalopram is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance." This information is taken from the website https://medlineplus.gov/druginfo/meds/a603005.html.	F 758		
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.	F 812		5/31/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 51 (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, it was determined that the facility staff failed to store food in a sanitary manner in 1 of 1 facility kitchens. The findings include: On 4/24/22 at 2:40 PM an inspection of the kitchen was conducted with OSM #3 (Other Staff Member) the Assistant Dietary Manager. The following items were observed in the walk-in freezer: 1. A box of breaded chicken breast, a box of hamburger patties, a box of biscuits, were noted to be open and exposed to the environment. 2. Two whole pies on a sheet pan on a cart were noted to be uncovered, exposed to the environment. On 4/24/22 at 2:47 PM OSM #3 was asked about the exposed items in the freezer. They stated that everything should be sealed or covered.	F 812	CORRECTIVE ACTIONS: During the kitchen tour with the surveyor, a box of breaded chicken breast, a box of hamburger patties, a box of biscuits, were noted to be open and exposed to the air in the freezer. These items were immediately removed and discarded. 4/24/22 Secondly, during the kitchen tour with the surveyor, two whole pies on a sheet pan were noted to be uncovered and exposed to the environment. To immediately correct the cited deficiency, the two whole pies were removed and discarded. 4/24/22 OTHER POTENTIAL RESIDENTS: All residents who consume food prepared in the dietary kitchen are potentially affected. However, no resident demonstrated symptoms of a food related	

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	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 812	Continued From page 52 A review of the facility policy, "Food and Supply Storage" was conducted. This policy documented, "Frozen Storage....Store bulk materials in NSF approved containers that have tight fitting lids. Label both the bin and the lid. Use food grade plastic bags for food storage...Wrap food tightly to prevent cross contamination." On 4/25/22 5:40 PM an end-of-day meeting was conducted with ASM #1 and ASM #2 (Administrative Staff Members) the Administrator and Director of Nursing, respectively. They were notified of this concern. No further information was provided by the end of the survey.	F 812	illness. 5/31/22 SYSTEMIC CHANGES: Dietary Staff will be re-educated on the Food and Supply Storage Policy focusing on how to seal food items securely. The staff will sign off once they attend the training and the sheet will be placed in the training file. This policy will also be reviewed in staff meetings weekly for one month. 5/31/22 MONITORING: A daily inspection of the freezer will be conducted by the dietary supervisor on duty and documented using the department walk through check list. Any discrepancies will be immediately corrected and brought to the attention of those responsible. Inspection results will be maintained on file by month and reported quarterly to the ILNRC Quality Assurance and Performance Improvement Committee (QAPI). After achieving a goal of 100% compliance for six months, reporting may cease but the monitoring will continue. The QAPI Committee will review a summary analysis of the monthly audits and provide additional recommendations, including the frequency of the continued audits. 5/31/22	
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	F 842		6/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 842	Continued From page 53	F 842		

resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight 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

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	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 842	Continued From page 54 record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for 1 of 50 residents in the survey sample; Resident #317. The findings include: Resident #317 was admitted to the facility on 1/28/22 and discharged on 2/22/22. On the admission MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 2/1/22, Resident #317 scored 7 out of 15 on the BIMS (brief interview for mental status, indicating	F 842	CORRECTIVE ACTION: To immediately correct the cited deficiency for failing to ensure a complete and accurate clinical record for Resident #317; LPN #5 and RN #6 were re-educated on the policy Charting-Skilled and Post-Acute Documentation to include clearly and specifically documenting resident behaviors and notifying the responsible party. 4/27/22 OTHER POTENTIAL RESIDENTS: All residents who receive medications by	

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	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 842	Continued From page 55 the resident was cognitively impaired for making daily decisions. The resident was coded as requiring extensive to total care for all areas of activities of daily living. A. 2/15/22: A review of the clinical record revealed a nurse's note dated 2/15/22 that documented, "...Sat in nurses station all shift. Not compliant with getting up by himself. This AM (morning) patient had a mental status change. MD (medical doctor) ordered Haldol (1) one time dose and not effective..." This note did not document that the family was notified of this behavior and the medication intervention required. In addition, the resident's behaviors were not clearly and specifically documented, as it was only documented as a "mental status change." On 4/26/22 at 10:45 AM, LPN #5 was interviewed, as the nurse who wrote the note. They stated that they did notify the family and even requested if someone could come sit with the resident as that may calm the resident down to have family there. They stated that when they wrote the note, they forgot to include that family was notified. They stated that when they documented "mental status change" it was because the resident started out in a good mood and then "flipped" suddenly, becoming combative, agitated, aggressive, hitting and kicking. B. 2/20/22 A review of the clinical record revealed a nurse's note dated 2/20/22 that documented, "...Resident	F 842	LPN #5 and RN #6 are potentially affected by the cited deficiency. However, an audit of their documentation was conducted, and no other non-compliance identified. 5/6/22 SYSTEMIC CHANGES: The facility policy Charting-Skilled and Post-Acute Documentation will be revised to include documentation of notifying the responsible party. All nurses will be re -educated by the Geriatric Education Coordinator on the revised policy, Charting- Skilled and Post-Acute Documentation focusing on notifying the responsible party when a PRN medication is given and clearly and specifically documenting resident behaviors who need PRN medication. The nurses will sign off once they attend the in-service training and the documentation will be kept in their training file. 6/6/22 MONITORING: The RN Unit Managers will audit 15% of clinical records weekly for four (4) weeks and then monthly for 3 months to ensure resident behaviors are clearly and specifically documented and the responsible party is notified. The results of the audits will be reported to the Director of Nursing for analysis of trends and patterns. The Director of Nursing will present a summary analysis of the audits to the Quality Assurance and Performance Improvement Committee (QAPI) for additional recommendations	

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F 842	Continued From page 56	F 842		

was combative this morning. Tried several times to get out of the recliner ....Dr (doctor) [name] was notified and ordered Haldol 1mg (milligram) IM (intramuscular) x1 dose. Haldol 1mg given. Resident was calm for some time. Was able to eat breakfast...patient kept in the nurses station for close monitoring."

On 4/26/22 at 3:06 PM, RN #6 was interviewed. They stated that on 2/20/22 upon arrival to work, the resident was already at the nurse's station and was very aggressive and combative. They stated that they called the family but the family was not able to come so the supervisor called the doctor to get the Haldol order. They stated that they waited a while to see if the resident would calm down but the resident did not so they gave the Haldol and then the resident calmed down but it took a while and they were able to clean the resident and assist the resident to bed. When asked if they notified the family about the Haldol, they stated that when the family did come in, they told them that they gave the resident the medication because he was very aggressive. They stated that they should have documented that they spoke to the family and notified them.

A review of the facility policy "Charting - Skilled and Post Acute Documentation" was conducted. The policy contained very little direction on what should be documented and did not address documenting family notifications and did not address documentation should be complete and accurate and the legalities of not charting pertinent and required information.

On 4/26/22 at 11:28 AM, ASM #1 and ASM #2 (Administrative Staff Member) the Administrator and the Director of Nursing, respectively, were

including the frequency of continued audits. 6/6/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

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F 842	Continued From page 57 notified of the concern. No further information was provided. COMPLAINT RELATED DEFICIENCY The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received...Because nurses and other healthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it." (1) Haldol - Is used to treat psychotic disorders. It is also used to treat severe behavioral problems such as explosive, aggressive behavior. Information obtained from https://medlineplus.gov/druginfo/meds/a682180.html	F 842		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as	F 947		6/6/22

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	495275	A. BUILDING _____ B. WING _____	C 04/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUDOUN NURSING AND REHAB CNTR	235 OLD WATERFORD ROAD, NORTHWEST LEESBURG, VA 20176

(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 947	Continued From page 58 determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review, it was determined that the facility staff failed to ensure that one of five CNA (certified nursing assistant) records reviewed received the required dementia training. The findings include: On 4/25/2022 at approximately 1:00 p.m., a review of the facility's CNA annual training was conducted. Review of five CNA training transcripts revealed one of five CNAs selected for review did not meet the required dementia training. Review of CNA #2's training transcript documented a hire date of 1/8/2007. Further review of the training transcript dated 1/1/2021 through 1/31/2022 failed to evidence dementia training during the review period. On 4/25/2022 at 2:44 p.m., an interview was conducted with RN (registered nurse) #2, education coordinator. RN #2 stated that they were new to the position but had a calendar they used with topics to assign to staff each month in the computer for them to complete. RN #2 stated that they also performed face to face inservices as needed. RN #2 reviewed the transcript	F 947	CORRECTIVE ACTION: In order to correct the cited deficiency, CNA #2 was counseled on completing her required annual in-service training as required. The CNA was given an in-service on dementia training by the Geriatric Nurse Educator and a copy of the documentation was put in her training record. 5/13/22 OTHER POTENTIAL RESIDENTS: All residents of CNA #2 are potentially affected by the deficient practice. The importance of dementia training and completing required in-services has been reviewed with CNA #2. 5/13/22 SYSTEMIC CHANGES: An educational in-service will be conducted by the Geriatric Education Coordinator on facility policy Mandatory Education Checklist for Clinical Staff and other Personnel to include Cognitive Impairment and Dementia training as required for CNAs. This in-service will be documented and placed in the CNAs	

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F 947	Continued From page 59 provided for CNA #2 and stated that the dementia training was assigned to them but it was not completed. RN #2 stated that the dementia training was assigned to all staff in March of 2021 and would show up on the transcript if it were completed. On 4/25/2022 at 2:57 p.m., an interview was conducted with RN #3, the infection preventionist. RN #3 stated that they were the previous education coordinator. RN #3 stated that the unit managers follow up with staff who do not complete the required training and the staff get emails from the computer program reminding them to complete the training. RN #3 stated that dementia training was mandatory and had to be completed annually. The facility policy "Mandatory Education Checklist for Clinical Staff and other Personnel" dated 2021, documented in part, "...Month Due: June, Hours: 2.0, Topic: Latex Allergy & Cognitive Impairment and Dementia..." On 4/25/2022 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing were made aware of the above concern. No further information was presented prior to exit.	F 947	training records. 6/6/22 MONITORING: An audit of five (5) CNA training records will be conducted monthly by the Geriatric Education Coordinator to ensure required dementia training has been completed. The results of these monthly audits will be reported to the Director of Nursing for analysis of trends and patterns. The Quality Assurance and Performance Improvement Committee (QAPI) will review a summary analysis of the monthly audits and provide recommendations, including the frequency of the continued audits. 6/6/22	