STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 10/05/2021 through 10/08/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/05/2021 through 10/08/2021. Corrections were required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 132 certified bed facility was 100 at the time of the survey. The final survey sample consisted of 20 current resident reviews and 5 (five) closed record reviews. Two (2) complaints were investigated.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including	F 583		11/22/21

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

Electronically Signed | 10/29/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 583	Continued From page 1 the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview and facility document review the facility staff failed to protect personal privacy for 1 of 25 residents, Resident #48. The findings included: For Resident #48 the facility staff failed to protect the resident's personal privacy while toileting. Resident #48's face sheet listed diagnoses which included but not limited to asthma, arthritis, depression, anxiety, type II diabetes, gout, morbid obesity, and hypertension. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 07/29/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section G,	F 583	F583 Personal Privacy/Confidentiality of Records This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements. 1. Resident #48 was observed on the bedside commode from the hallway without the curtain pulled or door closed. Resident immediately interviewed, no negative outcome reported. Care plan immediately updated to reflect resident preferences. 2. All residents on the unit using bedside	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 583	Continued From page 2	F 583		

functional status, coded the resident as needing extensive assistance of one person in the area of toileting.

Surveyor observed Resident #48 from hallway on 10/06/21 at 2:30 pm. Resident was seated on bedside commode. The privacy curtain was not pulled, the door to the resident's room was open. Resident's roommate was lying on their bed. Resident was clearly visible from hallway. There was a male resident ambulating in the hallway outside resident's room.

Surveyor spoke with Resident #48 on 10/06/21 at 2:45 pm. Resident was lying on bed at this time. Surveyor asked resident if it bothered them that the curtain was not pulled or the door was not closed while they were using commode, and Resident #48, stated "Sometimes". Resident also stated that they were afraid if the door was closed, staff would forget about them and leave them on the commode.

Surveyor requested and was provided a copy of facility policy entitled "Confidentiality of Information and Personal Privacy" which read in part, "Our facility will protect and safeguard resident confidentiality and personal privacy. 2. The facility will strive to protect the resident's privacy regarding his or her: d. personal care.."

Surveyor spoke with the administrative team (administrator, director of nursing, assistant director of nursing, regional nurse consultant) on 10/06/21 at 4:30 pm regarding not having the curtain pulled/door closed while resident was seated on bedside commode. Surveyor spoke with the administrative team again on 10/07/21 at 2:20 pm. Director of nursing stated they had

commodes may have been potentially affected. Nursing staff will be educated on the policy titled Confidentiality of Information and Personal Privacy.
3. The Director of Nursing/Designee will educate nursing staff on policy entitled Confidentiality of Information and Personal Privacy. The education will include but not be limited to ensuring privacy curtains are pulled between residents in dual rooms and/or shutting doors to resident room to provide privacy while providing resident care.
4. The Director of Nursing/Designee will perform an observation audit of staff assisting residents during toileting to ensure staff are maintaining confidentiality and privacy on 5 residents weekly for 4 weeks. Identified variances will be addressed with assigned responsible staff caring for the resident. The Director of Nursing/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation at least quarterly.
5. Date of Compliance: 11/22/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 583	Continued From page 3 spoken with resident #48, and they said they did not want the curtain pulled around them while using the bedside commode. Director of nursing provided the surveyor with an updated care plan for Resident #48 dated 10/07/21, which read in part "The resident refuses to let staff close door while on bedside commode. Resident is often on bedside commode while others walking by". No further information was provided prior to exit.	F 583		
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.	F 657		11/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 657	Continued From page 4 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to review and revise the comprehensive person-centered care plan for 2 of 25 residents in the survey sample, Resident #76 and #74. The findings included: 1. For Resident #76, the facility staff failed to revise the care plan for the use of a hand bell. Resident #76's diagnosis list indicated diagnoses, which included, but not limited to Schizoaffective Disorder Bipolar Type, Chronic Obstructive Pulmonary Disease Unspecified, Chronic Viral Hepatitis C, and Dysphagia following Unspecified Cerebrovascular Disease. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 8/30/21 assigned the resident a BIMS (brief interview for mental status score) of 13 out of 15 in section C, Cognitive Patterns. A review of Resident #76's current comprehensive person-centered care plan on 10/07/21 revealed a focus area stating "(Resident #76) uses psychotropic medications r/t (related to) Behavior management, hallucinations - Hears voices telling (him/her) to harm (him/her) self" with an intervention dated 3/19/21 stating "Remove call bell with cord and provide resident with hand held call bell".	F 657	F657 Care Plan Timing and Revision 1. Staff failed to revise Resident #76□s comprehensive care plan after completion of suicidal precautions. Resident care plan immediately updated, no negative outcomes. Resident #74□s representative requested a medication change during a comprehensive care plan meeting. Staff failed to relay this to a medical provider in a timely manner. Medication has been discontinued per request, no negative outcomes. 2. All residents may have potentially been impacted. The care plan for residents expressing suicidal thoughts will be reviewed to ensure the care plan has been updated and approaches/interventions are current. If variances are found the comprehensive care plan will be updated. Residents and/or resident representatives will be invited and encouraged to participate in care plan meetings. The Director of Nursing/Designee will provide a written summary to the medical provider after comprehensive care plan meetings. 3. The Director of Nursing/Designee will educate nursing staff on policy titled Care Plans, Comprehensive Person-Centered. The education will include but not be limited to revising care plans to be individualized by resident and the change in resident condition based upon on going	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 657	Continued From page 5 On 10/07/21 at 8:23 am, surveyor observed Resident #76 in bed with a corded call light within reach. Surveyor then spoke with the DON (director of nursing) and inquired if Resident #76 should have a corded call light in their room as the current care plan states the resident should only have a hand held call bell. The DON stated the resident is no longer considered a suicide risk and may have a call light. On 10/08/21 at 12:15 pm, surveyor spoke with the MDS Coordinator and discussed Resident #76's care plan for use of a hand held call bell. The MDS Coordinator stated they have corrected the care plan. Surveyor received a copy of Resident #76's current comprehensive person-centered care plan and the intervention stating "Remove call bell with cord and provide resident with hand held call bell" was resolved on 10/07/21. Surveyor requested and received the facility policy entitled, "Care Plans, Comprehensive Person-Centered" which states in part, "Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change". On 10/08/21 at 4:06 pm, surveyor met with the administrator, DON, assistant DON, and the Regional Nurse Consultant and discussed the concern of the facility staff failing to revise Resident #76's comprehensive person-centered care plan. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/08/21.	F 657	assessments of residents and notifying the medical provider in a timely manner. The Director of Nursing/Designee will provide a written summary to the medical provider after comprehensive care plan meetings. 4. The QA Coordinator/Designee will perform an audit of 5 resident care plans weekly for 4 weeks to ensure resident/representative requests are shared with provider timely, that the care plans have been updated accordingly and that summary note of the care plan meeting has been written. If variances are found, they will be corrected. The QA Coordinator/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation at least quarterly. 5. Date of Compliance: 11/22/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 657	Continued From page 6	F 657		

2. The facility staff failed to address Resident #74's Resident Representative's request to change the resident's care related to the medication gabapentin.

Resident #74's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/10/21, was dated as being completed on 9/22/21. Resident #74 was assessed as able to make self understood and as able to understand others. Resident #74's Brief Interview for Mental Status (BIMS) summery score was a 10 out of 15. Resident #74 was assessed as requiring assistance with bed mobility, transfers, and toilet use. Resident #74 was assessed as being totally dependent on others for personal hygiene, dressing, and bathing. Resident #74's diagnoses included, but were not limited to: dementia, difficulty swallowing, lung disease, anxiety, and depression.

The following information was found documented by the facility's Administrator in Resident #74's clinical record: "Meeting held with resident, resident representative (relationship omitted), Administrator, Social Worker, ADON and Unit Manager. Resident states "this place has been good to (them)" and "nothing we could do any better for (them)." This note did not address the discussion related to the resident's falls and/or medications. This note had an effective date of 7/2/21 at 1:40 p.m.

Resident #74's Resident Representative (RR) reported attending a meeting on 7/2/21 with the facility's Administrator, Assistant Director of Nursing (ADON), a Unit Manager, and a Social Services employee. The RR reported they had asked for one of Resident #74's medications to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 657	Continued From page 7	F 657		

be discontinued, gabapentin. (The RR stated they had discussed the medication with the resident's neurology provider; this discussion resulted in the request to discontinue Resident #74's gabapentin being made during the 7/2/21 meeting.)

The following written information was provided to the surveyor on 10/6/21 at 3:48 p.m.: "July 2, 2021 (Resident name omitted) Meeting held with resident, resident representative, Administrator, Social Worker, ADON (assistant director of nursing) and Unit Manager. Resident Representative (name and relationship to resident omitted) verbalized expectation that (the resident) should not have falls. Staff explained we cannot guarantee (the resident) will not fall. Resident Representative (RR) requests essentially one on one care; staff explained that one on one wouldn't be able to prevent every fall. Staff also discussed that we are unable to meet (the RR's) expectations and referred (the RR) to a higher level of care, but (the RR) declined and said, "we take good care of (the resident)." Resident states "this place has been good to (them)" and "nothing we could do any better for (them)." This document was signed by the Administrator. The Administrator reported the Social Worker (SW) would have kept the minutes from the meeting but that the SW was no longer an employee and the minutes were not available. The Administrator reported this documentation was written on 10/6/21.

On 10/6/21 at 4:28 p.m., the ADON and the (former) Unit Manager who were present during the aforementioned 7/2/21 meeting were interviewed. The Unit Manager reported the RR had asked for the gabapentin dose to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 657	Continued From page 8	F 657		

decreased. Both the Unit Manger and the ADON denied recalling the RR asking for the gabapentin to be discontinued.

Review of Resident #74's clinical documentation failed to include details of the 7/2/21 meeting between facility staff members and Resident #74's RR. No evidence was found by or provided to the surveyor to indicated the RR's request to change the resident's gabapentin had been communicated to a medical provider.

A facility Nurse Practitioner (NP) was interviewed, via telephone, about Resident #74's RR requesting the resident's gabapentin be discontinued. The NP reported they were asked by Resident #74's RR to discontinue the gabapentin; the gabapentin was discontinued on 7/14/21.

The facility's ADON provided the surveyor with evidence that Resident #74 was placed on the "Acute Concern Log" to be seen by a medical provider for 7/2/21; the "Concern" documented was "x-ray results". The ADON reported Resident #74 was not on the list for review of the gabapentin order.

The following information was found in a facility policy/procedure titled "Comprehensive Person-Centered Care Planning" (with an approval date of 2/27/17):
- "The resident/resident representative(s) is encouraged to participate in the development of and revisions to the resident's care plan."
- "The resident/resident representative will be encouraged to exercise his or her right to: ... Participate in the planning process, including the right to identify individuals or roles to be included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 657	Continued From page 9 in the planning process, the right to request meetings and the right to request revisions to the person centered plan of care". On 10/8/21 at 10:19 a.m., the failure of the facility staff to communicate Resident #74's RR's request for a change to the resident's gabapentin order to a medical provider was discussed with the facility's Director of Nursing, Assistant Director of Nursing, and Corporate Nurse.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, the facility staff failed to ensure that residents who are unable to carry out ADLs (activities of daily living) receive the necessary care and services to maintain personal hygiene and grooming for 1 of 25 residents in the survey sample, Resident #19. The findings included: For Resident #19, the facility staff failed to provide assistance with bathing per the resident's preference of twice weekly. Resident #19's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction Unspecified, Hemiplegia Unspecified Affecting Left Non-dominant Side, Parkinson's Disease, Acute Combined Systolic (Congestive)	F 677	F677 Care Provided for Dependent Residents 1. Resident #19 failed to receive assistance with bathing per the resident□s preference of twice weekly. No negative outcomes reported. The resident□s bathing preferences have been obtained and baths have been scheduled for twice weekly. 2. The Director of Nursing/Designee will review all residents bathing schedules and ensure accuracy of resident task. Bathing schedules will be communicated to the direct care staff so that each resident is scheduled for a bath at least twice weekly. 3. The Director of Nursing/Designee will educate nursing staff on policy titled Showering a Resident. The education will include but not be limited to ensuring	11/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 677	Continued From page 10	F 677		

and Diastolic (Congestive) Heart Failure, and Chronic Obstructive Pulmonary Disease Unspecified.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 7/06/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive Patterns. In section G, Functional Status, Resident #19 was coded as being totally dependent on staff for personal hygiene and bathing.

On 10/06/21 at 9:42 am, surveyor spoke with Resident #19 who stated sometimes (he/she) goes a week and a few days without a shower.

A review of Resident #19's clinical record indicated the resident was provided a shower on 9/03/21, 9/07/21, 9/17/21, 9/21/21, 10/01/21, and 10/05/21.

Resident #19's current comprehensive person-centered care plan included an intervention dated 7/12/17 stating "Bathing/Showering: The resident requires assistance by staff with bathing/showering".

Surveyor requested and received the facility policy entitled, "Showering a Resident" which states in part, "The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin".

On 10/08/21 at 4:06 pm, surveyor met with the administrator, director of nursing, assistant director of nursing, and the regional nurse consultant and discussed the concern of

resident baths are documented at minimum of twice weekly as scheduled and reflecting refusals if needed. Additionally, nursing staff will be educated on completing a correlating bath sheet identifying any skin abnormalities.
4. The Director of Nursing/Designee will audit 10 resident bath sheets and PCC documentation weekly for 4 weeks to ensure residents are being bathed and baths and/or resident refusals are documented so that substantial compliance is achieved. The Director of Nursing/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation at least quarterly.
5. Date of Compliance: 11/22/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 677	Continued From page 11 Resident #19 not being assisted with showers twice weekly. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/08/21.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician's orders for 1 of 25 residents in the survey sample, Resident #76. The findings included: For Resident #76, the facility staff failed to follow the physician's order for a Modified Barium Swallow, a procedure to assess swallowing. Resident #76's diagnosis list indicated diagnoses, which included, but not limited to Schizoaffective Disorder Bipolar Type, Chronic Obstructive Pulmonary Disease Unspecified, Chronic Viral Hepatitis C, and Dysphagia following Unspecified Cerebrovascular Disease.	F 684	F684 Quality of Care 1. Resident #76 failed to receive a Modified Barium Swallow as ordered. No negative outcomes reported. The resident has been evaluated by the provider and speech therapist and this order is no longer necessary and has been cancelled. 2. The Director of Nursing/Designee will review all new admissions/readmissions within the past 90 days to ensure that appointments/procedures for diagnostic studies have been obtained. If variances are found, the ordering practitioner will be notified, and clarification or discontinuation orders will be obtained. 3. The Director of Nursing/Designee will educate nursing staff on the importance of thoroughly reviewing all admissions,	11/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 8/30/21 assigned the resident a BIMS (brief interview for mental status score) of 13 out of 15 in section C, Cognitive Patterns. In section K, Swallowing/Nutritional Status, Resident #76 was coded as receiving 51% or more total calories received through parenteral or tube feeding and 501 cc/day or more of average fluid intake per day by IV or tube feeding while a resident of the facility and within the entire last 7 days. Resident #76's current physician's orders included an active order dated 6/22/21 stating "Modified Barium Swallow to be scheduled 6-8 weeks". Surveyor was unable to locate evidence of a Modified Barium Swallow for this time period. On 10/08/21 at 1:35 pm, surveyor spoke with the DON (director of nursing) who stated the modified barium swallow was not done and believes it was due to the resident being in and out of the ER (emergency room). The DON further stated that if the resident eats anything, they aspirate. On 10/08/21 at 4:06 pm, surveyor spoke with the administrator, DON, assistant DON, and the regional nurse consultant and discussed the concern of the facility staff failing to follow the physician's order for the Modified Barium Swallow for Resident #76. No further information regarding this issue was presented to the survey team prior to the exit conference on 10/08/21.	F 684	readmissions, and residents returning from appointments for additional appointments and/or diagnostic procedures. The Director of Nursing/Designee will educate nursing administration on reviewing admissions, readmissions, and after visit summaries of appointment and/or consultations. 4. The Director of Nursing/Designee will perform an audit on 5 residents report of consults/after visit summaries for new orders to ensure accuracy weekly for 4 weeks. Additionally, The Director of Nursing/Designee will audit all admissions/readmissions to ensure resident appointments/diagnostic procedures are scheduled as ordered weekly for 4 weeks. The Director of Nursing/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation at least quarterly. 5. Date of Compliance: 11/22/2021	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		11/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 761	Continued From page 13 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to properly store and label medications for 1 of 7 medication carts and dispose of expired medications for 1 of 7 medication carts and 1 of 4 medication rooms. The findings included: For medication cart on C-wing, the facility staff failed to ensure insulin pen was labeled with an "opened on" date and failed to dispose of an expired bottle of aspirin and an expired bottle of	F 761	F761 Label/Store Drugs and Biologicals 1. Staff failed to properly label insulin with an opened on date, failed to dispose of expired OTC medications, failed to dispose of expired Afluria Quadrivalent flu vaccine. These medications have been discarded. 2. The Director of Nursing/Designee will review all insulin pens for opening dates and all medication carts/med room refrigerators for expired medications. Medications not labeled/dated correctly or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 761	Continued From page 14 Super B complex. For the medication room on A-wing, the facility staff failed to dispose of expired Afluria Quadrivalent flu vaccine. Surveyor observed the medication cart on C-wing, along with LPN (licensed practical nurse) #1, on 10/07/21 at 1:30 pm. Surveyor observed an opened Novolog insulin pen in the top drawer of the cart. The insulin pen was not labeled with an "opened on" date. Surveyor asked LPN #1 how they knew how long the pen had been in use and when to discard, and LPN #1 stated there was no way to know without a date, and that they would dispose of pen and get a new one. Surveyor also observed a bottle of aspirin 325 mg with an expiration date on 09/2021 and a bottle of Super B Complex vitamins with an expiration date of 05/2021 in the medication cart. LPN #1 removed both medications from the cart. Surveyor observed the medication room on A-wing, along with LPN #2, on 10/07/21 at 1:45 pm. Surveyor observed a box with multiple vials of Afluria Quadrivalent flu vaccine in the refrigerator in the medication room, with an expiration date of 06/2021. Surveyor asked LPN #2 to confirm expiration date, which they did. LPN #2 stated they would dispose of flu vaccine. The DON (director of nursing) provided a facility policy entitled "Storage, Labeling, Expiration Dates & Disposal of Insulin and Refrigerated Multi-Dose Vials/Bottles" which read in part, "Insulin vials will be labeled with the current date when opened and disposed of in a Sharp's Container upon expiration .... 1. The nurse opening a new vial of insulin will date and initial the vial at the time of opening"	F 761	with expired dates will be discarded. 3. The Director of Nursing/Designee will educate nursing staff on policies titled Storage, Labeling, Expiration Dates, and Disposal of Insulin and Refrigerated Multi-Dose Vials/Bottles and Medication Storage. This education will include but not be limited to importance of labeling insulins with a date opened and disposing in sharps container upon expiration and disposing of expired medications promptly. 4. The Director of Nursing/Designee will perform an observation audit of 5 resident insulin pens weekly for 4 weeks to ensure proper labeling of opened on and expiration date. Additionally, The Director of Nursing/Designee will audit one medication cart and one refrigerator a week for 4 weeks to ensure no presence of discontinued, outdated, or deteriorated drugs are present to ensure that substantial compliance is achieved. The Director of Nursing/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation at least quarterly. 5. Date of Compliance: 11/22/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 761	Continued From page 15 The DON also provided the surveyor a facility policy entitled "Medication Storage" which read in part, "4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." The concern of insulin pen not being labeled and the expired medications was discussed with the administrative team during a meeting on 10/07/21 at 2:20 pm. No further information was provided prior to exit.	F 761		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident 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,	F 842		11/22/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 16	F 842		

regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 17 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 resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a complete and accurately documented clinical record for 4 of 25 residents in the survey sample, Resident #19, #87, #108, and #74. The findings included: 1. For Resident #19, the facility staff failed to document treatments provided to the resident's buttocks and upper back. Resident #19's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction Unspecified, Hemiplegia Unspecified Affecting Left Non-dominant Side, Parkinson's Disease, Acute Combined Systolic (Congestive) and Diastolic (Congestive) Heart Failure, and Chronic Obstructive Pulmonary Disease Unspecified. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 7/06/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive Patterns. Resident #19's current physician's orders included an active order dated 9/16/21 stating "Cleanse buttocks with soap and water, pat dry, apply calcium alginate to area, and cover with bordered foam dressing every day shift for wound care". An additional active order dated 9/16/21	F 842	F842 Resident Records - Identifiable Information 1. Facility staff failed to ensure a complete and accurately documented clinical record for 4 of 25 residents in the survey sample, Resident #19, #87, #108, and #74. Resident #19 wound orders have been reviewed and treatments are being documented as prescribed. Resident #87□s medications are being administered and documented as ordered by the practitioner. Resident #108 expired on 8/2/2021. The nurse making the documentation of vital signs after the resident□s death is no longer employed by the facility and wasn□t at the time of this survey. Resident #74□s representative requested a medication change during a comprehensive care plan meeting. Staff failed to relay this to a medical provider in a timely manner. Medication has been discontinued per request, no negative outcomes. No negative outcomes have been reported. 2. All other residents may have potentially been affected. Department heads and nursing staff will be educated on importance of accurate and timely documentation in the medical record. 3. The Director of Nursing/Designee will educate nursing staff on policies titled, "Medication and Treatment Record Documentation", and "Health Information Management" This education will include	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 18 states "Cleanse upper back healed pressure area with wound cleanse, pat dry, apply skin prep to peri wound area, apply xeroform, ABD pad and secure with hypofix tape. Moisten ABD pad with NS (normal saline) prior to removal to avoid skin injury every day shift for wound care". A review of Resident #19's September 2021 and October 2021 TAR (treatment administration record) revealed the aforementioned physician's orders were not initialed as being completed on 9/10/21, 9/11/21, 9/16/21, 9/20/21, 9/21/21, 9/24/21, 9/25/21, and 10/04/21. On 10/08/21 at approximately 12:30 pm, Surveyor spoke with the DON (director of nursing) who stated the same nurse did complete the treatments to Resident #19's buttocks and upper back on 9/10/21, 9/11/21, 9/16/21, 9/20/21, 9/21/21, 9/24/21, 9/25/21, and 10/04/21 but failed to sign the TAR each time. On 10/08/21 at 12:55 pm, surveyor spoke with Resident #19 and asked if the facility staff provide treatments and dressing changes every day and the resident stated "they usually do it every day". Surveyor then asked the resident if the staff have missed any treatments recently and the resident stated "no, I don't think so". Surveyor requested and received the facility policy entitled, "Medication and Treatment Record Documentation" which states in part, "The Licensed Nurse completes the MAR (medication administration record)/TAR documentation as soon as possible after administering medications or treatments. The nurse will signify completion by placing their initials in the appropriate box". The concern of Resident #19's treatment	F 842	but not be limited to importance of accurate and timely documentation in the medical record. 4. The QA Coordinator/designee will review medical records of 6 residents weekly for 4 weeks to ensure that prescribed treatments have been administered and documented on the TAR. The QA Coordinator/designee will review medication administration records of 10 residents weekly for 4 weeks to monitor that medications have been administered and documented as ordered by the practitioner. The QA Coordinator/designee will review medical records residents who expired at the facility weekly for 6 weeks to monitor for accurate and timely documentation. When variances are identified in the weekly audits, the variance will be investigated, and the responsible nurse will be educated/counseled on the incident. The QA Coordinator/Designee will perform an audit of 5 resident care plans weekly for 4 weeks to ensure resident/representative requests are shared with provider timely, that the care plans have been updated accordingly and that summary note of the care plan meeting has been written. If variances are found, they will be corrected. The QA Coordinator/Designee will track the weekly audits for trends and a summary will be provided to the QAPI Committee for additional oversight/recommendation at least quarterly. 5. Date of Compliance: 11/22/2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 19	F 842		

omissions on the TAR were discussed with the administrator, DON, assistant DON, and the regional nurse consultant during a meeting on 10/08/21 at 4:06 pm.

No further information regarding this issue was presented to the survey team prior to the exit conference on 10/08/21.

2. For Resident #87, the facility staff failed to document medications as administered on 9/29/21.

Resident #87's diagnosis list indicated diagnoses, which included, but not limited to Wedge Compression Fracture of T11-T12 Vertebra Sequela, Unspecified Displaced Fracture of Seventh Cervical Vertebra Sequela, Wedge Compression Fracture of T5-T6 Vertebra Sequela, Trigeminal Neuralgia, Enterocolitis due to Clostridium Difficile Recurrent, Hypothyroidism Unspecified, and Gastro-Esophageal Reflux Disease without Esophagitis.

The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 10/05/21 assigned the resident a BIMS (brief interview for mental status) score of 15 out of 15 in section C, Cognitive Patterns.

Resident #87's current physician's orders included the following active orders: Gabapentin 100 mg by mouth three times a day for neuralgia, Protonix Tablet Delayed Release 40 mg by mouth one time a day for GERD (gastro-esophageal reflux disease), and Synthroid 112 mcg tablet by mouth one time a day for hypothyroidism.
Resident #87's clinical record included a completed order for Vancomycin HCL 125 mg by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 20	F 842		

mouth every 6 hours for C-diff for 10 days which began on 9/28/21.

A review of Resident #87's September 2021 MAR (medication administration record) revealed Gabapentin, Protonix, Synthroid, and Vancomycin were not initialed on the MAR as being administered on 9/29/21 at 6:00 am as scheduled.

On 10/08/21 at 9:56 am, surveyor spoke with the DON (director of nursing) and the assistant DON who stated the nurse stated they did give the medications but did not sign them off on the MAR. At 10.01 am, the DON provided the surveyor with a copy of Resident #87's Controlled Drug Record for Gabapentin 100 mg with documentation of one Gabapentin 100 mg capsule signed out as administered on 9/29/21 at 0600 (6:00 am).

Surveyor requested and received the facility policy entitled, "Medication and Treatment Record Documentation" which states in part, "The Licensed Nurse completes the MAR/TAR (treatment administration record) documentation as soon as possible after administering medications or treatments. The nurse will signify completion by placing their initials in the appropriate box".

The concern of Resident #87's MAR omissions were discussed with the administrator, DON, assistant DON, and the Regional Nurse Consultant during a meeting on 10/08/21 at 4:06 pm.

No further information regarding this issue was presented to the survey team prior to the exit

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 21	F 842		

conference on 10/08/21.
3. For Resident #108, the facility staff documented a skilled evaluation, including vital signs and mental status on the resident after they had expired.

Resident #108's face sheet listed diagnoses which included but not limited to congestive heart failure, pulmonary fibrosis, type II diabetes mellitus, hypertension, dysphagia, respiratory failure, urinary tract infection, and dysphagia.

The admission MDS (minimum data set) with an ARD (assessment reference date) of 07/13/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, cognitive patterns. This indicates that the resident was cognitively intact.

Resident #108's clinical record was reviewed on 10/08/21 and contained a nurses' progress note dated 08/01/2, which read in part "Alerted by ... (name omitted) that pt (patient) was unresponsive. Found pt supine in bed apneic and pulseless. No apical pulse. Pt is DNR (do not resuscitate). TOD (time of death) 7:51 AM Contacted Hospice on call and pt son." This note was signed by RN (registered nurse) #1.

Resident #108's clinical record also contained a nurses' progress note dated 08/02/21, which read in part "Skilled Evaluation. Vitals: Temperature: T 97.7-8/2/2021 12:45 Route: Forehead (non-contact) ...Neurologic: Resident obeys commands. Denies weakness, tremors, numbness or tingling. Mental Status: Alert & Oriented x3, communicated verbally, speech is clear, is able to understand and be understood when speaking ..." This note was also signed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 22	F 842		

RN #1.

Surveyor requested and was provided with a facility policy entitled "Health Information Management", which read in part "The purpose of these guidelines and an accurate/complete medical record is to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care. 7. A legal record that protects the resident, physician, nurse, and the facility."

The concern of the inaccurate clinical record was discussed with the administrative team during a meeting on 10/08/21 at 4:00 pm.

No further information was provided prior to exit.
4. The facility staff failed to ensure Resident #74's clinical documentation included details of a facility staff meeting with the resident's RR (Resident Representative). During this meeting, a change in medication and/or medication dosing as related to Resident #74's fall risk was discussed; these details were not included in the resident's clinical documentation.

Resident #74's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/10/21, was dated as being completed on 9/22/21. Resident #74 was assessed as able to make self understood and as able to understand others. Resident #74's Brief Interview for Mental Status (BIMS) summery score was a 10 out of 15. Resident #74 was assessed as requiring assistance with bed mobility, transfers, and toilet use. Resident #74 was assessed as being totally dependent on others for personal hygiene, dressing, and bathing. Resident #74's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 23	F 842		

diagnoses included, but were not limited to: dementia, difficulty swallowing, lung disease, anxiety, and depression.

Resident #74's RR reported attending a meeting on 7/2/21 with the facility's Administrator, Assistant Director of Nursing (ADON), a Unit Manager, and a Social Services employee. Resident #74's RR reported they had asked for one of Resident #74's medications to be discontinued, gabapentin. (The RR stated they had previously discussed the medication with the resident's neurology provider; this discussion resulted in the request to discontinue Resident #74's gabapentin being made on 7/2/21.)

The following information was found documented by the facility's Administrator in Resident #74's clinical record: "Meeting held with resident, resident representative (relationship omitted), Administrator, Social Worker, ADON and Unit Manager. Resident states "this place has been good to (them)" and "nothing we could do any better for (them)." This note did not address the discussion related to the resident's falls and/or medications. This note had an effective date of 7/2/21 at 1:40 p.m.

The following written information was provided to the surveyor on 10/6/21 at 3:48 p.m.: "July 2, 2021 (Resident name omitted) Meeting held with resident, resident representative, Administrator, Social Worker, ADON (assistant director of nursing) and Unit Manager. Resident Representative (name and relationship to resident omitted) verbalized expectation that (the resident) should not have falls. Staff explained we cannot guarantee (the resident) will not fall. Resident Representative (RR) requests

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 24	F 842		

essentially one on one care; staff explained that one on one wouldn't be able to prevent every fall. Staff also discussed that we are unable to meet (the RR's) expectations and referred (the RR) to a higher level of care, but (the RR) declined and said, "we take good care of (the resident)." Resident states "this place has been good to (them)" and "nothing we could do any better for (them)." This document was signed by the Administrator. The Administrator reported the Social Worker (SW) would have kept the minutes from the meeting but that the SW was no longer an employee and the minutes were not available. The Administrator reported this documentation was written on 10/6/21.

On 10/6/21 at 4:28 p.m., the ADON and the (former) Unit Manager who were present during the 7/2/21 meeting were interviewed. The Unit Manager reported the RR had asked for the gabapentin dose to be decreased. Both the Unit Manger and the ADON denied recalling the RR asking for the gabapentin to be discontinued.

Review of Resident #74's clinical documentation failed to include details of the 7/2/21 meeting between facility staff members and Resident #74's RR. No evidence was found by or provided to the survey to indicate the RR's request to change the resident's gabapentin was communicated to a medical provider.

A facility Nurse Practitioner (NP) was interviewed, via telephone, about Resident #74's RR requesting the resident's gabapentin be discontinued. The NP reported they had been asked by Resident #74's RR to discontinue the gabapentin; the gabapentin was discontinued on 7/14/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 842	Continued From page 25	F 842		

The following information was found in a facility document titled "HEALTH INFORMATION MANAGEMENT ... CHARTING GUIDELINES" (this document was not dated): "The purpose of these guidelines and an accurate/complete medical record is to provide: ... Guidance to the physician in prescribing appropriate medications and treatments ... Assistance in the development of a plan of care for each resident ..."

On 10/8/21 at 10:19 a.m., the surveyor met with the facility's Director of Nursing, Assistant Director of Nursing, and the Corporate Nurse. During this meeting, the failure of the facility staff to document, in the resident's clinical record, the concerns voiced by Resident #74's adult child during the meeting on 7/2/21 was discussed. These concerns included issues with resident falls and the medication gabapentin.

On 10/8/21 at 2:30 p.m., the failure of the facility staff to document details of the 7/2/21 meeting with Resident #74's RR was shared, for a final time, with the facility's DON (the QA Coordinator was present during this interaction).