STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495216	A. BUILDING _____ B. WING _____	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 6/28/22 through 6/30/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five (5) complaints were investigated during the survey: 1. VA00054014 - unsubstantiated 2. VA00054112 - unsubstantiated 3. VA00055238 - substantiated with deficient practice 4. VA00055518 - substantiated without deficient practice 5. VA00054372 - unsubstantiated The census in this 120 certified bed facility was 108 at the time of the survey. The survey sample consisted of 4 current Resident reviews and 5 closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		8/5/22

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

Electronically Signed | 07/22/2022

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F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure a resident's medical provider and/or	F 580	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets	

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F 580	Continued From page 2 responsible party (RP) was notified of a change in condition for three (3) of nine (9) sampled residents, Resident #1, Resident #8, and Resident #9. For Resident #1, the facility staff failed to notify a medical provider of changes in the resident's weight, temperature, and oxygen saturation level. For Resident #8, the facility staff failed to notify the responsible party of a significant weight loss. For Resident #9, the facility staff failed to notify a medical provider of a change in the resident's weight. The findings include: 1. The facility staff failed to notify Resident 1's medical provider of changes in the resident's weight, oxygen saturation level, and temperature. Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/13/22, was dated as completed on 1/17/22. Resident #1 was assessed as being able to make self understood and as being able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. Resident #1 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and bathing. Resident #1's diagnoses included, but were not limited to: high blood pressure, arthritis, anxiety, and hyperlipidemia. Resident #1's clinical documentation included the following weights:	F 580	forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F580 1. Resident #1 and Resident #8 no longer in facility. 2. Resident #9 physician and responsible party were notified of the significant weight change on 6.30.2022. 3. A review for the last 30 days of current residents in the facility was completed for weights, temperatures and O2 stats to ensure any falling outside the normal range has been reported to the medical provider and responsible party with documentation in the medical record. 4. Licensed nurses will be educated by the DON/designee on notifications to the medical provider/responsible party for weights/temperatures/O2 stats that fall outside the normal range. 5. The DON/designee will review temperatures/weights/O2 stats 3x weekly in clinical meeting to ensure notification has occurred to the medical director/responsible party of 6. The results will be reported m to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random	

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F 580	Continued From page 3 - On 1/11/22 at 6:40 p.m., the resident's weight was documented as 182 pounds. This weight was documented as being obtained using a mechanical lift. - On 2/4/22 at 4:24 p.m., the resident's weight was documented as 168 pounds. The method of obtaining this weight was not documented. - On 2/20/22 at 2:11 p.m., the resident's weight was documented as 140 pounds. This weight was documented as being obtained using a wheelchair. - On 2/20/22 at 3:06 p.m., the resident's weight was documented as 140 pounds. This method of obtaining this weight was not documented. The following information was found in a facility policy/procedure titled "Documentation and Notification" (with an effective date of 11/1/19): "The Charge Nurse is responsible for notifying the Physician (MD) and/or the Responsible Party (RP) whenever there is a change related to the care of the patient. Notification will occur when there is a ... significant weight variance ..." Resident #1's nurse practitioner (NP) was interviewed on 6/29/22 at 1:00 p.m. The NP reported they were not made aware of the resident's weight loss. The facility's Registered Dietitian (RD) was interviewed on 6/29/22 at 3:44 p.m. The RD reported they did not see documentation of medical provider addressing Resident #1's weight loss. The RD's note, dated 2/7/22 at 3:55 p.m., indicated: (a) the NP was notified of the weight loss and (b) a recommendation to continue the weekly weight to re-establish baseline. (The RD reported they notify the nurse practitioner (NP) using messaging via the facility's computerized	F 580	basis. 7. Date of compliance August 5th, 2022.	

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documentation system; the RD reported that evidence of the message being sent automatically drops after 7-days.)

On 6/30/22 at 1:04 p.m., the facility's Administrator, Director of Nursing (DON), and Regional Director of Clinical Services (RDCS) were interviewed about Resident #1's following assessment information:
- A decreased oxygen saturation of 87% documented on 2/23/22 at 9:12 a.m. and 10:27 a.m. and
- An elevated temperature of 104.3 degrees Fahrenheit on 2/23/22 at 9:12 a.m. and 101.4 degrees Fahrenheit on 2/23/22 at 10:28 a.m.

No evidence of medical provider or responsible party notification of Resident #1's aforementioned elevated temperatures and/or decreased oxygen saturation level was found by or provided to the survey team. On 6/30/22 at 1:09 p.m., the DON reported they would have called to obtain treatment at the time the aforementioned oxygen saturation levels and temperatures were identified.

The following information was found in a facility policy/procedure titled "Significant Change of Condition" (with an effective date of 11/1/19):
- "All staff members shall communicate any information about patient status change to appropriate licensed personnel immediately upon observation."
- "The patient's change of condition shall be reported immediately to a licensed nurse".
- "A licensed nurse shall assess the patient for signs and symptoms of physical or mental change of condition."
- "This assessment shall be reported to [sic]

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primary physician or designated alternate."
- "Responsible party will also be notified of a change of condition."

Resident #1's nurse practitioner (NP) was interviewed on 6/29/22 at 1:00 p.m. The NP reported that they were not notified of Resident #1's increased temperature and decreased oxygen saturation level; the NP stated that they are usually called with such information. The NP also reported they were not made aware of the resident's weight loss.

On 6/29/22 on 5:45 p.m., the failure to notify a medical provider of Resident #1's weight loss was discussed during a survey team meeting with the facility's Administrator, Assistant Director of Nursing, Infection Preventionist, Regional Director of Clinical Services, and Registered Nurse #2. It was reported that concerns with Resident #1's weight loss was identified during a chart review with an action plan implemented on 6/2/22; it was discussed that the survey team could not consider past non-compliance due to finding similar current issues.

This is a complaint deficiency.

2. The facility staff failed to notify a medical provider of Resident #9's weight loss.

Resident #9's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/6/22, was dated as completed on 6/10/22. Resident #9's was assessed as able to make self understood and as able to understand others. Resident #9's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or

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borderline cognition. Resident #9 was assessed as requiring assistance with bed mobility, transfers, dressing, and toilet use. Resident #9's diagnoses included, but were not limited to: anemia, heart failure, high blood pressure, kidney disease, thyroid disorder, and respiratory failure.

On 6/29/22 at 11:05 a.m., Resident #9's clinical record was reviewed. The only weights documented in Resident #9's chart, for the current admission, were dated 6/19/22; these weights were documented as 219 pounds. (Resident #9 had two (2) separate entries dated 6/19/22 of the 219 pound weight.) Resident #9's weight documentation did not have weekly, post-admission, weights. On 6/29/22 at 11:11 a.m., the facility's Regional Director of Clinical Services (RDCS) was asked about the resident's missing weights; the RDCS stated they would check on the missing weights.

On 6/29/22 at 1:40 p.m., the facility's Assistant Director of Nursing (ADON) provided the surveyor with copies of an "ADMISSION CHECK LIST" form and copies of lists of weights that included information on multiple residents. From these documents the following weights were added to Resident #9's clinical record:
- On 6/2/22 at 6:45 p.m., the resident's weight was documented as 249 pounds. This weight was documented as being obtained using a mechanical lift scale. This weight was found on the resident's "ADMISSION CHECK LIST" form.
- On 6/12/22 at 12:27 p.m., the resident's weight was documented as 241.2 pounds. This weight was documented as being obtained using a wheelchair scale. This weight was found on a form, dated 6/12/22, which included multiple resident weights.

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- On 6/26/22 at 12:28 p.m., the resident's weight was documented as 231.2 pounds. The method of obtaining this weight was not documented. This weight was found on a form, dated 6/26/22, which included multiple resident weights. These weights were added to Resident #9's clinical record on 6/29/22.

Resident #1 was weighed on 6/29/22 at 12:29 p.m. The resident's weight was documented as 231.8 pounds. This weight was documented as being obtained using a wheelchair.

The facility's Registered Dietitian (RD) was interviewed on 6/29/22 at 3:44 p.m. The RD was asked about Resident #9's weight change. The RD reported they were not made aware of Resident #9's weight loss when the resident's weight was documented as 219 pounds on 6/19/22. The RD reviewed Resident #9's weights that were entered into the clinical record on 6/29/22. The RD reported the 6/26 weight of 231.2 pounds indicated a 7.1% weight loss in less than a month; the RD reported no evidence was found of provider notification of the weight loss. The RD reported being unable to identify evidence of the facility staff addressing Resident #9's weight loss; the RD reported the weight loss was being addressed on 6/29/22.

On 6/29/22 on 5:45 p.m., the failure of facility staff to notify a medical provider of Resident #9's weight loss was discussed during a survey team meeting with the facility's Administrator, Assistant Director of Nursing, Infection Preventionist, Regional Director of Clinical Services, and Registered Nurse #2.

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3. Resident #8's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia with Behavioral Disturbance, Essential Hypertension, Atherosclerotic Heart Disease of Native Coronary Artery, Congestive Heart Failure and Gastro-Esophageal Reflux Disease (GERD) without Esophagitis.

The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 5/13/22 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #8 was coded as weighing 98 pounds with a weight loss of 5% or more in the last month or 10% or more in the last 6 months without a physician-prescribed weight-loss regimen.

Resident #8's current comprehensive person-centered plan of care included a focus area created on 1/11/22 and revised on 6/24/22 stating in part "Nutrition risk: dementia with behavioral disturbances/combative behavior, GERD, UTI (urinary tract infection), h/o (history of) dysphagia - L4 textures per family request, BMI (body mass index) classified as underweight, recent WT (weight) loss. Therapeutic diet: receives supplements to promote WT gain/stabilize WT. Rsd's (resident's) WT hx (history) has large discrepancies. Rsd has triggered for significant WT loss x 90 and x 180 D (days). PO (by mouth) intake has been consistent and supplements have been increased resulting in desired nonsignificant WT gain x 60 D. Nursing notified". An intervention of "weekly weights" was created on 4/18/22.

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A review of Resident #8's clinical record revealed a weight of 132 pounds obtained on 2/01/22, the following weight on 3/10/22 was 104.6 pounds indicating a significant weight loss of 27.4 pounds.

Surveyor reviewed Resident #8's clinical record and was unable to locate documentation of responsible party notification of the resident's significant weight loss identified on 3/10/22.

On 6/29/22 at 1:54 pm, surveyor spoke with the registered dietitian (RD) who stated nursing notifies the RPs of weight loss. On 6/30/22 at 10:40 am, surveyor spoke with Resident #8's Unit Manager (UM) who stated they remember speaking with the resident's daughter about weight loss when they were in the facility but it was not documented.

On 6/30/22 at 11:01 am, surveyor spoke with the director of nursing (DON) who stated Resident #8's RP should have been notified when the significant change alert appeared on the weight summary list in the resident's electronic clinical record.

Surveyor requested and received the facility policy entitled "Documentation and Notification" which read in part:
1. The Charge Nurse is responsible for notifying the Physician (MD) and/or the Responsible Party (RP) whenever there is a change related to the care of the patient. Notification will occur when there is a:
- Significant weight variance
3. The Unit Manager is ultimately responsible to ensure that notification of the MD/RP has

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F 580	Continued From page 10 occurred and has been documented accurately. On 6/30/22 at 1:02 pm, the survey team met with the administrator, director of nursing, and the regional nurse consultant and discussed the concern of staff failing to notify Resident #8's RP of their significant weight loss. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/30/22.	F 580		
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 interview, clinical record reviews, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure care and services were provided to address the needs for one (1) of nine (9) sampled residents, Resident #1. Resident #1's bowel needs were not addressed by facility staff members for an episode where the resident went five (5) days without a documented bowel movement (BM). Resident #1 experienced an elevated temperature and decreased blood oxygen saturation level that wasn't addressed by	F 684	F684 1. Resident number #1 no longer in facility. 2. A review of current residents in the resident for the last 7 days was reviewed to ensure each resident has had a Bowel movement every three days, and if not, interventions were implemented and were effective. 3. Licensed nurses will be educated by the DON/designee to review the BM list in PCC dashboard daily to ensure residents	8/5/22

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F 684	Continued From page 11 facility staff members. The findings include: Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/13/22, was dated as completed on 1/17/22. Resident #1 was assessed as being able to make self understood and as being able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. Resident #1 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and bathing. Resident #1's diagnoses included, but were not limited to: high blood pressure, arthritis, anxiety, and hyperlipidemia. Resident #1's bowel movement (BM) documentation indicated the resident had a five (5) day period in which no bowel movement was documented; these dates were 1/14/22 through 1/18/22. No treatment to address the aforementioned lack of a BM was documented. The following information was found in a facility policy/procedure titled "Constipation Prevention" (with an effective date of 11/1/19): - "Patients will be monitored for regular bowel elimination by a bowel movement every three days or as determined by individual assessment, medical condition or functional status." - "Nurse will routinely review to determine patients in need of interventions to facilitate bowel movement." - "Document bowel movements in the clinical record." - "Contact physician for any needed orders."	F 684	who do not have a BM documented for the last three days will have interventions implemented with effectiveness documented in the EHR. 4, The DON/designee will review the BM dashboard in PCC 5x weekly during clinical meeting to ensure residents documented without a BM in the last three days have interventions implemented with effectiveness documented in the medical record 5, The results will be reported to the Quality Assurance Committee quarterly for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. 6. Date of compliance August 5th ,2022.	

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Resident #1 was care planned for the use of psychotropic medications. This care planned focus area included an intervention to 'monitor for side effects'. The following was the goal for this focused area: "The resident will be/remain free of psychotropic drug related complications, including ... constipation/impaction ..."

On 6/29/22 at 4:21 p.m., the facility's Regional Director of Clinical Services (RDCS) reported resident BMs are reviewed daily. The RDCS reported the fourth consecutive morning, with no BM documented for the previous three (3) days, should be addressed by facility staff members. On 6/29/22 at 5:35 p.m., the facility's RDCS reported no treatment was identified to address when Resident #1 had not had a BM from 1/14/22 to 1/18/22.

On 6/30/22 at 1:49 p.m., the facility's Administrator confirmed no treatment was found to address Resident #1 lack of a BM from 1/14/22 to 1/18/22.

On 6/30/22 at 1:04 p.m., the facility's Administrator, Director of Nursing (DON), and Regional Director of Clinical Services (RDCS) were interviewed about Resident #1's following assessment information:
- A decreased oxygen saturation of 87% documented on 2/23/22 at 9:12 a.m. and 10:27 a.m. and
- An elevated temperature of 104.3 degrees Fahrenheit on 2/23/22 at 9:12 a.m. and 101.4 degrees Fahrenheit on 2/23/22 at 10:28 a.m.

No evidence of medical provider or responsible party notification of Resident #1's aforementioned

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F 684	Continued From page 13 elevated temperatures and/or decreased oxygen saturation level was found by or provided to the survey team. Resident #1's nurse practitioner (NP) was interviewed on 6/29/22 at 1:00 p.m. The NP reported that they were not notified of Resident #1's increased temperature and decreased oxygen saturation level; the NP stated that they are usually called with such information. On 6/30/22 at 1:09 p.m., the facility's Director of Nursing (DON) confirmed no treatment was found documented to address Resident #1's elevated temperature and decreased oxygen saturation levels. The DON reported they would have called to obtain treatment at the time the aforementioned oxygen saturation levels and temperatures were identified. This is a complaint deficiency.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		8/5/22

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F 692	Continued From page 14 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, clinical record reviews, facility document review, and in the course of a complaint investigation, the facility staff failed to address a change in weight for three (3) of nine (9) sampled residents, Resident #1, Resident #8, and Resident #9. For Resident #1, the facility staff failed to address a significant weight loss. For Resident #8, the facility staff failed to follow the registered dietician's recommendation and comprehensive plan of care for weekly weights and failed to address a significant weight loss when identified. For Resident #9, the facility staff failed to identify and address a significant weight loss. The findings include: 1. Resident #1 was documented as having a significant decrease in weight while at the facility. No medical provider intervention, addressing this weight loss, was found by or provided to the surveyor. Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/13/22, was dated as completed on	F 692	F692 1. Resident #1 and Resident #8 no longer in facility. 2. Resident #9 physician and responsible party were notified of the significant weight change on 6.30.2022. 3. A review for the last 30 days of current residents in the facility was completed for weights, temperatures and O2 stats to ensure any falling outside the normal range has been reported to the medical provider and responsible party with documentation in the medical record. 4. Licensed nurses will be educated by the DON/designee on notifications to the medical provider/responsible party for weights/temperatures/O2 stats that fall outside the normal range. 5. The DON/designee will review temperatures/weights/O2 stats 3x weekly in clinical meeting to ensure notification has occurred to the medical director/responsible party of 6. The results will be reported m to the Quality Assurance Committee for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis.	

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F 692	Continued From page 15 1/17/22. Resident #1 was assessed as being able to make self understood and as being able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. Resident #1 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and bathing. Resident #1's diagnoses included, but were not limited to: high blood pressure, arthritis, anxiety, and hyperlipidemia. Resident #1's clinical documentation included the following weights: - On 1/11/22 at 6:40 p.m., the resident's weight was documented as 182 pounds. This weight was documented as being obtained using a mechanical lift. - On 2/4/22 at 4:24 p.m., the resident's weight was documented as 168 pounds. The method of obtaining this weight was not documented. - On 2/20/22 at 2:11 p.m., the resident's weight was documented as 140 pounds. This weight was documented as being obtained using a wheelchair. - On 2/20/22 at 3:06 p.m., the resident's weight was documented as 140 pounds. This method of obtaining this weight was not documented. A document from a local hospital dated 1/10/22 had Resident #1's weight documented as 160 pounds. Resident #1's care plan included a focus area of "Nutritional Risk". This focus area included the intervention of "Weights per protocol". The goal for this focus area was: "The resident will maintain adequate nutritional status (as evident by) no significant weight change by next review."	F 692	7. Date of compliance August 5th, 2022.	

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The following information was found in a facility policy/procedure titled "Documentation and Notification" (with an effective date of 11/1/19): "The Charge Nurse is responsible for notifying the Physician (MD) and/or the Responsible Party (RP) whenever there is a change related to the care of the patient. Notification will occur when there is a ... significant weight variance ..."

The following information was found in a facility policy/procedure titled "Weight Monitoring and Tracking" (with an effective date of 11/1/19):
- "The Center has a system in place to weigh, monitor, and track patient's weights on a timely schedule. Weights are tracked and monitored by way of the interdisciplinary Weight Variance Committee."
- "All patients will be weighed on admission/readmission and weekly x 4 weeks, or until the interdisciplinary team determines weight is stable, then monthly thereafter if weight is stable."
- The following information was part of a table detailing 'significant weight changes': (a) a weight change of 5% in one (1) month; (b) a weight change of 7.5% in three (3) months; and/or (c) a weight change of 10% in six (6) months.

Resident #1's nurse practitioner (NP) was interviewed on 6/29/22 at 1:00 p.m. The NP reported they were not made aware of the resident's weight loss.

The facility's Registered Dietitian (RD) was interviewed on 6/29/22 at 3:44 p.m. The RD reported they did not see documentation of medical provider addressing Resident #1's weight loss. The RD's note, dated 2/7/22 at 3:55 p.m.,

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indicated: (a) the NP was notified of the weight loss and (b) a recommendation to continue the weekly weight to re-establish baseline. (The RD reported they notify the nurse practitioner (NP) using messaging via the facility's computerized documentation system; the RD reported that evidence of the message being sent automatically drops after 7-days.)

Review of Resident #1's clinical documentation failed to provide evidence of the facility staff following the RD's weekly weight recommendation dated 2/7/22.

On 6/29/22 on 5:45 p.m., the failure of facility staff members to address Resident #1's weight loss was discussed during a survey team meeting with the facility's Administrator, Assistant Director of Nursing, Infection Preventionist, Regional Director of Clinical Services, and Registered Nurse #2. It was reported that concerns with Resident #1's weight loss was identified during a chart review with an action plan implemented on 6/2/22; it was discussed that the survey team could not consider past non-compliance due to finding similar current issues.

This is a complaint deficiency.

2. Initial review of Resident #9's clinical documentation, on 2/29/22 at 11:05 a.m., revealed that not all of the resident's weights were documented in the clinical record. The documentation of Resident #1's additional weights, found on an "ADMISSION CHECK LIST" form and on lists of weights that included information on multiple residents, revealed a significant change in Resident #9's weight; this significant change had not been addressed by a

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medical provider.

Resident #9's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 6/6/22, was dated as completed on 6/10/22. Resident #9's was assessed as able to make self understood and as able to understand others. Resident #9's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #9 was assessed as requiring assistance with bed mobility, transfers, dressing, and toilet use. Resident #9's diagnoses included, but were not limited to: anemia, heart failure, high blood pressure, kidney disease, thyroid disorder, and respiratory failure.

On 6/29/22 at 11:05 a.m., Resident #9's clinical record was reviewed. The only weights documented in Resident #9's chart, for the current admission, were dated 6/19/22; these weights were documented as 219 pounds. (Resident #9 had two (2) separate entries dated 6/19/22 of the 219 pound weight.) Resident #9's weight documentation did not have weekly, post-admission, weights. On 6/29/22 at 11:11 a.m., the facility's Regional Director of Clinical Services (RDCS) was asked about the resident's missing weights; the RDCS stated they would check on the missing weights.

On 6/29/22 at 1:40 p.m., the facility's Assistant Director of Nursing (ADON) provided the surveyor with copies of an "ADMISSION CHECK LIST" form and copies of lists of weights that included information on multiple residents. From these documents the following weights were added to Resident #9's clinical record:
- On 6/2/22 at 6:45 p.m., the resident's weight

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was documented as 249 pounds. This weight was documented as being obtained using a mechanical lift scale. This weight was found on the resident's "ADMISSION CHECK LIST" form.
- On 6/12/22 at 12:27 p.m., the resident's weight was documented as 241.2 pounds. This weight was documented as being obtained using a wheelchair scale. This weight was found on a form, dated 6/12/22, which included multiple resident weights.
- On 6/26/22 at 12:28 p.m., the resident's weight was documented as 231.2 pounds. The method of obtaining this weight was not documented. This weight was found on a form, dated 6/26/22, which included multiple resident weights.
These weights were added to Resident #9's clinical record on 6/29/22.

Resident #1 was weighed on 6/29/22 at 12:29 p.m. The resident's weight was documented as 231.8 pounds. This weight was documented as being obtained using a wheelchair.

The facility's Registered Dietitian (RD) was interviewed on 6/29/22 at 3:44 p.m. The RD was asked about Resident #9's weight change. The RD reported they were not made aware of Resident #9's weight loss when the resident's weight was documented as 219 pounds on 6/19/22. The RD reviewed Resident #9's weights that were entered into the clinical record on 6/29/22. The RD reported the 6/26 weight of 231.2 pounds indicated a 7.1% weight loss in less than a month; the RD reported no evidence was found of provider notification of the weight loss. The RD reported being unable to identify evidence of the facility staff addressing Resident #9's weight loss; the RD reported the weight loss was being addressed on 6/29/22.

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Resident #9's care plan included a focus area of "Nutritional Risk". This focus area included the intervention of "Weights per protocol". The goal for this focus area was: "The resident will maintain adequate nutritional status (as evident by) no significant weight change by next review."

On 6/29/22 on 5:45 p.m., the failure of facility staff members to address Resident #9's weight loss was discussed during a survey team meeting with the facility's Administrator, Assistant Director of Nursing, Infection Preventionist, Regional Director of Clinical Services, and Registered Nurse #2.

3. Resident #8's diagnosis list indicated diagnoses, which included, but not limited to Unspecified Dementia with Behavioral Disturbance, Essential Hypertension, Atherosclerotic Heart Disease of Native Coronary Artery, Congestive Heart Failure and Gastro-Esophageal Reflux Disease (GERD) without Esophagitis.

The most recent significant change minimum data set (MDS) with an assessment reference date (ARD) of 5/13/22 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #8 was coded as weighing 98 pounds with a weight loss of 5% or more in the last month or 10% or more in the last 6 months without a physician-prescribed weight-loss regimen.

Resident #8's current comprehensive

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person-centered plan of care included a focus area created on 1/11/22 and revised on 6/24/22 stating in part "Nutrition risk: dementia with behavioral disturbances/combative behavior, GERD, UTI (urinary tract infection), h/o (history of) dysphagia - L4 textures per family request, BMI (body mass index) classified as underweight, recent WT (weight) loss. Therapeutic diet: receives supplements to promote WT gain/stabilize WT. Rsd's (resident's) WT hx (history) has large discrepancies. Rsd has triggered for significant WT loss x 90 and x 180 D (days). PO (by mouth) intake has been consistent and supplements have been increased resulting in desired nonsignificant WT gain x 60 D. Nursing notified". An intervention of "weekly weights" was created on 4/18/22.

A review of Resident #8's clinical record revealed a weight of 132 pounds obtained on 2/01/22, the following weight on 3/10/22 was 104.6 pounds indicating a significant weight loss of 27.4 pounds. A review of Resident #8's medication history did not reveal any diuretic medications prescribed during this time period.

According to Resident #8's clinical record, this identified weight loss was not addressed until 3/29/22. A progress note by the registered dietitian (RD) dated 3/29/22 at 8:50 am identified a 27.4 pound or 20.8 % weight loss in the past 30 days and a 24.1 pound or 18.7 % weight in loss in the past 180 days. The note stated in part "Rsd has triggered for WT loss. Observed WTs on 11/30/21, 1/31/22, and 2/01/22 were significant gains. Per EMR (electronic medical record), PO intake remained consistent. Recommended scaled weekly WTs of same weighing method x 4 wks (weeks) to re-establish baseline. Notified NP

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(nurse practitioner)/nursing of WT hx and recs (recommendations) ..." The resident continued with the diet order dated 8/24/20 of Level 4 pureed texture with Magic Cups twice daily and Nutritious Drink three times a day.

The next documented weight of 94.5 occurred on 4/03/22, indicating an additional loss of 10.1 pounds. This weight loss was not addressed in the clinical record until 4/15/22. A RD progress note dated 4/15/22 at 10:44 am stated in part "Rsd has triggered for significant WT loss. PO intake has been consistent and supplements on board. Rsd with h/o large WT discrepancies. Rsd at risk d/t (due to) dx (diagnosis) dementia, BMI classified as underweight and recent WT loss. Recommended continue nutritional treats and drinks, add Med Plus BID (twice a day) and rsd on weekly WTs to establish trend. Notified nursing/NP of loss and recs ..." The intervention of weekly weights was added to the resident's care plan on 4/18/22.

Surveyor reviewed Resident #8's documented weights and was unable to locate evidence of weekly weights as recommended by the RD again on 4/15/22 and as care planned on 4/18/22. A RD progress note dated 5/13/22 at 11:47 am stated in part "continue weekly WTs to establish trend". According to clinical record documentation, Resident #8 has been weighed only three (3) times since 4/15/22: 5/02/22 97.5 pounds, 5/11/22 98 pounds, and 6/15/22 96.6 pounds.

Surveyor requested and received the facility policy entitled "Weight Monitoring and Tracking" which read in part:
1. The Director of Nursing is responsible for

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ensuring patients are weighed in a timely manner using proper technique. Nursing staff is responsible for recording weight in the patient medical record.
4. Weights will be verified within five days when a weight variance of 5# from last weight and/or when a significant weight change is identified.
5. An interdisciplinary weight variance committee will meet at least monthly to discuss patients with significant weight change. Weekly weight meetings are encouraged and may be incorporated into other interdisciplinary team meetings.
6. Significant weight changes will be identified and discussed by the interdisciplinary team using the table below:

Significant Weight Change	Interval
5%	1 month
7.5%	3 months
10%	6 months

9. Patients being followed by the committee for weekly weights may meet one or more of the following criteria:
Significant unplanned weight change
Identified Trends in weight change
Patients < 100 pounds if <UBW (usual body weight)/IBW
11. The committee will investigate possible causes of the weight change, discuss interventions, and document a progress note in the patient's electronic medical record.

On 6/29/22 at 1:30 pm, surveyor observed staff assisting Resident #8 with lunch. Resident had consumed over 75% of the meal and was continuing to eat.

On 6/29/22 at 1:54 pm, surveyor spoke with the RD who stated on 3/29/22 a message was sent to

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the Unit Manager via the Point Click Care messaging system concerning Resident #8's weight loss. The RD stated on 4/13/22 they sent an email to the Unit Manager requesting a re-weight for Resident #8. RD stated the next weight following the email was dated 5/02/22. Surveyor asked the RD if an investigation was done to identify the cause of the resident's weight loss and the RD stated not to their knowledge. Surveyor asked if Resident #8's weight loss had been discussed by the weight committee and RD stated they have not participated in the facility weight committee meetings recently. Surveyor asked why interventions addressing the loss were not recommended until 4/15/22 and the RD stated they wanted to verify if the weights were correct.

On 6/30/22 at 10:40 am, surveyor spoke with the Unit Manager (UM) and asked the reason for Resident #8 not being weighed weekly as recommended by the RD, the UM stated they were not sure. UM stated the usual process was nursing proceeds with the recommended weekly weights and talks to the doctor. UM further stated they were not sure where the disconnect occurred. Surveyor also asked if Resident #8 was discussed by the Weight Committee and UM stated "I think we did" but UM did not recall if weekly weights were discussed.

On 6/30/22 at 11:01 am, surveyor met with the director of nursing (DON) who stated they did not recall anything about Resident #8's weight loss and did not remember if they were discussed in the weight committee meeting. The DON stated the process for RD recommendations were the UM forwards the recommendation to the NP or physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495216	A. BUILDING _____ B. WING _____	C 06/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

(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 692	Continued From page 25 On 6/30/22 at 1:02 pm, the survey team met with the administrator, DON, and the Regional Nurse Consultant and discussed the concern of Resident #8 not being weighed weekly as recommended by the RD and interventions not being in place until 4/15/22 following the loss identified on 3/10/22. No further information regarding this concern was presented to the survey team prior to the exit conference on 6/30/22.	F 692		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews, clinical record reviews, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure pain medications were provided as ordered by a medical provider for one (1) of nine (9) sampled residents, Resident #1. The facility staff failed to provide Resident #1's pain medication, hydromorphone, as ordered by the medical provider. The findings include: Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 1/13/22, was dated as completed on	F 697	F 697 1. Resident #1 no longer in the facility. Current residents in the center who are on routine pain management protocol have the potential to be affected. 2. Licensed nurses will be educated by the DON/designee on following physician orders for pain medication with documentation on the EMAR(s). If the medication is not given for any reason, the medical provider/ responsible party will be notified with documentation in the EHR. 3. The DON/designee will review the PCC dashboard 5x weekly in clinical meeting	8/5/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495216	A. BUILDING _____ B. WING _____	C 06/30/2022

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STANLEYTOWN HEALTH AND REHABILITATION CENTER	240 RIVERSIDE DRIVE BASSETT, VA 24055

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F 697	Continued From page 26 1/17/22. Resident #1 was assessed as being able to make self understood and as being able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact or borderline cognition. Resident #1 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and bathing. Resident #1's diagnoses included, but were not limited to: high blood pressure, arthritis, anxiety, and hyperlipidemia. Resident #1's medication orders included an order for hydromorphone 8 mg to be administered five (5) times a day (on a scheduled for 14 days) for pain; this ordered was dated 1/24/22 at 6:54 p.m. Review of Resident #1's medication administration records (MARs) revealed this medication was not provided for the following six (6) scheduled dosed: 1/25/22 at 2:00 p.m.; 1/25/22 at 5:00 p.m.; 1/26/22 at 2:00 p.m.; 1/27/22 at 5:00 p.m.; 1/29/22 at 9:00 p.m.; and 2/2/22 at 5:00 p.m. Resident #1 aforementioned six (6) missed doses of hydromorphone was discussed with the facility's Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) on 6/30/22 at 12:38 p.m. On 6/30/22 at 1:02 p.m., the DON confirmed Resident #1's aforementioned six (6) hydromorphone doses had not been administered. Resident #1's care plan included a focus area of "pain (related to) Arthritis" [sic]. "Administer analgesia per order" was a care planned intervention for this focus area. The goal for this focus area was: "The resident will not have an interruption in normal activities due to pain though	F 697	for missed documentation on the EMAR to ensure medications have been given as ordered. 4. The results will be reported to the Quality Assurance Committee Quarterly for review and discussion. Once the QA Committee determines the problem no longer exists, audits will be conducted on a random basis. 5. Date of compliance August 5th ,2022.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495216	A. BUILDING _____ B. WING _____	C 06/30/2022

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F 697	Continued From page 27 the review date." On 6/30/22 at 1:22 p.m., the failure of the facility staff to administer Resident #1's pain medication as ordered by the medical provider was discussed with the facility's Administrator, Director of Nursing, and Regional Director of Clinical Services. This is a complaint deficiency.	F 697		