STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495280	A. BUILDING ______ B. WING ______	C 06/23/2022

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WESTMINSTER AT LAKE RIDGE	**12185 CLIPPER DRIVE LAKE RIDGE, VA 22192**

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/21/2022 through 06/23/2022. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/21/2022 through 06/23/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint (VA00051365- Substantiated with no deficiency) was investigated during the survey. The census in this 60 certified bed facility was 38 at the time of the survey. The survey sample consisted of 19 resident reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by:	F 607		7/31/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/08/2022

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

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F 607	Continued From page 1	F 607		

Based on facility documentation review and staff interview, the facility staff failed to implement their abuse policy for screening employees for 8 employees (Employee#1, Employee #4, Employee #5, Employee #8, Employee #9, Employee #10, Employee #16, Employee #23) in a sample size of 25 employees.

The findings included:

On 06/22/2022, the facility staff provided a copy of their policy entitled, "Abuse Prevention Program." In Section 2(a), it was documented, "Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has (a) been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law ..." Section 2(b) documented, " ...had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property ..."

On 06/23/2022 at approximately 10:45 A.M., this surveyor and Employee E, the Human Resources Manager, reviewed 25 employee files which revealed the following:

Employee #1, a housekeeper with a hire date of 09/08/2020, did not have a criminal background check on file.

Employee #4, a Licensed Practical Nurse (LPN) with a hire date of 04/07/2021, had a license verification completed on 03/23/2021. The LPN license had an expiration date of 02/28/2022. There was not another license verification until

Westminster at Lake Ridge is filing this Plan of Correction for the purposes of regulatory compliance. This Center is submitting this plan of correction to comply with applicable laws and not as an admission or statement of agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

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Continued From page 2

06/22/2022, nearly 4 months after the license had expired. There was no evidence the license was verified to be renewed or evaluated for findings.

Employee #5, a Certified Nursing Assistant (CNA) with a hire date 05/05/2021, had a license verification completed on 09/23/2021, over 4 months after the date of hire.

Employee #8, a Certified Nursing Assistant (CNA) with a hire date of 06/30/2021, had a license verification completed on 06/15/2021. The CNA license had an expiration date of 02/28/2022. The next license verification to verify active status was not completed until 05/25/2022, nearly 3 months after the license was due to expire.

Employee #9, a CNA with a hire date of 08/19/2021, had a license verification on 09/20/2021, one month after the date of hire.

Employee #10, a CNA with a hire date of 08/25/2021, had a certification verification on 09/20/2021, nearly one month after the date of hire.

Employee #16, a CNA with a hire date of 03/09/2021, had a certification verification completed on 02/05/2021. The CNA license had an expiration date of November 2021. The next license verification to verify active status was not completed until June 2022, 7 months after the license was due to expire.

Employee #23, a certified physical therapy assistant with a hire date of 02/26/2021, had a license verification on 03/01/2022, over one year after the date of hire.

F 607

F607: Develop/Implement Abuse/Neglect Policies
CFR(s): 483.12(b)(1)-(3)

1) What corrective action will be accomplished for those employees found to have been affected by the deficient practice?

Employee #1 no longer works for the facility.

Employee #4 has a current and active LPN license on file.

Employees #5, #8, #9, #10, and #16 all have current and active license on file.

Employee #23 has a current and active CPT license on file.

2) How will you identify other employees having the potential to be affected by the same deficient practice and what corrective action will be taken?

Current community staff have the potential to be affected by this deficient practice.
An audit will be completed by the Director of Human Resources of center staff to validate current licensures and background checks are in place.

3) What measures will be put into place or

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F 607	Continued From page 3 On 06/23/2022 at approximately 11:30 A.M., when asked why many of the license/certification verifications were performed late, Employee E stated that licenses used to be checked prior to hire but due to a "time crunch" with the implementation of a new process and electronic system, some licenses did not get verified timely. On 06/23/2022 at approximately 1:15 P.M., the administrator and Director of Nursing were notified of findings. The administrator indicated there was no further information or documentation to submit.	F 607	what systemic changes will be made to ensure the practice does not recur? Human Resources Director and Coordinator will be educated by the Vice President of Human Resource on the pre-employment screening requirements as stipulated in the facility's abuse policy and as required by regulation. . 4) How will the corrective action be monitored to ensure the deficient practice will not recur? Human Resource Director will complete an audit weekly for one month, followed by monthly for two months of new employee files to validate criminal background and licensures are current in employee record. Findings will be submitted to the Quality Assurance and Assessment Committee for review. The Committee will determine if further audits and/or actions are required. This Plan of Correction for F607 is cross-referenced to 12VAC5-371-140E(3)(a)&(b) of the state of Virginia.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.	F 645		7/31/22

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F 645 Continued From page 4 F 645

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission

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F 645	Continued From page 5 to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, clinical record review and staff interview, the facility staff failed to ensure a Pre-admission Screening and Resident Review (PASARR) was completed within 30 days of admission (prior to admission is being waived due to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency) for 1 resident (Resident #11) in a sample of 19 residents. For Resident #11, facility staff failed to ensure a Preadmission Screening and Resident Review (PASARR) was completed within 30 days of admission.	F 645	F_645: PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #1 remains in the facility and continues to meet long term care placement requirements. Level 1 PASSAR has been completed at this time, and does not require a Level II referral.	

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F 645	Continued From page 6	F 645		

The Findings included:

Resident #11 was admitted on 9-8-21 with diagnoses including: Schizophrenia, Non-Alzheimer's dementia, and anxiety disorder.

On 6-22-22 an observation, Resident interview, and review of Resident #11's record was conducted. Resident #11 was noted to have diagnoses including "schizophrenia, and non-Alzheimer's dementia". Geriatric psychiatry notes, resident history, and admission information revealed that the illnesses were long standing. No previous to admission PASARR was found in the Electronic Health Record (EHR). The facility staff were asked to locate Resident #11's PASARR.

On 6-23-22, an interview was conducted with the Director of Nursing (DON). The DON stated there was no PASARR completed for Resident #11, and stated that this error would be corrected.

The Administrator and Director of Nursing were informed of the findings at the end of day meeting on 6-23-22. The Administrator stated, "we will correct this immediately" and indicated they would be auditing all residents' PASARRs. No further documents were provided.

2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?

Current long-term center residents have the ability to be affected. An audit will be completed by the Director of Social Services and any identified resident without a level 1 PASSAR will be immediately assessed and referred for Level II if appropriate.

3) What measures will be put into place or what systemic changes will be made to ensure the practice does not recur?

The Licensed Nursing Home Administrator educated the Director of Social Services on the requirements for pre-admission screening.

4) How will the corrective action be monitored to ensure the deficient practice will not recur?

Director of Social Services or Licensed Nursing Home Administrator will complete audits weekly for one month, followed by monthly for two months for compliance to PASARR regulations.

Findings will be submitted to the Quality Assurance and Assessment Committee

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F 645	Continued From page 7	F 645	for review. The Committee will determine if further audits and/or actions are required.	
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;	F 886		7/31/22

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F 886	Continued From page 8 §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on staff interview, and facility documentation review, the facility staff failed to develop a procedure for unvaccinated and vaccinated staff who refuse or are unable to be tested for COVID-19 in accordance with the Centers for Disease Control and Prevention (CDC) guidance. The findings included:	F 886	F886: COVID-19 Testing -Residents & Staff CFR(s): 483.80(h)(1)-(6) 1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?	

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F 886	Continued From page 9 There were no COVID positive staff nor Residents present in the facility during the course of the survey, from 6-21-22 through 6-23-22. Staff were observed wearing eye protection and face masks during the survey in accordance with community transmission rates, and according to CDC guidance. Staff were interviewed and asked what the procedure was for those staff who are unable or unwilling to be tested. Two direct care staff members, and one house keeping staff member, were interviewed. Each of them stated they did not know, and would ask the Director of Nursing (DON). On 6-22-22 at 10:00 a.m., the DON was asked for policies regarding testing of staff. The document title was "Universal COVID-19 Testing Policy". The policy was reviewed and revealed under "General Considerations", "Staff who decline COVID-19 testing will not be allowed to continue to work, removed from the work calendar and sent home immediately to self-quarantine for 14 days." This is the only mention of refusal or inability to test staff in all of the COVID-19 facility policies. On 6-22-22 at the end of day debriefing at 5:00 p.m., the Administrator and DON were asked what happened at the end of the 14 day quarantine? Was the staff member allowed to return to work? The DON stated "I see what you mean. We need a contingency plan for staff refusals and those staff which can't be tested, for them to be able to return safely to work, or not to return. This will include what PPE to wear and what areas they may safely work in. We will be	F 886	Review of center records does not reveal refusal of COVID testing by resident or staff within the last 60 days. 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Current center residents and staff have the ability to be affected. An audit of center records indicates staff and residents have consented to COVID testing. 3) What measures will be put into place or what systemic changes will be made to ensure the practice does not recur? Universal COVID-19 Testing policy was been updated to include education to staff who refuse testing, removal from the work schedule and referral to Human Resources. 4) How will the corrective action be monitored to ensure the deficient practice will not recur? Company will continue to review and update policies in conjunction with current CDC and CMS guidance as necessary. Findings will be submitted to the Quality Assurance and Assessment Committee	

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F 886	Continued From page 10 fixing this policy this week." On 6-23-22 at 2:00 p.m., the Administrator and DON were made aware of the facility need for a contingency plan for testing refusals. No further information was provided by the facility.	F 886	for review. The Committee will determine if further audits and/or actions are required.	