STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495338	A. BUILDING _____ B. WING _____	C 06/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT ABINGDON	600 WALDEN ROAD ABINGDON, VA 24210

(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 06/22/22 through 06/23/22. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. VA00054647 Substantiated with deficient practice. VA00054540 Substantiated with deficient practice. The census in this 120 certified bed facility was 76 at the time of the survey. The survey sample consisted of 3 current Resident reviews (Residents #1 through #3) and 1 closed record review (Resident #4).	F 000		
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 staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to provide Activities of Daily Living (ADL) care for 2 of 4 residents, Resident #4 and #1. For Resident #4 and #1 the facility staff failed to provide Resident showers and/or bed baths according to the facility process. The findings included:	F 677	F677 No Action was taken for residents #4 and #1 due to time frame has already passed.	7/14/22

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

Electronically Signed | 06/29/2022

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F 677	Continued From page 1 1. This was a closed record review. Resident #4's diagnoses included dementia, depressive disorder, and adult failure to thrive. Section C (cognitive patterns) of Resident #4's significant change in status Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/08/22 included a Brief Interview for Mental Status (BIMS) summary score of 4 out of a possible 15 points. Per the MDS manual a score of 0-7=severe impairment. Section G (functional status) was coded (4/3) for bathing to indicate Resident #4 was totally dependent on two staff to complete this task. Personal hygiene was coded (3/2) to indicate the resident required extensive assistance of one person for this task. Resident #4's comprehensive care plan included the focus area requires staff assistance with ADL care. A review of Resident #4's ADL sheets revealed that Resident #4 received a shower on 03/01/22, a partial bath on 03/02/22 and 03/03/22, a bed bath on 03/04/22, partial bath on 03/05/22-03/10/22, a shower on 03/11/22, a partial bath on 03/12/22-03/18/22, for 03/19/22 the staff documented not applicable, partial bath on 03/20/22, no data was documented for 03/21/22-03/24/22, a partial bath was documented for 03/25-03/28/22, a shower was documented for 03/29/22, and a partial bath was documented for 03/30/22 and 03/31/22. 06/22/22 2:30 p.m., Licensed Practical Nurse (LPN) #4 stated the family expressed concerns	F 677	Current residents in the center have the potential to be affected. Current clinical staff will be educated by the Director of Nursing/Designee on ensuring that showers and/or bed baths are provided according to the facility process. The Director of Nursing/Designee will review during morning clinical meeting 5x weekly, residents who are to have showers to ensure residents receive their showers and/or bed baths according to schedule. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, then the review will be completed on a random basis The Administrator and DON are responsible for the implementation of the plan of correction.	

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F 677	Continued From page 2	F 677		

about the residents bathing and they made sure the resident received a bath that day.

06/22/22 3:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Regional DON, and Clinical Nurse Educator the issue with Resident #4's bathing was reviewed.

06/23/22 9:15 a.m., Registered Nurse (RN) #3 stated the residents were scheduled for 2 showers a week, a bed bath (partial) every day during am and pm care, and peri-care was given as needed.

06/23/22 9:25 a.m., the MDS coordinator #2 stated there was no documentation to indicate Resident #4 had refused a bath.

06/23/22 9:35 a.m., the regional DON stated the expectation was for the residents to receive a bath/shower 2 times a week.

06/23/22 10:00 a.m., Certified Nursing Assistant (CNA) #4 stated Resident #4 did refuse bathing at times and that they did not like to go to the shower room and they were offered bed baths. CNA #4 stated when this happened they filled out a shower sheet, gave it to the nurse, and wrote refused on the form.

06/23/22 10:05 a.m., the DON stated they no longer had these forms.

The surveyor was unable to locate any documentation to indicate Resident #4 had refused to be bathed.

No further information regarding this issue was

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F 677	Continued From page 3	F 677		

provided to the survey team prior to the exit conference.

This is a complaint deficiency.

2. The facility staff failed to ensure Resident #1's shower/bathing needs were consistently addressed.

Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/9/22, was dated as completed on 4/20/22. Resident #1 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a four (4) out of 15; this indicated severe cognitive impairment. Resident #1 was documented as being dependent on others for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing. Resident #1's diagnoses included, but was not limited to: anemia, high blood pressure, and chronic pain syndrome.

Resident #1's bed bath/shower documentation was reviewed. During March of 2022, Resident #1 was documented a receiving a full bed bath on 3/4/22 and again on 3/29/22. Between 3/4/22 and 3/29/22, Resident #1 was documented as receiving at least one (1) partial bed bath each day (some days the resident was documented as receiving two (2) or three (3) partial bed baths).

Review of Resident #1's recent bed bath/shower documentation provided the following information:
- For the week of 5/1/22 - 5/7/22, the resident had one (1) full bed bath documented; this was on 5/3/22.

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F 677	Continued From page 4	F 677		

- For the week of 5/15/22 - 5/21/22, the resident had one (1) full bed bath documented; this was on 5/17/22.
- For the week of 5/29/22 - 6/4/22, the resident had one (1) full bed bath documented, this was on 6/3/22.
- For the week of 6/5/22 - 6/11/22, the resident had no full bed baths or showers documented.
- For the week of 6/12/22 - 6/18/22, the resident had one (1) full bed bath documented, this was on 6/14/22.

Resident #1 had no showers documented during the aforementioned time periods.

Resident #1's care plan included a focus area, initiated on 9/2/20, indicating the resident required assistance with all activities of daily living; this focus area also indicated the resident was non-ambulatory and incontinent.

The following information was found in a facility's policy titled "Bathing a Resident" (with an implemented date of 11/1/20): "It is the practice of this facility to assist residents with their choice of bathing/hygiene options to maintain proper hygiene and help prevent skin issues." This policy detailed the process for providing a shower and bed bath but did not identify a minimum frequency for residents' bathing.

The failure of the facility staff to have documented evidence of Resident #1 being provided two (2) full bed baths and/or showers each week was discussed during a survey team meeting, on 6/22/22 at 3:05 p.m., with the facility's Administrator, Director of Nursing (DON), Clinical Nurse Educator, and Regional DON.

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F 677	Continued From page 5 On 6/23/22 at 9:00 a.m., Nurse Aide (NA) #11 was asked about the minimum frequency of bathing for residents. NA #11 reported residents should receive a minimum of two (2) full bed baths or showers per week. On 6/23/22 at 9:16 a.m., Registered Nurse (RN) #3 was asked about the minimum frequency of bathing for residents. RN #3 stated residents should receive a minimum of two (2) full bed baths and/or showers per week. RN #3 reported that partial bed baths were provided daily. The aforementioned resident bathing findings were discussed during a survey team meeting, on 6/23/22 at 9:35a.m., with the facility's Administrator, DON, and Regional DON. It was confirmed that the facility did not have a written policy that detailed the minimum frequency for resident bathing. It was reported that residents should be provided a full bed bath and/or shower twice a week.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent	F 686		7/14/22

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F 686	Continued From page 6 new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to provide ordered treatments to address pressure wounds for 1 of 4 sampled residents, Resident #1. The findings include: Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 4/9/22, was dated as completed on 4/20/22. Resident #1 was assessed as rarely or never able to make self understood and as rarely or never able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a four (4) out of 15; this indicated severe cognitive impairment. Resident #1 was documented as being dependent on others for bed mobility, dressing, eating, toilet use, personal hygiene, and bathing. Resident #1's diagnoses included, but was not limited to: anemia, high blood pressure, and chronic pain syndrome. Resident #1's current care plan included a focus area of "Pressure Ulcer to Sacrum". The focus area included the following intervention: "Treatements [sic] as ordered by physician to the wound care area". Resident #1 was unable to be interviewed due to having severe cognitive impairment. Resident #1's nurse practitioner note dated 6/22/22 indicated the resident had a stage IV	F 686	F 686 No action was taken for resident #1 due to the time frame had already passed Current residents in the center have the potential to be affected. Current licensed nurses will be educated by the Director of Nursing/designee on following physician orders and ensuring wound care is provided with documentation on the treatment administration record when treatment is completed. The Director of Nursing/Designee will review the treatment administration record during clinical meeting 5x weekly to ensure that documentation has been completed for wound care.	

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F 686	Continued From page 7 sacral pressure area with measurements of 5.0 cm by 1.8 cm by 1.0 cm. Resident #1's Treatment Administration Records (TARs) provided the following information: - During April of 2020, Resident #1 was to have sacral wound care provided on Monday, Wednesday, and Friday. This wound care included the use of a "vacuum-assisted closure device". Resident #1's documentation failed to provide evidence this wound care was performed on 4/20/22 and 4/29/22. - During May of 2020, Resident #1 was to have sacral wound care provided on Monday, Wednesday, and Friday. This wound care included the use of a "vacuum-assisted closure device". Resident #1's documentation failed to provide evidence this wound care was performed on 5/6/22 and 5/27/22. The following information was found in a facility policy titled "Documentation of Wound Treatments" (with an implemented date of 11/1/20): - "The facility completes accurate documentation of wound assessments and treatments, including response to treatment, change in condition, and changes in treatment." - "Wound treatments are documented at the time of each treatment on the Treatment Administration Record in (the name of the computerized documentation system omitted)." The failure of the facility staff to have documented evidence of providing Resident #1's wound care was discussed during a survey team meeting, on 6/22/22 at 3:05 p.m., with the facility's Administrator, Director of Nursing (DON), Clinical Nurse Educator, and Regional DON.	F 686	The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, then the review will be completed on a random basis The Administrator and Director of Nursing are responsible for the implementation of the plan of correction.	

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F 686	Continued From page 8 The absence of documented evidence of Resident #1's receiving medical provider ordered wound care was discussed for a final time, during a survey team meeting on 6/23/22 at 9:35a.m., with the facility's Administrator, DON, and Regional DON. This is a complaint deficiency.	F 686		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §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	F 761		7/14/22

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F 761	Continued From page 9 by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a physician ordered medication was kept under direct observation by the nursing staff until it was consumed by the resident for 1 of 4 Residents, Resident #2. The medication Creon was left at the bedside and out of the nurses view. The findings included: Section C (cognitive patterns) of Resident #2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/11/22 included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 points. Indicating the resident was alert and orientated. Diagnoses included, but were not limited to, exocrine pancreatic insufficiency, chronic kidney disease, and anemia. 06/22/22 11:15 a.m., during an interview with Resident #2 regarding medications this resident picked up a clear medication cup from their over the bed table and stated the nurse had left this medication in the room for them to take later. This medication cup contained a blue and reddish brown capsule the resident stated the medication was for their stomach. 06/22/22 11:30 a.m., Licensed Practical Nurse (LPN) #1 identified the medication as Creon and stated Resident #2 was talking on the phone and they did not normally leave medications in the room.	F 761	F 761 Resident # 2 was administered her medications. Current residents in the center have the potential to be affected. Current licensed nurses in the center will be educated by the Director of Nursing/designee on ensuring residents take their medication prior to them leaving the room. In addition, current licensed nurses will be educated on the 5 (R)s of medication administration. Director of Nursing/Designee will observe medication pass 2x weekly x 6 weeks to ensure medications are being given as ordered and not being left unattended at residents' bedside and the 5 R(s) of medication administration is completed.	

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F 761	Continued From page 10 Resident #2's physician orders included an order for Creon everyday before meals. During the clinical record review, the surveyor was unable to locate any information to indicate this resident had been assessed for self-administration of medications. 06/22/22 12:08 p.m., the Director of Nursing (DON) was made aware of the medication being left unattended and at the residents bedside. When asked if the medication should have been left in the residents room the DON replied, No, I don't believe so. 06/22/22, DON provided the surveyor with a copy of their policy titled, "Medication Administration." This policy read in part, "...Observe resident consumption of medication..." 06/22/22 3:05 p.m., during an end of the day meeting with the Administrator, DON, Regional DON, and Clinical Nurse Educator, the issue with the medication being left unattended at the residents bedside was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 761	The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, then the review will be completed on a random basis. The Administrator/DON are responsible for the implementation of the plan of correction.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is 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	F 842		7/14/22

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agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

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

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 12 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review, and clinical record review, the facility staff failed to ensure complete and/or accurate clinical records for two (2) of four (4) sampled residents, Resident #2 and Resident #3. Resident #2 and Resident #3's medical provider ordered wound care treatments were not consistently documented as being provided. The findings include: 1. Resident #3's Treatment Administration Records (TARs) did not consistently include documentation of medical provider ordered vascular wound care being provided. Resident #3 was interviewed on 6/22/22 at 1:00 p.m., the resident reported the facility staff members were providing their medications and treatments.	F 842	F 842 No action taken for resident #2 and resident #3 due to timeframe has already passed Current residents in the center have the potential to be affected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495338	A. BUILDING _____ B. WING _____	C 06/23/2022

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F 842	Continued From page 13 Resident #3 denied problems with the facility staff not providing wound care as ordered. Resident #3's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/12/22, was dated as completed on 5/24/22. Resident #3 was assessed as able to make self understood and as able to understand others. Resident #3's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #3 was documented as requiring limited assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #3's diagnoses included, but were not limited to: anemia, heart disease, high blood pressure, renal disease, diabetes, and lung disease. Resident #3's TARs provided the following findings: - For January of 2022, medical provider ordered right lower extremity vascular wound care was not documented as being provided as ordered on 1/14/22 and 1/24/22. - For March of 2022, medical provider ordered right lower extremity vascular wound care was not documented as being provided as ordered on 3/30/22. - For April of 2022, medical provider ordered right lower extremity vascular wound care was not documented as being provided as ordered on 4/15/22, 4/21/22, and 4/28/22. - For May of 2022, medical provider ordered right lower extremity vascular wound care was not documented as being provided as ordered on 5/1/22, 5/4/22, 5/6/22, and 5/24/22. Resident #3's current care plan included a focus	F 842	Current Licensed nurses will be educated on ensuring documentation is completed for medical provider ordered wound care treatments as provided. Director of Nursing/Designee will review the treatment administration record during clinical meeting 5x weekly to ensure wound care treatments are documented as provided. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then the review will be completed on a random basis. The Administrator and DON are responsible for implementation of the plan of correction.	

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F 842	Continued From page 14	F 842		

area of "Vascular Ulcer" to the right lower extremity. This focus area included an intervention to "Provide treatment per order."

The following information was found in a facility policy titled "Documentation in Medical Record" (with an implemented date of 11/1/20): "Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress though complete, accurate, and timely documentation."

The failure of the facility staff to consistently document providing Resident #3's wound care was discussed during a survey team meeting, on 6/22/22 at 3:05 p.m., with the facility's Administrator, Director of Nursing (DON), Clinical Nurse Educator, and Regional DON.

The absence of Resident #3's wound care documentation was discussed for a final time, during a survey team meeting on 6/23/22 at 9:35a.m., with the facility's Administrator, DON, and Regional DON. The Regional DON reported in-services, with facility staff members, related to documentation were started on 6/22/22.
2. Section C (cognitive patterns) of Resident #2's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 03/11/22 included a Brief Interview for Mental Status (BIMS) score of 15 out of 15 points. Indicating the resident was alert and orientated.

Diagnoses included, but were not limited to, exocrine pancreatic insufficiency, chronic kidney disease, and anemia.

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F 842	Continued From page 15	F 842		

06/22/22, a review of Resident #2's treatment administration records revealed that for the month of May 2022 the facility nursing staff failed to document for Resident #2's treatments on May 1, 2, 3, 6, 7, 20, 24, 27, and 28. For the month of June, the facility nursing staff failed to document for the residents treatments on June 19 on day shift.

06/22/22 11:15 a.m., Resident #2 stated the nurses completed their wound care with no issues and that they were seen today by the wound care nurse.

06/22/22, the facility staff documented this resident was seen by the Family Nurse Practitioner (FNP) and the sacral pressure ulcer was resolved.

06/22/22 11:45 a.m., Licensed Practical Nurse (LPN) #2 stated they had completed the treatments on June 19 and did not know why they had not signed for them.

06/22/22 3:05 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Regional DON, and Clinical Nurse Educator the issue with the missing documentation was reviewed.

No further information regarding this issue was provided to the survey team prior to the exit conference.