STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Emergency Preparedness Survey was conducted onsite 10/25/22-10/26/22. The facility was in substantial compliance with 42 CFR Part 483.73 emergency preparedness regulations, and has implemented The Centers for Medicare & Medicaid Services and Centers for D sease Control recommended practices to prepare for COVID-19.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey and a COVID-19 Focused Infection Control survey were conducted 10/25/22 through 10/26/22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Seven complaints were investigated during the survey (VA00056605- unsubstantiated, VA00056443= substantiated with related deficiency, VA00056425-substantiated with related deficiency, VA00056471-substantiated with related deficiency, VA0056567-substantiated with related deficiency, VA00056467-substantiated with no deficiency and VA00056636-substantiated with no deficiency). The census in this 190 certified bed facility was 138 at the time of survey. The survey sample consisted of 18 resident reviews (Residents #1 through #7 were closed record reviews and Residents #8 through #18 were current residents). Of the 138 current residents, one (1) resident was currently positive for the COVID-19 virus.	F 000	This plan of correction will serve as the facility's allegation of substantial compliance.	
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jonathon Zenell — TITLE: Executive Director — (X6) DATE: 11/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

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ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 584 SS=E	Continued From page 1 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584	1. Resident # 3 Room 222 Door gauges repaired and painted, area behind the bed repaired and painted, area under the sink cleaned, and tile in the bathroom cleaned and repaired. Cove based replaced in rooms 115, 116, 120, 122, 123, 125, 126, and 132. Resident #13 room 300 gauges in chest of drawers repaired and painted, baseboard underneath chest of drawers repaired and painted, and air conditioner cleaned. Hallway tiles on unit 3 near the entrance to the secure unit repaired or replaced. Door leading to secure unit dayroom repaired and repainted. Unit 300 dayroom walls repaired and repainted. Unit 300 hallways cleaned and free of debris and persistent urine odor 2. All residents have the potential to be impacted by the alleged deficient practice. Executive Director/Maintenance Director/DCS will conduct facility inspection to include resident rooms to identify areas for environmental improvement. Follow-ups will be done based on findings. 3. Quality assurance committee team members and maintenance team will be educated by Executive Director on providing residents a safe/clean/comfortable environment and reporting of any findings that require repair. Issuesfound during quality monitoring will be discussed in the am meeting and maintenance will be notified of the need for repair. The ED will log these concerns and will follow up maintenance staff daily to ensure each is resolved. 4. The Executive Director/maintenance staff to conduct environmental rounds, weekly x 6 weeks focusing on providing a safe clean comfortable environment. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee	12-7-2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 2	F 584		

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain a clean, comfortable, homelike environment for two of 18 residents in the survey sample, Residents #3 and #13; and in eight of 35 rooms on the 100 unit, (Rooms #115, 116, 120, 122, 123, 125, 126 and 132); and on one of three facility units, Unit 300.

The findings include:

1. For Resident #3 (R3), the facility failed to maintain the area behind the resident's bed, the area under the sink, and the bathroom floor tile in a clean, homelike condition.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 9/22/22, Resident #3 (R3) was coded as being moderately cognitively impaired for making daily decisions, having scored ten out of 15 on the BIMS (brief interview for mental status).

On 10/25/22 at 12:55 p.m., R3 was was observed sitting up in bed. R3 declined to participate in an interview. The room was neat and without odor. No flies were visible. The area behind the resident's bed had an approximately 3.5 feet by 1 foot area of gouges and chipped paint. The area underneath the sink had dark areas, and the corners contained dark dirt-like areas. The tile surrounding the toilet was dark and dirty.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3	F 584		

On 10/26/22 at 8:40 a.m., observations of the condition of R3's room and bathroom were unchanged from the previous day.

On 10/26/22 at 10:52 a.m., OSM (other staff member) #6, the housekeeping manager, was interviewed. She stated the facility was cited on the last standard survey in June for having areas that were not cleaned. She stated all resident bathrooms had been pressure washed, and all rooms had been cleaned. She stated all resident bedroom and bathroom floors are swept and mopped daily. She stated the housekeepers use a different mop for the bathroom than for the bedroom. She stated a floor tech buffs the floors in the resident bedrooms every other day. When asked who checks behind housekeepers to make sure rooms are being cleaned well, she stated she checks seven to eight rooms each day after the housekeeper has finished.

On 10/26/22 at 1:16 p.m., OSM #7, a housekeeper, was interviewed. When asked about her process for cleaning the floors in resident bedrooms and bathrooms, she stated she sweeps first, then mops. She stated she puts a disinfectant chemical in the mop water. She stated some floors are impossible to "clean" completely, as they are stained. She stated the floors need to be stripped in order to look like they are cleaned. She stated cleaning the corners takes extra work, including, sometimes, scraping. She stated sometimes she has time to do the extra work, and sometimes she does not.

On 10/26/22 at 1:21 p.m., ASM (administrative staff member) #1, the executive director, and OSM #4, the maintenance director, observed R3's bedroom and bathroom. OSM #4 stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 584	Continued From page 4	F 584		

gouged area behind R3's bed needed to be repaired, and was not home like. ASM #1 and OSM #4 agreed the area under R3's sink was not clean or home like. They agreed the bathroom was dirty, and the tile around the toilet needed to be repaired and cleaned. ASM #1 stated: "I am passionate about clean and home like."

On 10/26/22 at 3:50 p.m., ASM #1, ASM #2, assistant director of clinical services, and ASM #3, regional director of clinical services, were informed of these concerns.

On 10/26/22 at 5:18 p.m., ASM #3 stated there was no policy related to a clean, comfortable, home like environment.

A review of the facility policy, "Cleaning and Disinfection of Environmental Surfaces, revealed, in part: "Non-critical items are those that come in contact with intact skin but not mucous membranes.(1) Non-critical environmental surfaces include bed rails, some food utensils, bedside tables, furniture and floors. (2) Most non-critical items can be decontaminated where they are used (as opposed to being transported to a central processing location). 2. Non-critical surfaces will be disinfected with an EPA-registered intermediate or low-level hospital disinfectant according to the label's safety precautions and use directions. a. Most EPA-registered hospital disinfectants have a label contact time of 10 minutes. b. By law, all applicable label instructions on EPA-registered products must be followed...Housekeeping surfaces (e.g., floors, tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

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F 584	Continued From page 5	F 584		

A review of the facility policy, "Maintenance," revealed, in part: "Policy: The facility's physical plant and equipment will be maintained through a program of preventive maintenance and prompt action to identify areas/items in need of repair. Procedure: The Director of Environmental Services will follow all policies regarding routine periodic maintenance. The Director of Environmental Services will perform daily rounds of the building to ensure the plant is free of hazards and in proper physical condition. All employees will report physical plant areas or equipment in need of repair or service to their supervisor."

No further information was provided prior to exit.

2. For Resident #13 (R13), the facility staff failed to maintain the resident's chest of drawers and air conditioner in a clean, homelike condition.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/17/22, Resident #13 (R13) was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status.

On 10/25/22 at 2:02 p.m., R13 was not in the room. The air conditioner contained a cobweb near the filter. A section of the baseboard was missing underneath the chest of drawers. The chest of drawers contained black marks.

On 10/26/22 at 8:23 a.m., R13 was not in the room. There were no changes in observations of the condition of the room from the previous day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 584	Continued From page 6	F 584		

On 10/26/22 at 1:21 p.m., ASM (administrative staff member) #1, the executive director, and OSM #4, the maintenance director, observed R13's room. OSM # 4 stated the air conditioner was dirty, and it did not look like it had been cleaned in the recent past. OSM #4 and ASM #1 agreed that a section of the baseboard was missing and the chest of drawers contained multiple black marks. Both staff members agreed this was not a homelike environment. OSM #4 stated the staff can alert him to repair needs, or the staff can request the work through the facility software system. ASM #1, who has been employed at the facility only a month, stated: "I am passionate about clean and home like."

On 10/26/22 at 3:50 p.m., ASM #1, ASM #2, assistant director of clinical services, and ASM #3, regional director of clinical services, were informed of these concerns.
3. The facility staff failed to provide a homelike environment in 8 of 34 resident rooms on Unit One.

On 10/25/2022 at 1:33 p.m., an observation was conducted of Unit One of the facility. Observation of the resident rooms on unit one revealed exposed sheet rock with a dried substance on the wall and no baseboard in place from the doorway entrance to the sink from the floor approximately six inches up the wall in 8 of 34 rooms on the unit This was visible from the hallway in Rooms 115, 116, 120, 122, 123, 125, 126 and 132.

Additional observations on 10/26/2022 at 10:28 a.m., revealed the findings remained as above.

On 10/26/2022 at 9:28 a.m., an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 584	Continued From page 7	F 584		

conducted with OSM (other staff member) #4, maintenance director. OSM #4 stated that there were four rooms on Unit Two that had baseboards removed for pest control purposes but they were the only rooms that were removed.

On 10/26/2022 at approximately 1:30 p.m., an observation was conducted with OSM #4, maintenance director and ASM (administrative staff member) #1, the executive director of Unit One. OSM #4 and ASM #1 observed Rooms 115, 116, 120, 122, 123, 125, 126 and 132 with the exposed sheet rock with a dried substance on the wall and no baseboard in place from the doorway entrance to the sink. OSM #4 stated that they had started a project to replace the baseboards on Unit One and had run out of supplies to complete the project and the supplies had not come in. OSM #4 and ASM #1 were asked to provide any work orders and additional information regarding the project and supplies for review.

On 10/26/2022 at 3:50 p.m., ASM #1, the executive director, ASM #2, the assistant director of clinical services and ASM #3, the regional director of nursing were made aware of the above concern.

No further information was presented prior to exit.
4. a. On Unit 300, the facility staff failed to maintain the hallway and the day room in a homelike manner.

On 10/25/22 at 2:07 p.m., on the 300 unit, the door leading into the day room contained areas of chipped paint and gouges. A section of wall just to the left of the air conditioner contained an area of chipped paint/gouged wall. All around the day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 584	Continued From page 8	F 584		

room walls, intermittently, was a strip of black marks, approximately 18 inches above the floor. In the hallway just outside the day room, the floor against the baseboard contained crumb-like debris and debris, and dark areas in each corner.

On 10/26/22 at 10:52 a.m., OSM (other staff member) #6, the housekeeping manager, was interviewed. She stated housekeepers go to the dementia unit three times a day: in the morning for ordinary cleaning, including sweeping and mopping, after lunch to clean up after the meals, and again at 3:30 p.m. or 4:00 p.m.

On 10/26/22 at 1:21 p.m., ASM (administrative staff member) #1, the executive director, and OSM #4, the maintenance director observed the Unit 300 day room and hallway. They agreed the gouges and chips on the day room door were not home like, and the hallway was not clean.

On 10/26/22 at 3:50 p.m., ASM #1, ASM #2, assistant director of clinical services, and ASM #3, regional director of clinical services, were informed of these concerns.

4. b. The facility staff failed to maintain the locked/secured portion of the 300 unit without a persistent urine odor.

On 10/25/22 at 1:21 p.m. and 3:38 p.m., and on 10/26/22 at 8:18 a.m., a persistent urine odor was present throughout the halls on the locked/secured portion of the 300 unit.

On 10/26/22 at 10:52 a.m., an interview was conducted with OSM (other staff member) #6 (the housekeeping manager). OSM #6 stated the housekeepers are on unit three three times a day

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 584	Continued From page 9	F 584		

due to the persistent urine odor. OSM #6 stated the housekeepers clean each room and bathroom in the morning, then complete walk-throughs with spot checks and spot cleaning after lunch and in the afternoon. OSM #6 stated the housekeepers deep clean the floors with a chemical disinfectant. OSM #6 stated she sprays the disinfectant, lets it sit for a few minutes, wipes down the floor then sprays an odor eliminator. OSM #6 stated the persistent urine odor is not clean and homelike and that is why the housekeepers go to unit three three times a day. OSM #6 stated there is a resident with dementia who resides on the unit and that resident urinates in trash cans. OSM #6 stated all housekeeping employees leave the facility in the afternoon and do not return until the next morning so the nursing staff has to clean the urine during the evenings and nights.

On 10/26/22 at 12:49 p.m., an interview was conducted with CNA (certified nursing assistant) #2. (A CNA who has worked all three shifts on the locked/secure portion of unit three). CNA #2 stated that there is a male resident who resides on the unit and who urinates on the floor. CNA #2 stated the CNAs initially clean the urine with towels and hand soap then call the housekeepers to come and sanitize the floor. CNA #2 stated the CNAs do not have access to cleaning materials but they do the best they can with hand soap.

On 10/26/22 at 1:05 p.m., an interview was conducted with LPN (licensed practical nurse) #4 (a nurse who works day and evening shifts on the locked/secured portion of unit three). LPN #4 stated the urine odor on the unit persists some days more than others because there is a gentleman who wanders and tends to urinate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 584	Continued From page 10 where ever he is. LPN #4 stated the urine odor is not homelike and that is why the nursing staff tries to educate the resident and takes the resident to the restroom more often. LPN #4 stated the nursing staff cleans the urine with soap and water then the housekeeping staff disinfects the area where the resident urinated. LPN #4 stated the nursing staff does not have access to cleaning materials besides soap and water. On 10/26/22 at 4:00 p.m., ASM (administrative staff member) #1 (the executive director) and ASM #2 (the assistant director of clinical services) were made aware of the above concern. No further information was presented prior to exit. Complaint deficiency.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §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, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes	F 607	1. Facility submitted a FRI on 10/26/2022 for an Allegation of Verbal Abuse involving resident #4. The facility investigated the incident and reported their findings on 11/2/2022. 2. All residents have the potential to be impacted by the alleged deficient practice. Residents with a BIMS of 9 or above were interviewed to determine if anyone has mistreated them, threatened or verbally abused them since residing at the facility, ask if they are fearful of anyone, been hit or threatened, and document and signs of distress. Residents with a BIMS of 8 and below were assessed to determine if the presented with any signs of distress or had any suspicious or unknown injuries. No additional incidents were identified. 3. Facility staff and external providers will be educated on Resident Abuse Policy by Executive Director or Designee to ensure residents are free from abuse and expectation of reporting suspected incidents. Executive Director or Designee to conduct quality monitoring of allegations of abuse/grievances weekly x6 weeks and as needed to ensure policies are followed to include timely reporting, thorough investigation, and 5 day follow up. 4. Executive Director/DCS will interview/inspect 10 residents to ensure that they are free from abuse weekly x6 weeks and as needed to ensure policies are followed to include timely reporting, thorough investigation, and 5 day follow up. Follow ups will be done based on findings. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	12-7-2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 607	Continued From page 11	F 607		

occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.

§483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act.

§483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility failed to implement their abuse policy for investigating and reporting an allegation of verbal abuse for one of 18 residents in the survey sample, Resident #4 (R4).

The findings include:

For R4, the facility staff failed to implement their abuse policy to investigate and report an allegation of verbal abuse that was reported to a facility staff member.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/18/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

R4 no longer resided at the facility and could not be observed during the survey dates. The record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 607	Continued From page 12	F 607		

was reviewed as a closed record.

A complaint allegation received on 9/7/2022 alleged R4 called the police for neglect and verbal abuse. The complaint alleged a staff member threatened and yelled at them down the hallway.

Review of the FRI's (facility reported incidents) from 6/7/2022 through the present failed to evidence any FRI's for R4.

Review of R4's clinical record failed to evidence documentation of the police being called or allegations of verbal abuse by staff.

On 10/26/2022 at 11:20 a.m., an interview was conducted with ASM (administrative staff member) #4, the nurse practitioner. ASM #4 stated that they cared for R4 when they were a resident at the facility. ASM #4 stated that R4 had reported an evening or night shift male CNA (certified nursing assistant) being verbally abusive to them one day when they were seeing them. ASM #4 stated that they did not remember the exact details or date but remembered that R4 had reported that the aide had refused to get R4 water for some tea and had said something to them in a tone that they did not like. ASM #4 stated that they had reported the allegation to the nurse that was working with R4 that day. ASM #4 stated that they were not aware of what the outcome was of the allegation but they knew that the CNA was still working at the facility. ASM #4 stated that they did not know the CNA's name or the nurse that they reported it to. ASM #4 stated that their process was to report any allegation of abuse to the nurse working with the resident and then to go up the chain of command if nothing was done about the allegation. ASM #4 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 607	Continued From page 13	F 607		

that R4 never mentioned the CNA being verbally abusive after that day.

On 10/26/2022 at 1:40 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that they did not remember R4. LPN #9 stated that if a resident reported verbal abuse they would take a statement from the resident. LPN #9 stated that if the staff member named in the allegation were there they would send them home. LPN #9 stated that they reported any abuse allegations to the executive director immediately and completed a head to toe assessment on the resident. LPN #9 stated that they completed witness statements and the administrative team normally handled the staff member interviews and investigation completion. LPN #9 stated that they reported the allegation immediately because they knew that any abuse allegation needed to be a facility reported incident and they needed to ensure that all of the residents were kept safe.

On 10/26/2022 at 1:55 p.m., ASM (administrative staff member) #1, the executive director was made aware of the complaint allegation of verbal abuse from R4 and the interview with ASM #4 confirming R4 reporting verbal abuse to them when they were at the facility.

On 10/26/2022 at 3:02 p.m., an interview was conducted with ASM #2, the assistant director of clinical services. ASM #2 stated that they did not remember any conversations with R4 except for speaking with them regarding COVID-19 isolation protocols. ASM #2 stated that if a resident reports any type of abuse the first step was to ensure that the resident was safe. ASM #2 stated that if the named staff member was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 607	Continued From page 14	F 607		

working on the floor they would send them home while they investigated the allegation. ASM #2 stated that they notified the executive director immediately who made sure that the allegation was completely investigated and reported to the appropriate agencies. ASM #2 stated that the allegation should be reported within two hours to the state agency. ASM #2 stated that all staff were educated on abuse and neglect upon hire and at each monthly staff meeting.

On 10/26/2022 at 4:38 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that they remembered R4. RN #1 stated that they worked the night shift after R4 had called the police the evening prior. RN #1 stated that R4 did not say why they had called them or mention any verbal abuse to them at that time. RN #1 stated that if a resident reported any abuse they would contact the executive director immediately. RN #1 stated that the executive director interviewed the staff member involved in the allegations and they interviewed patients. RN #1 stated that they would contact the police and speak to the employee as needed if they were the only staff member there.

On 10/26/2022 at 3:50 p.m., ASM #1, the executive director, ASM #2, the assistant director of clinical services and ASM #3, the regional director of nursing were made aware of the findings.

The facility policy "Abuse, Neglect, Exploitation & Misappropriation" dated 11/28/2017 documented in part, "It is the inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 607	Continued From page 15 exploitation and/or misappropriation of property...Employee Obligation: All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of clinical services is the designated abuse coordinator..." No further information was provided prior to exit. Complaint deficiency.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609	1. Facility submitted a FRI on 10/26/2022 for an Allegation of Verbal Abuse involving resident #4. The facility investigated the incident and reported their findings on 11/2/2022. 2. All residents have the potential to be impacted by the alleged deficient practice.Residents with a BIMS of 9 or above were interviewed to determine if anyone has mistreated them, threatened or verbally abused them since residing at the facility, ask if they are fearful of anyone, been hit or threatened, and document and signs of distress. Residents with a BIMS of 8 and below were assessed to determine if the presented with any signs of distress or had any suspicious or unknown injuries. No additional incidents were identified. 3. Facility staff and external providers will be educated on Resident Abuse Policy by Executive Director or Designee to ensure residents are free from abuse and expectation of reporting suspected incidents. Executive Director or Designee to conduct quality monitoring of allegations of abuse/grievances weekly x6 weeks and as needed to ensure policies are followed to include timely reporting, thorough investigation and 5 day follow up. 4. Executive Director or Designee will interview 10 residents to ensure that they are free from abuse weekly x6 weeks and as needed to ensure policies are followed to include timely reporting, thorough investigation, and 5 day follow up. Follow ups will be done based on findings. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	12/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 609	Continued From page 16	F 609		

serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that the facility failed to report an allegation of verbal abuse for one of 18 residents in the survey sample, Resident #4 (R4).

The findings include:

The facility staff failed to report an allegation of verbal abuse to the administrator and the State Agency, that was reported to a facility staff member by R4.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/18/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 609	Continued From page 17	F 609		

decisions.

R4 no longer resided at the facility and could not be observed during the survey dates. The record was reviewed as a closed record.

A complaint allegation received on 9/7/2022 alleged R4 called the police for neglect and verbal abuse. The complaint alleged a staff member threatened and yelled at them down the hallway.

Review of the FRI's (facility reported incidents) from 6/7/2022 through the present failed to evidence any FRI's for R4.

Review of R4's clinical record failed to evidence documentation of the police being called or allegations of verbal abuse by staff.

On 10/26/2022 at 11:20 a.m., an interview was conducted with ASM (administrative staff member) #4, nurse practitioner. ASM #4 stated that they cared for R4 when they were a resident at the facility. ASM #4 stated that R4 had reported an evening or night shift male CNA (certified nursing assistant) being verbally abusive to them when they had seen them at the facility. ASM #4 stated that they did not remember the exact details or date but remembered that R4 had reported that the aide had refused to get R4 water for some tea and had said something to them in a tone that they did not like. ASM #4 stated that they had reported the allegation to the nurse that was working with R4 that day. ASM #4 stated that they were not aware of what the outcome was of the allegation but they knew that the CNA was still working at the facility. ASM #4 stated that they did not know the CNA's name or the nurse that they reported it to. ASM #4 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 609	Continued From page 18	F 609		

that their process was to report any allegation of abuse to the nurse working with the resident and then to go up the chain of command if nothing was done about the allegation. ASM #4 stated that R4 never mentioned the CNA being verbally abusive after that day.

On 10/26/2022 at 1:40 p.m., an interview was conducted with LPN (licensed practical nurse) #9. LPN #9 stated that they did not remember R4. LPN #9 stated that if a resident reported verbal abuse they would take a statement from the resident. LPN #9 stated that they reported the allegation immediately because they knew that any abuse allegation needed to be a facility reported incident and they needed to ensure that all of the residents were kept safe.

On 10/26/2022 at 1:55 p.m., ASM (administrative staff member) #1, the executive director was made aware of the complaint allegation of verbal abuse from R4 and the interview with ASM #4 confirming R4 reporting verbal abuse to them when they were at the facility.

On 10/26/2022 at 3:02 p.m., an interview was conducted with ASM #2, the assistant director of clinical services. ASM #2 stated that they did not remember any conversations with R4 except for speaking with them regarding COVID-19 isolation protocols. ASM #2 stated that if a resident reports any type of abuse the first step was to ensure that the resident was safe. ASM #2 stated that if the named staff member was working on the floor they would send them home while they investigated the allegation. ASM #2 stated that they notified the executive director immediately who made sure that the allegation was completely investigated and reported to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 609	Continued From page 19	F 609		

appropriate agencies. ASM #2 stated that the allegation should be reported within two hours to the state agency. ASM #2 stated that all staff were educated on abuse and neglect upon hire and at each monthly staff meeting.

On 10/26/2022 at 4:38 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that they remembered R4. RN #1 stated that they worked the night shift after R4 had called the police the evening prior. RN #1 stated that R4 did not say why they had called them or mention any verbal abuse to them at that time. RN #1 stated that if a resident reports any abuse they would contact the executive director immediately.

The facility policy "Abuse, Neglect, Exploitation & Misappropriation" dated 11/28/2017 documented in part, "It is the inherent in the nature and dignity of each resident at the center that he/she be afforded basic human rights, including the right to be free from abuse, neglect, mistreatment, exploitation and/or misappropriation of property...Employee Obligation: All employees have a duty to respect the rights of all residents, to treat them with dignity and to prevent others from violating their rights. Any employee, who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 609	Continued From page 20 Administrator and to other officials in accordance with State law. In the absence of the Executive Director, the Director of clinical services is the designated abuse coordinator..." On 10/26/2022 at 3:50 p.m., ASM #1, the executive director, ASM #2, the assistant director of clinical services and ASM #3, the regional director of nursing were made aware of the findings. No further information was provided prior to exit. Complaint deficiency.	F 609		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential	F 842	1. Facility recognizes that it failed to document if treatment was completed for resident #7, failed to maintain an accurate ADL record for incontinence care for resident #4, and fail to evidence complete and accurate documentation for fluids offered for resident #2. 2. All residents have the potential to be impacted by the alleged deficient practice. Resident treatment records and ADL records will have a quality review completed to ensure documentation is present and accurate. Clinical staff will be reeducated by DCS/designee on documentation guidelines and expectations with a focus on treatments and ADLs.The clinical team will review ADL and treatment documentation in the am clinical meeting to ensure the documentation is completed and accurate with appropriate follow up as needed. 4. The DCS/designee to conduct quality monitoring of ADL and treatment documentation weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	12/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 21	F 842		

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 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;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 842	Continued From page 22 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined the facility staff failed to maintain a complete and accurate clinical record for three of 18 residents in the survey sample, Resident #7, #4 and #2. The findings include: 1. For Resident #7 (R7), the facility staff failed to document if a treatment was completed. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/10/2022, the resident scored a 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired for making daily decisions. In Section M - Skin Conditions, the resident was not coded as having any pressure ulcers/injuries. In Section M1040 - Other Ulcers, Wounds & Skin Problems, the resident was coded as having Moisture Associated Skin Damage (MASD). The physician order dated, 12/21/2021, documented, "Cleanse buttock with normal saline, pat dry, apply alginate to sacrum and right buttock, secure with DSD (dry sterile dressing) q (every) day until healed." The January 2022 TAR (treatment administration record) documented the above order. On	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 23	F 842		

1/13/2022, 1/19/2022, and 1/31/2022, the place on the TAR was blank for the administration of the treatment.

The February 2022 TAR documented the above order. On 2/1/2022, 2/3/2022, 2/5/2022, and 2/6/2022, the place on the TAR was blank for the administration of the treatment.

Review of the nurse's notes for the above dates failed to evidence documentation of why the treatment was not performed.

An interview was conducted with ASM (administrative staff member) #2, the assistant director of clinical services, on 10/26/2022 at 2:16 p.m. When asked what the blanks on a TAR indicated, ASM #2 stated it was probably overlooked and not checked off when it was done. When asked if she could tell if the treatment was done, ASM #2 stated, "No, it's blank."

An interview was conducted with LPN (licensed practical nurse) #3, on 10/26/2022 at 2:45 p.m. When asked what it indicates when there are blanks on the TAR where documentation should be for a treatment order, LPN #3 stated, "The textbook answer is if it wasn't documented, it wasn't done." LPN #3 stated, "We, nurses, do things all the time that we forget to sign off, it's human error."

The facility policy, "Clinical/Medical Records," documented in part, "Clinical Records are maintained in accordance with professional practice standards to provide complete and accurate information on each resident for continuity of care."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 24	F 842		

ASM #1, the executive director, ASM #2 and ASM #3, the regional director of clinical services, were made aware of the above concern on 10/26/2022 at 4:07 p.m.

No further information was provided prior to exit.
2. For Resident #4 (R4), the facility staff failed to maintain an accurate ADL (activities of daily living) record for incontinence care for August 2022.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 8/18/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating they were cognitively intact for making daily decisions. R4 was coded as being occasionally incontinent of urine.

Review of the ADL record for August 2022 documented in part, "B&B (bowel and bladder)-Bladder function." The document failed to evidence documentation on 8/12/2022 and 8/25/2022 day shift, 8/18/2022 and 8/21/2022 evening shift and 8/19/2022 night shift. The documentation areas on the record were blank.

On 10/26/2022 at 10:52 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that incontinence care was provided for residents at a minimum every two hours. CNA #7 stated that incontinence care was documented in the computer under the ADL documentation. CNA #7 stated that there was a section for bladder and they documented how many times the resident voided and whether the resident was incontinent or continent every shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 25	F 842		

CNA #7 stated that R4 was incontinent but could tell them when they needed to be changed. CNA #7 stated that if the area for the shift was blank that it did not mean that the care was not provided and that the CNA had not documented the care. CNA #7 stated that the record was not accurate when there were blanks in it.

On 10/26/2022 at 3:50 p.m., ASM (administrative staff member) #1, the executive director, ASM #2, the assistant director of clinical services and ASM #3, the regional director of nursing were made aware of the findings.

No further information was provided prior to exit.

3. For Resident #2, the facility staff failed to evidence complete and accurate documentation for fluids offered.

Resident #2 was admitted to the facility on 6/14/22 with diagnoses that included but were not limited to: traumatic
brain injury, traumatic hemorrhage of cerebrum, fracture of clavicle and fall. Resident #2 was on hospice services and expired on 7/12/22.

The most recent MDS (minimum data set) assessment, a five day Medicare assessment, with an ARD (assessment
reference date) of 6/21/22, coded the resident as scoring a 99 out of 15 on the BIMS (brief interview for mental
status) score, indicating the resident was unable to complete the interview. A review of the MDS Section G-
functional status coded the resident as requiring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 26	F 842		

extensive assistance for bed mobility, transfer, dressing, eating,
locomotion and hygiene/bathing.

A review of the comprehensive care plan with a revision date of 6/16/22, revealed, "FOCUS: Resident ' s code status
is a DNR (do not resuscitate). Resident is on Hospice services. INTERVENTIONS: Resident has an advanced
directive.

During the survey period of 10/25/22-10/26/22, observations were made of residents with fluids at bedside, fluids
being replenished by the CNA (certified nursing assistant) one to two times a shift and fluids offered with breakfast
and lunch.

A review of the June and July ADL (activities of daily living) fluids documentation revealed the following:

June day shift: 15 shifts total with no fluids offered/documented, as evidenced by blank spaces, on two shifts, 6/24/22 and 6/27/22.
June evening shift: 15 shifts total with no fluids offered/documented on three shifts, 6/14/22, 6/20/22 and 6/28/22.
June night shift: 16 shifts total with no fluids offered/documented on 15 shifts, 6/15/22-6/18/22 and 6/20/22-
6/30/22.

July day shift: 11 shifts total with no fluids offered/documented on nine shifts, 7/1/22-7/3/22 and 7/6/22-7/11/22.
July evening shift: fluids documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 27	F 842		

offered/consumed.
July night shift: fluids documented as offered/consumed.

The amounts of fluid intakes that were documented ranged from sips to 300 milliliters at a time. There was no evidence to indicate that Resident #2 was dehydrated.

An interview was conducted on 10/26/22 at 8:25 AM with CNA (certified nursing assistant) #1. When asked how
often fluids are offered to residents who are extensive assistance with feeding, CNA #1 stated, we offer every two
hours or more often if possible. When asked how much 5 milliliters equals, CNA #1 stated, "It is about a sip." When
asked what the blank documentation means on the ADL forms CNA #1 stated, it means that it was not done.

An interview was conducted on 10/26/22 at 2:05 PM with CNA #3. When asked how often fluids are offered to
residents who are extensive assistance with feeding, CNA #3 stated, at least every two hours. When asked where
the fluids are documented, CNA #3 stated, in the ADL form. When asked if there are blanks in the documentation,
what does that mean, CNA #3 stated, if it was not documented, it was not done.

An interview was conducted on 10/26/22 at 3:00 PM with ASM (administrative staff member) #2, the assistant
director of clinical services. When asked what the blank spaces where fluids are documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 28 means, ASM #2 stated, "It may mean that it was not done, or it could mean that it was not documented. I will have to get back to you on that." On 10/26/22 at 3:40 PM, ASM #1, the executive director and ASM #2, the assistant director of clinical services andASM #3, the regional director of clinical services were informed of the above findings. No further information was provided prior to exit.	F 842		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the	F 865	1. The facility failed to provide evidence that the plan of correction submitted following the 6/7/2022 standard survey was implemented and completed by the AOC 7/12/2022. Resident # 3 Room 222 Door gauges repaired and painted, area behind the bed repaired and painted, area under the sink cleaned, and tile in the bathroom cleaned and repaired. Cove based replaced in rooms 115, 116, 120, 122, 123, 125, 126, and 132. Resident #13 room 300 gauges in chest of drawers repaired and painted, baseboard underneath chest of drawers repaired and painted, and air conditioner cleaned. Hallway tiles on unit 3 near the entrance to the secure unit repaired or replaced. Door leading to secure unit dayroom repaired and repainted. Unit 300 dayroom walls repaired and repainted. Unit 300 hallways cleaned and free of debris and persistent urine odor 2. All residents have the potential to be impacted by the alleged deficient practice. Executive Director/maintenance Director/DCS will conduct facility inspection to include resident rooms to identify areas for environmental improvement. Follow-ups will be done based on findings. 3. Quality assurance committee team members and maintenance team will be educated by Executive Director on providing residents a safe/clean/comfortable environment and reporting of any findings that require repair. The Regional Director of Operations/Regional Director of Clinical Services will attend (either in person or remotely) the facility QAPI meeting quarterly for two quarters, to ensure appropriate follow up with identified items. 4. Executive Director or Designee to conduct quality monitoring of facility environment weekly x 6 weeks to identify areas in need of environmental improvement. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	12/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 865	Continued From page 29	F 865		

promulgation of this regulation;

§483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and

§483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request.

§483.75(b) Program design and scope.
A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

§483.75(b)(1) Address all systems of care and management practices;

§483.75(b)(2) Include clinical care, quality of life, and resident choice;

§483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF.

§483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.

§483.75(f) Governance and leadership.
The governing body and/or executive leadership

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 865	Continued From page 30 (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as	F 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 865	Continued From page 31	F 865		

a basis for sanctions.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility document review, it was determined that the facility staff failed to implement an effective QAPI (quality and performance improvement) plan following the most recent standard survey for eight of 34 resident rooms on the 100 unit, and in the area surrounding and inside the day room on one of three resident units, the 300 unit.

The findings include:

For each room and area, the facility failed to provide evidence that the plan of correction submitted following the 6/7/22 standard survey was implemented and completed by the AOC (allegation of compliance) date of 7/12/22.

On 10/25/22 at 12:55 p.m., in Room 222, the area behind the bed nearest the door had an approximately 3.5 feet by 1 foot area of gouges and chipped paint. The area underneath the sink had dark areas, and the corners contained dark dirt-like substance. In the bathroom, the tile surrounding the toilet was dark and dirty, and the bathroom corners contained dark debris.

On 10/25/2022 at 1:33 p.m., Observation of the resident rooms on unit one revealed exposed sheet rock with a dried substance on the wall and no baseboard in place from the doorway entrance to the sink from the floor approximately six inches up the wall in 8 of 34 rooms on the unit This was visible from the hallway in Rooms 115, 116, 120, 122, 123, 125, 126 and 132.

On 10/25/22 at 2:02 p.m., in room 300, the air

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 865	Continued From page 32	F 865		

conditioner contained a cobweb near the filter. A section of the baseboard was missing underneath the chest of drawers. The chest of drawers contained black marks.

On 10/25/22 at 2:07 p.m., on the 300 unit, the door leading into the day room contained areas of chipped paint and gouges. A section of wall just to the left of the air conditioner contained an area of chipped paint/gouged wall. All around the day room walls, intermittently, was a strip of black marks, approximately 18 inches above the floor. In the hallway just outside the day room, the floor against the baseboard contained crumb-like substance and debris, and dark areas in each corner.

A review of the plan of correction from the facility's 6/7/22 standard survey revealed, in part: "An audit was completed by the Maintenance Director/designee on repairs needed including, but not limited to, walls, bathroom tiles, ceilings and fixtures. Items in need of repair were completed. An audit was completed by the Maintenance Director to ensure the package terminal air conditioner (PTAC) filters were clean and free from debris. An audit was completed by the Housekeeping Director to ensure...rooms presented as clean and home-like...AOC date 7/12/22."

10/26/22 at 9:14 a.m., ASM (administrative staff member) #1, the executive director was asked to provide credible evidence of the repairs alleged to have been done in the plan of correction for the 6/27/22 survey.

On 10/26/22 at 11:11 a.m., ASM #1 stated he could not provide evidence that the corrections

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 865	Continued From page 33	F 865		

were completed per the recent plan of correction with an AOC date of 7/12/22. He stated he has only been employed at this facility for one month. He stated he cannot speak to what went on before his arrival at the facility. He stated he has instituted stand up meetings where staff members are able to identify concerns with the facility being a home like environment for residents. He stated he has put plans in place for these kinds of concerns, but he could not provide evidence of any of those plans. He stated the facility has completely redone four rooms on Unit 200, and have plans to keep moving forward with the room rehabilitation.

On 10/26/22 at 1:05 p.m., OSM (other staff member) #6, the housekeeping manager, provided evidence of cleaning related to corrections needed to complete the plan of correction with an AOC date of 7/12/22. These audits were dated as follows in 2022: 7/18, 7/21, 7/25, 7/28, 8/1, 8/8, 8/15, 8/24, and 8/29. All of these were documented as completed after the AOC date of 7/12/22.

On 10/26/22 at 3:50 p.m., ASM #1, ASM #2, assistant director of clinical services, and ASM #3, regional director of clinical services, were informed of these concerns.

A review of the facility policy, "Quality Assurance Performance Improvement (QAPI)," revealed, in part: "Leadership: The Center Executive Director is accountable for the overall implementation and functioning of the QAPI program. This includes but is not limited to:
a) Implementation
b) Identify priorities
c) Ensures adequate resources

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 865	Continued From page 34 d) Ensures performance indicators, resident and staff input and other information is used to prioritize problems and opportunities e) Ensures corrective actions are implemented to address identified problems in systems f) Evaluates the effectiveness of actions g) Establishes expectations for safety, quality, rights and choice and respect 4. The program is a coordinated effort among departments and services within the organization that involves leadership working with input from Center staff, residents and families. 5. The Quality Assessment and Assurance Committee (QAA) meetings are at least quarterly, but may be held more frequently as appropriate...Identifying Quality Deficiencies and Corrective Action: The center will monitor department performance systems to identify issues or adverse events. 14. Center will review department system data 15. If a quality deficiency is identified, the committee will oversee the development of corrective action(s) 16. The center may choose the method of corrective action i.e. "Plan, Do, Study, Act" or "Performance Improvement Project" No further information was provided prior to exit.	F 865		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and	F 883	1. For resident #15 the facility failed to provide evidence of the vaccination status for the pneumococcal vaccination. All residents will be audited and the pneumococcal vaccine was offered/given/refused and the medical record updated as indicated. 2. All residents have the potential to be impacted by the alleged deficient practice. The DCS/designee will conduct a quality review of residents and their pneumococcal vaccination status to determine a base line of needs. 3. Clinical staff will be reeducated by DCS/designee on the pneumococcal vaccination policy and appropriate documentation. Once the quality review has been completed the clinical team will review new resident pneumococcal vaccination status in the am clinical meeting and document accordingly i in the medical record.	12/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 35 potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative	F 883	4. The DCS/designee to conduct quality monitoring of 5 residents and their pneumococcal vaccination status weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 883	Continued From page 36	F 883		

was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement a complete immunization program for one of five record reviews for immunizations, Resident #15.

The findings include:

For Resident #15 (R15), the facility staff failed to provide evidence of the vaccination status for the pneumococcal vaccination.

On the most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 10/17/2022, the resident was assessed as being severely impaired for making daily decisions. In Section O - Special Treatments, Programs and Procedures, the resident was coded as not having a pneumococcal vaccine, and it was coded as not offered.

Review of the clinical record for R15, failed to evidence documentation of the administration or the refusal of the pneumococcal vaccination.

The Admission Evaluation dated 5/13/2021 failed to evidence documentation of a pneumococcal vaccination in the immunization dates area on the assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 883	Continued From page 37	F 883		

The physician orders for R15 documented in part, "Pneumovax if needed. Order Date: 10/11/2022."

On 10/26/2022 at 10:15 a.m., a request was made to ASM (administrative staff member) #1, the executive director, for evidence of pneumococcal vaccination for R15.

On 10/26/2022 at 2:53 p.m., ASM #2, the assistant director of clinical services stated that they did not have any documentation of consent or refusal and education provided for the pneumococcal vaccine.

On 10/26/2022 at 3:02 p.m., an interview was conducted with ASM #2, the assistant director of clinical services. ASM #2 stated that residents were assessed on admission to see if they were due for the pneumonia vaccine and offered the vaccine when it was due. ASM #2 stated that consent was obtained from the responsible party in person or by telephone and education on the vaccine was provided to them. ASM #2 stated that if the responsible party refused the vaccine it was documented in the medical record. ASM #2 stated that if the responsible party consented to the vaccine it was ordered from the pharmacy for that resident and administered as ordered. ASM #2 stated that residents were monitored after the vaccine per the facility protocol. ASM #2 stated that the vaccine, consent and education were all documented in the residents medical record.

The facility policy, "Pneumococcal Vaccine" dated October 2019, documented in part, "All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections...Before receiving a pneumococcal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 883	Continued From page 38 vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine...Provisions of such education shall be documented in the medical record..." On 10/26/2022 at 3:50 p.m., ASM #1, the executive director, ASM #2, the assistant director of clinical services and ASM #3, the regional director of nursing were made aware of the findings. No further information was provided prior to exit.	F 883		
F 886 SS=D	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	F 886	1. The facility recognizes it failed to evidence a complete and accurate tracking of Required COVID-19 testing. Employee CNA#6 will be tested in accordance with CDC guidelines. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review will be conducted by the Director of Clinical Services/Assistant of the most recent testing episode in the facility to determine testing as required 3. Licensed nurses will be re-educated by the Director of Clinical services/Assistant related to The LTC facility must test residents and facility staff for COVID-19 in accordance to the community transmission rate and the CDC. During testing the clinical team will validate that staff requiring testing were completed by utilizing a staff roster/exemption tracking log and test results against lists. 4. The Executive Director/Director of Clinical Services to conduct quality monitoring of testing logs, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	12/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

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F 886	Continued From page 39	F 886		

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;

§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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 886	Continued From page 40	F 886		

This REQUIREMENT is not met as evidenced by:
Based on staff interview and facility document review, it was determined the facility staff failed to evidence a complete and accurate tracking of required COVID-19 testing for one of three staff members sampled, CNA #6.

The findings include:

On 10/25/2022 at approximately 2:00 p.m., a request was made to ASM (administrative staff member) #2, the assistant director of clinical services, for documentation related to COVID-19 testing, staff testing positive in the past 4 weeks and a completed COVID-19 Staff Vaccination Matrix or a list containing the same information.

After receiving and review of the COVID-19 Staff Vaccination Matrix and the staff testing positive in the past 4 weeks documents, a sample of three staff members were chosen to review for COVID-19 testing compliance.

The facility provided COVID-19 testing schedule for October 2022 documented residents and staff tested on 9/23/2022, 9/29/2022, 10/6/2022, 10/17/2022 and 10/20/2022.

Review of the facility provided documents evidenced two residents positive for COVID-19 in the past four weeks, one on 9/29/2022 and 10/20/2022 and two staff members positive for COVID-19 in the past four weeks, one on 10/15/2022 and one on 10/22/2022.

On 10/26/2022 at 8:25 a.m., a request was made to ASM #2 for evidence of COVID-19 testing for the past four weeks of three staff members,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 886	Continued From page 41	F 886		

including CNA (certified nursing assistant) #6.

On 10/26/2022 at 12:21 p.m., ASM #2 provided negative COVID-19 testing results for CNA #6 dated 10/6/2022. ASM #2 stated that they knew that CNA #6 was tested on the other dates however, these were all of the results they had to provide. ASM #2 stated that the facility went into outbreak mode on 10/15/2022 and prior to that they were not in an outbreak. ASM #2 stated that they tested all staff and residents according to the testing schedule provided. The documents provided for CNA #6 failed to evidence testing on 10/17/2022 and 10/20/2022.

On 10/26/2022 at 10:47 a.m., an interview was conducted with LPN (licensed practical nurse) #8. LPN #8 stated that they were tested for COVID-19 at the facility twice a week on Mondays and Thursdays.

On 10/26/2022 at 10:52 a.m., an interview was conducted with CNA (certified nursing assistant) #7. CNA #7 stated that they were currently being tested at the facility for COVID-19 every Thursday.

On 10/26/2022 at 2:02 p.m., an interview was conducted with ASM #2, the assistant director of clinical services. ASM #2 stated that the facility had gone into outbreak testing on 10/15/2022 and had tested all residents and staff on 10/17/2022 with no new cases identified. ASM #2 stated that they had tested all staff and residents again on 10/20/2022 and identified one resident who was positive who had been admitted the day before from the hospital. ASM #2 stated that CNA #6 had contacted them from home and stated they had a positive home test on 10/22/2022 and were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 42	F 886		

currently not working. ASM #2 stated that they were testing all staff and residents again on 10/27/2022. ASM #2 stated that when they tested the residents they printed off a census sheet and checked off the sheet as they tested the residents and completed the testing forms as they did the test. ASM #2 stated that when they tested the staff, they had the schedule for the day and the staff came in prior to the start of their shift and were tested and filled the form out at the time of testing. ASM #2 stated that any staff who were not working were tested on their next scheduled work day. ASM #2 stated that there were two staff members who assisted them with the testing and all of the completed testing forms were returned to her. ASM #2 stated that they did not have any staff testing logs to provide because they had not been updated.

The facility policy, "COVID-19 Pandemic Plan" dated 9/24/2022 documented in part, "...Testing: 1. Centers will follow Federal and State regulations for testing of staff and residents...Documentation: Outbreak Investigation (defined as any single new infection in staff or any nursing home onset infection in a resident) includes: Date case was identified. Date other residents and staff were tested. Date residents and staff were retested. Results of all test. Outbreak testing strategy used and rationale (contact tracing or broad-based testing)..."

On 10/26/2022 at 3:50 p.m., ASM #1, the executive director, ASM #2, the assistant director of clinical services and ASM #3, the regional director of nursing were made aware of the findings.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 888 SS=C	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.	F 888	1.The facility recognizes that it failed to implement their COVID 19 vaccination policy and procedures to ensure staff were fully vaccinated. 2. All residents have the potential to be impacted by the alleged deficient practice. The human Resource coordinator will conduct a quality review of staff to obtain their vaccination status and this information will be updated on the staff matrix form as indicated. 3. The Human Resource coordinator, staffing coordinator and department heads will be educated by the Executive Director on: the staff vaccination policy, staff matrix and obtaining staff vaccination status upon hire/assignment. The Human Resource Coordinator will review new hires in the am meeting and will confirm that their vaccination status has been obtained and this information will be documented on the staff matrix. 4. The Executive Director/designee to conduct quality monitoring of 10 staff vaccination status, weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the Regional Director of Clinical Services/designee.	12/07/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 888	Continued From page 44 §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 888	Continued From page 45 documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 888	Continued From page 46 the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined the facility staff failed to implement their COVID-19 vaccination policy and procedures to ensure staff were fully vaccinated for one of eight staff members reviewed, OSM (other staff member) #8. The findings include: On 10/25/2022 at approximately 2:00 p.m., a request was made to ASM (administrative staff member) #2, the assistant director of clinical services for a completed COVID-19 Staff Vaccination Matrix or a list containing the same information. After a review of the COVID-19 Staff Vaccination Matrix received from ASM #2, a sample of eight staff members were chosen to review for COVID-19 vaccination compliance. On 10/26/2022 at 8:25 a.m., a request was made to ASM #2 for evidence of COVID-19 vaccination for four facility employees and four contract employees, including OSM #8, the dietary aide. On 10/26/2022 at approximately 11:45 a.m., ASM #2 provided a copy of OSM #8's COVID-19 Vaccination Record card with a first dose of the Pfizer COVID-19 vaccine (1) documented as given on 8/23/2022. The vaccination record failed to evidence the second dose of the vaccine administered.	F 888		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 888	Continued From page 47	F 888		

According to Centers for Disease Control, it documented in part, "...People ages 12 years and older, especially those at higher risk of myocarditis associated with mRNA COVID-19 vaccines, may receive the second primary dose of the COVID-19 vaccine by Pfizer BioNTech 3-8 weeks after the first primary dose. The second dose should not be received earlier than 3 weeks after the first dose. People ages 12 years and older who recently had SARS-CoV-2 infection may receive a second primary dose after a deferral period of 3 months from symptom onset or positive test (if infection was asymptomatic). (2)

On 10/26/2022 at approximately 12:21 p.m., a request was made to ASM #2 for evidence of the second dose of the COVID-19 vaccine for OSM #8 or documentation for temporary delay.

On 10/26/2022 at 2:02 p.m., an interview was conducted with ASM #2, the assistant director of clinical services. ASM #2 stated that they were still researching OSM #8's COVID-19 vaccine and they should have received the second vaccine by now. ASM #2 stated they had contacted [Name of Pharmacy] and the staff member and she had gotten the second vaccine but they had not faxed over the evidence of it nor had it been updated on the vaccine website yet. OSM #8 was out of the facility and unable for interview.

The facility policy, "COVID-19 Vaccinations" dated 10/13/2022 documented in part, "The Company requires that all eligible staff be fully vaccinated against COVID-19 in compliance with applicable laws, rules and regulations. This policy applies to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 888	Continued From page 48	F 888		

the following eligible personnel, both current and new: Care center employees. Personnel providing support to Company Care Centers...Providers who are contracted with the company to deliver care to residents..." The policy further documented, "...Eligible personnel are required to have received their second dose of a two dose vaccine series by February 28, 2022. New hires will be subject to the same requirements as current staff and must have received, at a minimum; the first dose of a two-dose COVID-19 vaccine; a one-dose COVID-19 vaccine; or have submitted a request for medical or religious exemption, by the regulatory deadline or prior to providing any care, treatment, or other services for the facility and/or its patients..."

On 10/26/2022 at 3:50 p.m., ASM #1, the executive director, ASM #2, the assistant director of clinical services and ASM #3, the regional director of nursing were made aware of the findings.

No further information was provided prior to exit.

(1) Pfizer COVID-19 vaccine
On August 23, 2021, FDA announced the first approval of a COVID-19 vaccine. The vaccine has been known as the Pfizer-BioNTech COVID-19 Vaccine, and the approved vaccine is marketed as Comirnaty, for the prevention of COVID-19 in individuals 12 years of age and older.
Comirnaty is a monovalent COVID-19 vaccine that is approved for use as a two-dose primary series for the prevention of COVID-19 in individuals 12 years of age and older. It is also authorized for emergency use to provide a third primary series dose to individuals 12 years of age

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495362	A. BUILDING _____ B. WING _____	C 10/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASHLAND NURSING AND REHABILITATION	906 THOMPSON STREET ASHLAND, VA 23005

(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 888	Continued From page 49 and older with certain kinds of immunocompromise. This information was obtained from the website: https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/pfizer-biontech-covid-19-vaccines (2) This information was obtained from the website: https://www.cdc.gov/vaccines/covid-19/eui/downloads/Pfizer-Caregiver.pdf.	F 888		