STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 12/28/2022 through 12/29/2022. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint (VA00057178 - substantiated with deficiency) was investigated during the survey. The census in this 80 certified bed facility was 73 at the time of the survey. The survey sample consisted of 3 resident reviews.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide safe assistance for transfers for 2 Residents (Resident #1, Resident #2) in a sample size of 3 Residents. Resulting in harm for Resident #1. The findings included: 1) For Resident #1, the facility staff failed to safe transfer from the bed to the wheelchair on	F 689	F689 Based on observation, Resident interview, staff interview, clinical record review, facility documentation review, and in the course of the complaint investigation, the facility staff failed to provide safe assistance for transfers for 2 Residents (Resident #1, Resident #2) in a sample size of 3 residents, resulting in harm for Resident # 1. 1. Resident #1 was interviewed and reports no issues with unsafe transfers	2/10/23

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

Electronically Signed | 01/17/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 689	Continued From page 1 11/10/2022 resulting in right distal femoral fracture which required surgical intervention. This is harm. On 12/28/2022 and 12/29/2022, Resident #1's clinical record was reviewed. According to Resident #1's annual Minimum Data Set with an Assessment Reference Date of 09/01/2022, Resident #1's Brief Interview for Mental Status was coded as "15" out of possible "15" indicative of intact cognition. Functional status for transfers was coded as requiring extensive assistance from staff with 2+ persons for physical assistance and support. Diagnoses included but were not limited to hemiplegia following cerebral infarction affecting the right dominant side and a left below-the-knee amputation. A care plan problem dated 08/03/2021 entitled, "[Resident #1] is at risk for impaired Quality of Life" included but was not limited to the following intervention: "Encourage resident to allow use of lift x 2 staff for transfers out of bed." On 12/28/2022 at approximately 10:55 A.M., Resident #1 was interviewed. When asked about the fall that occurred in November 2022, Resident #1 stated that the CNA (certified nursing assistant) entered the room and told Resident #1 that they needed to be weighed in a weight chair. Resident #1 stated that she informed the CNA (CNA B) she wanted to use the slide board to transfer from the bed to her wheelchair and then transfer to the weight chair. Resident #1 then stated that the CNA didn't listen to her and tried to transfer Resident #1 from the bed to the weight chair without using a slide board or first donning Resident #1's prosthetic leg. Resident #1 then stated she fell to the floor. Resident #1 stated she	F 689	since the incident on 11/10/2022. Staff member who failed to follow Resident #1's plan of care is no longer employed. Resident #2 sustained no injuries during the transfer. The staff member involved in the transfer was educated and performed a return demonstration on proper use of the total lift. 2. Current residents who require a mechanical lift for transfers have been observed at least once during transfer to ensure staff provide safe assistance. 3. Nurses were reeducated on how to pull resident transfer status information to provide to Certified Nurse Aides. Certified Nurse Aides were reeducated on “How to Properly Provide Safe Assistance for Resident Transfers”. This education includes a return demonstration on the proper use of the sit to stand and total lifts and where the resident specific transfer status can be found. 4. The DON/Designee will observe five transfers per week for eight weeks to ensure the staff involved in the transfer are conducting the transfer properly and per plan of care. Any variances observed will be immediately corrected. The DON/ designee will review the audit results for any patterns or trends and report any findings to our Quality Assessment and Assurance Committee. 5. All corrective actions will be completed by February 10, 2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 689	Continued From page 2	F 689		

was in a lot of pain (right leg) after the fall and eventually went to the hospital and had to have surgery.

On 12/28/2022 at approximately 11:00 A.M., Resident #1 called a family member to discuss the incident with the surveyor. When asked about the fall that occurred in November 2022, the family member stated that (Resident #1) told the CNA there should be 2 people to conduct the transfer but the CNA attempted the transfer alone.

On 12/28/2022 at 11:30 A.M., CNA B was interviewed. CNA B verified they have worked at the facility approximately 6 months. When asked about the fall that occurred in November 2022 involving Resident #1, CNA B stated that the nurse told her to weigh (Resident #1). CNA B then stated that (Resident #1) refused to don the leg prosthesis and that Resident #1 told the CNA she could stand and get in the chair without it. CNA B stated she then assisted Resident #1 to stand and pivot but that Resident #1 "missed the chair" and went to the floor. CNA B stated that Resident #1's right leg bent under her and the CNA was unable to hold (Resident #1) up." CNA B stated that after the incident, staff told her she should've used a "hoyer" (which is a mechanical lift). When asked about the process for knowing how to transfer each Resident, CNA B stated that, after the incident, she was told about a worksheet that listed how each Resident is to be safely transferred but she was unaware of the worksheet at the time. When asked if she currently had a worksheet, CNA B indicated she did not have a worksheet but they're kept in a book at the nurse's station. When asked to see the book, CNA B was unable to locate it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 689	Continued From page 3	F 689		

On 12/28/2022 at approximately 12:00 P.M., Registered Nurse B (RN B) was interviewed. When asked about the worksheets, RN B verified that nurses are supposed to print out the CNA Worksheet and give it to the CNA's. When asked if this was done today, RN B stated she printed some out yesterday and put them in the book at the (Liberty) nurse's station. When asked to see the book, it did not contain any CNA worksheets. A staff member nearby then printed out a CNA worksheet. For Resident #1 under "Transfer Notes", it was documented, "Hoyer lift only when resident declining to use prosthetic." Under the column entitled, "Minimum Transfer Assist" it was documented, "Total lift, Assist x 2 [meaning 2 people]."

On 12/28/2022 at approximately 12:25 P.M., Employee G, occupational therapy assistant, was interviewed. When asked about transfer options for Resident #1 prior to the fall in November 2022, Employee G stated that therapy was working with Resident #1 to use a sliding board with moderate assistance (meaning Resident #1 needed cues for leaning forward) or a step and shift over (when prosthetic was on) and only with therapy staff. Employee G stated that nursing staff was told to use a mechanical lift for safety. When asked about the weight chair, Employee G stated that weights can be obtained on the mechanical lift and the weight chair should not be used for anyone who cannot safely transfer.

An excerpt of a physician's progress note dated 11/10/2022 under the header "History of Present Illness" documented, " ...being seen today for fall which resulted in RT [right] knee pain and lower leg pain. She fell while transferring."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 689	Continued From page 4	F 689		

A radiology report dated 11/10/2022 documented the following excerpts:
"History: Fall. Findings: a distal femoral fracture is seen with lateral positioning and shortening. The fracture looks acute."

An excerpt of a physician's progress note dated 11/10/2022 under the header "History of Present Illness" documented, " ...presents following hospitalization at [hospital name redacted] on 11/10/2022 after mechanical fall that resulted in a right distal femoral fracture. She underwent a nailing procedure for this." "She does have some pain associated with the injury aggravated with activity and relieved adequately with her current pain management regimen."

On 12/29/2022 at approximately 12:15 P.M., the Assistant Administrator and Director of Clinical Support were notified of findings. When asked if staff were supposed to use a mechanical lift to transfer Resident #1 prior to the fall on 11/10/2022, the Director of Clinical Support referred to a CNA Worksheet dated 11/09/2022 and stated a hoyer should've been used if the Resident (#1) refused to wear the leg prosthetic. The Director of Clinical Support also referred to a quarterly Transfer Assistance Evaluation dated 09/02/2022 which documented the following excerpt: "Based on the above evaluation, the resident will be transferred with the minimum assistance of: Total lift with at least two staff members."

On 12/29/2022 at approximately 1:45 P.M., the Assistant Administrator and the Director of Clinical Support stated there was no further documentation or information to submit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 689	Continued From page 5	F 689		

2) For Resident #2, the facility staff failed to operate the mechanical lift according to manufacturers instructions while transferring Resident #2 from the shower chair to the bed on 12/28/2022.

On 12/28/2022 at approximately 11:15 A.M., Resident #2 was observed seated in a shower chair in her room. Certified Nursing Assistant C (CNA C) and another CNA were positioning the mechanical lift in preparation to transfer Resident #2 to her bed. CNA C moved the mechanical lift legs under the shower chair from the left side of the chair. CNA C and the other CNA activated the lift, rolled the lift away from the shower chair, transferred Resident #2 to the bed, and lowered the lift. At no time in the process (lifting/lowering) did the facility staff open the lift legs to widen the base. After the procedure and exiting the room, CNA C was interviewed. When asked about the process for opening the lift legs, CNA C explained that if the shower chair was approached from the front of the chair, the lift legs would need to be opened but since the chair was approached from the side, it wasn't necessary to open the lift legs.

On 12/28/2022, the facility staff provided a copy of the manufacturers instructions for the lift. On pg 4 of the instructions under the header, "Warnings" an excerpt documented, "Patient lift may tip over if used incorrectly. Read and adhere to the operating instructions prior to lifting anyone." On page 5, an excerpt documented, "Warning: During lifting or lowering, whenever possible, always keep the patient lift legs in maximum open position."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING _____ B. WING _____	C 12/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 689	Continued From page 6 On 12/28/2022 at approximately 5:00 P.M., the Director of Clinical Support was notified of findings. The Director of Clinical Support stated the expectation is to spread the base of the mechanical lift for stability.	F 689		