STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495333	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 1/24/23 through 1/31/23. Three (3) complaints (VA00057512 - substantiated with a related deficiency; VA00057431 - substantiated with no related deficiency; VA00056706 - substantiated with a related deficiency) were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 132 certified bed facility was 128 at the time of the survey. The survey sample consisted of eight (8) current resident reviews and four (4) closed record reviews.	F 000		
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 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	F 609		2/24/23

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

Electronically Signed | 02/19/2023

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F 609	Continued From page 1 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, clinical record review, and facility document review, the facility staff failed to report an incident of alleged resident abuse within two (2) hours of being aware the allegation for two (2) of 12 sampled residents, Resident #4 and Resident #10. The findings included: 1. The facility staff failed to report, with in the required time frame, an allegation of a bed-control remote striking Resident #4 in the face when it was tossed to them by a facility staff member. Resident #4 had a minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/9/22, dated as completed on 12/16/22. Resident #4 was assessed as able to make self understood and as able to understand others. Resident #4's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact and/or borderline cognition. Resident #4 was assessed as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene.	F 609	F Tag 609 Reporting of Alleged Violations This Plan of Correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the areas cited have been made and the facility is following participation requirements. 1. Alleged abuse was reported and investigated for resident #4 and # 10. 2. All residents have the potential to be affected. An audit of all grievances was conducted to ensure all concerns have been investigated and resolved. Administrator/ Designee to ensure that any grievances logged did not require further reporting as allegations of abuse. Residents with appropriate BIM scores were interviewed to ensure they had no concerns about the care they have received from staff. 3. Administrator/Designee has educated all staff that all allegations should immediately be reported to the Administrator/DON for review. All staff have been educated on the types of	

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F 609	Continued From page 2 On 1/27/23 at 8:46 a.m., the facility's Regional Director of Operations (RDO) notified the survey team of a new facility reported incident (FRI). The RDO reported there was a delay in reporting this allegation. Documentation provided to the survey team indicated, on the morning of 1/25/23, Resident #4 reported a staff member had tossed a remote control to her resulting in the remote control striking them in the face. The surveyor interviewed Certified Nurse Aide (CNA) #6 on 1/30/23 at 3:45 p.m. CNA #6 reported on the morning of 1/25/23 (CNA #6 was unsure of the time) that Resident #4 alleged CNA #6 had hit the resident with a remote. CNA #6 reported they had handed the remote to the resident; CNA #6 denied tossing the remote to the resident. On 1/27/23 at 9:13 a.m., the surveyor interviewed Resident #4 about the alleged event. Resident #4 stated a staff member was angry with them and tossed them a remote control that struck them in the face. On 1/27/23 at 9:43 a.m., Administrative Staff Member (ASM) #6 reported they became aware of Resident #4's aforementioned allegation on 1/25/23 at approximately 7:00 a.m. ASM #6 reported they obtained statements from the facility staff members involved prior to them leaving the building after their shift. The following information was found in a facility document titled "Abuse Investigation and Reporting" (this document was not dated): "An alleged violation of abuse, neglect, exploitation, or	F 609	abuse and how to effectively communicate allegations. 4. All grievances will be reviewed daily in Stand up to ensure they are investigated for prompt resolution and that further reporting and investigation is not necessary. Administrator/Designee will audit the grievance log weekly x 4 weeks and then monthly x 2 months to ensure all grievances are reported and investigated properly. Any issues identified will be addressed immediately. The Administrator/Designee will identify any trends and /or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly to review compliance. All allegations will be reviewed 5x week at stand up and stand down meetings to ensure concerns are investigated properly. 5. Date of Compliance: 2/24/23	

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F 609	Continued From page 3	F 609		

mistreatment (including injuries of unknown source and misappropriation or resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse ..."

The facility staff provided the survey team with evidence of the aforementioned allegation being reported to the required individuals/agencies on 1/26/23 at approximately 6:45 p.m.

On 1/31/23 at 11:18 a.m., the survey team met with the facility's Regional Director of Operations, Regional Nurse Consultant, and Assistant Director of Nursing. The delay in reporting the aforementioned allegation of abuse was discussed for a final time; no additional information was provided to the survey team.

2. The facility staff failed to report, with in the required time frame, an allegation of Resident #10 being place in and prevented from leaving a room in the facility.

Resident #10 had a minimum data set (MDS) assessment completed, with an assessment reference date (ARD) of 11/18/22. Resident #10 was assessed as usually able to make self understood and as usually able to understand others. Resident #10 Brief Interview for Mental Status (BIMS) summary score was documented as a three (3) out of 15; this indicated severe cognitive impairment. Resident #10 was assessed as requiring assistance with bed mobility, toileting, dressing, transfers, and personal hygiene.

The following information was found in a facility document titled "Abuse Investigation and

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Reporting" (this document was not dated): "An alleged violation of abuse, neglect, exploitation, or mistreatment (including injuries of unknown source and misappropriation or resident property) will be reported immediately, but not later than: a. Two (2) hours if the alleged violation involves abuse ..."

On 1/26/23 at 9:10 a.m., Administrative Staff Member (ASM) #6 was interviewed about an allegation that facility staff members were keeping Resident #10 from exiting a room against the Resident #10's wishes. ASM #6 reported Licensed Practical Nurse (LPN) #6 notified them on 11/7/22 at approximately 10:00 a.m., that another resident had reported seeing a staff member block Resident #10 from leaving a room by placing a chair between Resident #10 and the door exiting the room. ASM #6 stated they had reported this to the Assistant Director of Nursing (ADON). On 1/26/23 at 9:45 a.m., LPN #6 confirmed they had reported this allegation to ASM #6.

The facility staff provided the survey team with evidence of the aforementioned allegation being reported to the required individuals/agencies on 11/16/22.

The surveyor interviewed the facility's Regional Director of Operations and Director of Nursing (DON) about the delay in reporting the allegation that Resident #10 had been prevented from exiting a room at the facility. The DON acknowledged the allegation should have been reported within the two (2) hour time frame.

On 1/31/23 at 11:18 a.m., the survey team met with the facility's Regional Director of Operations,

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F 609	Continued From page 5 Regional Nurse Consultant, and Assistant Director of Nursing. The delay in reporting the aforementioned allegation of abuse was discussed for a final time; no additional information was provided to the survey team.	F 609		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		2/24/23

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F 656	Continued From page 6 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan (CCP) regarding refusal of Activity of Daily Living care (ADL's) for 1 of 12 residents, Resident #4. The findings included: The facility staff failed to develop a CCP when the resident refused ADL care regarding bathing/showers. Resident #4's diagnoses included, but were not limited to, unspecified dementia and need for assistance with personal care. Section C (cognitive patterns) of Resident #4's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/09/22 included a brief interview for mental status (BIMS) summary score of 14 out of a possible 15 points. Indicating the resident was alert and orientated. Section G (functional status) had been coded 3/3	F 656	F Tag 656 Develop/Implement Comprehensive Care Plan This Plan of Correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the areas cited have been made and the facility is following participation requirements. 1. The Care Plan for resident #4 was updated to reflect the resident□s chronic refusal of showers. 2. All residents have the potential to be affected. An audit of all residents with chronic refusals has been completed by the ADON. Care Plans were updated to reflect their current behaviors. 3. DON/Designee has educated all Clinical Staff to document all resident refusals of care. Unit Managers will review notes and ensure the behavior is	

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F 656	Continued From page 7 extensive assistance of 2 people for transfers, 3/2 extensive assistance of one person for personal hygiene. Bathing was coded 8/8 activity itself did not occur. Resident #4's CCP included the focus area has ADL self-care performance deficit. Interventions included, but were not limited to, physical assist as needed with ADL's and requires staff assistance with personal hygiene and oral care. A review of Resident #4's clinical record revealed that for the month of January 2023, the facility staff had documented Resident #4 had received a shower on 01/17/23, refusals were documented on 01/03, 01/10, 01/13, and 01/25/23. The facility staff had documented not applicable for 01/07, 01/21, and 01/28/23. For the month of December 2022, the facility nursing staff documented Resident #4 had refused a bath on 12/07, 12/10, 12/14, 12/16, and 12/20/22. The nursing staff documented not applicable for 12/03, 12/23, 12/28, 12/30/22. 01/31/23 8:33 a.m., Licensed Practical Nurse (LPN) #7 was asked why the refusals for bathing had not been care planned (CP) and stated anything episodic the nurses would complete. 01/31/23 at approximately 9:00 a.m., LPN #8 (agency nurse) stated they did not do CCP. 01/31/23 10:55 a.m., LPN #7 stated Resident #4's refusals of ADL care should have been care planned. 01/31/23 11:20 a.m., the Regional Nurse Consultant, Assistant Director of Nursing, and Regional Director of Operations were made	F 656	recorded on the resident□s care plan during daily clinical meeting. 4. The DON/Designee will audit care plans of all residents with behaviors weekly x4 and then monthly x2 to ensure care plans have been updated. Any issues identified will be addressed immediately. The DON/Designee will identify any trends and/or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly to review compliance. 5. Date of compliance: 2/24/23	

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F 656	Continued From page 8 aware of the issue with the development of the CCP regarding bathing/showering refusals. 01/31/23 11:37 a.m., Registered Nurse (RN) #3 stated they would only do what the care area assessment (CAA) flagged and if the unit manager was aware of an issue with bathing it should have been CP. 01/31/23 11:50 a.m., Administrative Staff #6 reviewed Resident #4's CCP, stated it wasn't individualized, and the refusals should have been CP. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, resident interview and during the course of a complaint investigation, the facility staff failed to provide Activities of Daily Living care to three of 12 residents. Residents #2, #7, and #4. The findings included: 1. For resident #2 the facility staff failed to provide activity of daily living (ADL) care, specifically bathing. Resident #2's diagnoses include but are not	F 677	F Tag 677 ADL Care Provided for Dependent Residents This Plan of Correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that deficiencies existed or that we agree with them. It is an affirmation that corrections to the areas cited have been made and the facility is following participation requirements. 1. Resident # 2 and 4 have received	2/24/23

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F 677	Continued From page 9 limited to; nondisplaced unspecified condyle fracture of the lower end of the right femur, dysphagia, generalized muscle weakness, difficulty walking and other reduced mobility. Resident #2 was interviewed during the initial tour of the facility on 1/24/23 at 2:30 P.M. Surveyor asked if they were getting showers since admission and they replied, "not too many". She reported that she enjoyed her showers when she was able to get them. Resident stated that she thought she would be getting one on 1/24/23, but so far no one had come to do it. She stated that Occupational Therapy had assisted her with maintaining her hygiene during the course of her stay and that she was able wash off at the sink as she needed to. Resident #2 had a neat, clean appearance. On 1/25/23 at 9:42 A.M. surveyor asked resident if she had gotten a shower the previous day and she said she had not. On 1/26/23 at 10:14 A.M. resident reported that she did get a shower the afternoon of 1/25/23. The admission minimum data set (MDS) with an assessment reference date (ARD) of 12/20/22 assigned resident #2 a brief interview for mental status (BIMS) score of 15 which indicates they are cognitively intact. Under section G resident #2 was coded as needing physical assistance in part of the bathing activity. Resident #2's care plan included a focus area for ADL self-care performance deficit as evidenced by impaired physical mobility due to right femur fracture with surgical repair. Interventions included physical assistance as needed with ADL's. Clinical record review revealed that no showers or	F 677	their shower during survey. Resident #10 discharged prior to survey. 2. All residents have the potential to be affected. An audit of the current residents was completed by ADON/designee to ensure showers have been completed. If not, investigated the reason and ensured the resident agreed with shower assignment. Schedules revised as indicated by resident. 3. DON/Designee has educated all clinical staff on the shower assignments and the policy for providing assistance with personal hygiene to include offering showers a minimum of 2 times per week. All shower documentation will be reviewed daily by the Unit Managers during the daily Clinical Meeting. 4. The DON/Designee will audit all ADL records weekly x4 and monthly x2 to ensure all ADL care has been completed as ordered. Any issues identified will be addressed immediately. The DON/Designee will identify any trends and/or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly to review compliance. 5. Date of Compliance: 2/24/23	

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baths were scheduled or documented for resident #2 in the month of December 2022. There was one refusal documented for 12/29/22. Resident #2 was admitted to the facility on December 15, 2022. For the month of January, a shower for 1/13/23 was scheduled but not given, a shower for 1/24/23 was scheduled but not given. A refusal for 1/2/23 was documented as well as for 1/6/23.

LPN #2 was interviewed on 1/26/23 at 8:33 A.M. regarding the expectation for showers on the unit. They replied, "It's twice per week and as needed. If time and staffing permit and they ask for more, we do more. If a shower is missed, it's put on for the next day. If a shower is refused, the nurse is to document it and the physician and responsible party are notified".
Surveyor asked for and received a copy of the policy entitled, "Activities of Daily Living (ADLs)". The policy is not dated and reads in part, "Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly or as required by state law. Residents' preference and/or whose medical conditions prohibit tub or shower baths shall have a sponge bath daily".
The surveyor met with and discussed this issue with the acting Administrator, Regional Nurse Consultant and Assistant Director of Nursing on 1/30/23 at 4:02 P.M. and again 1/31/23 at 11:18 A.M. No further information was provided to the surveyor team prior to exit.

2. For resident #7 the facility staff failed to provide ADL care, specifically bathing. This was a closed record review.

Resident #7's diagnoses included but were not limited to heart failure, chronic obstructive

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pulmonary disease, morbid obesity, other chronic pain, bipolar disorder without psychotic features, depression, anxiety, spinal stenosis and generalized muscle weakness.
The most recent Minimum Date Set (MDS) with an Assessment Reference Date (ARD) of 8/11/22 was reviewed. In section C, Cognitive Patterns, resident #7 was assigned a Brief Interview for Mental Status (BIMS) score of 15 indicating they were cognitively intact. Under section G, functional status, for bathing resident #7 was coded an 8/8 which means the activity did not occur.

The comprehensive care plan for resident #7 included a focus area for an ADL self-care performance deficit as evidenced by impaired mobility. Interventions included physical assistance as needed with ADLs.

On 1/25/23 the surveyor asked for and received a printed copy of resident #7's bathing documentation for July and August 2022. Resident was scheduled for baths on Tuesdays and Fridays. There were blanks noted on the record for Friday August 5, Friday August 26, and Tuesday August 30. There were no refusals documented.

LPN #2 was asked about the expectation for showers on 1/26/23 at 8:33 A.M. and stated, "it's twice per week and as needed, if time and staffing permit and they ask for more, we do more". LPN #2 was asked if there was anywhere other than the medical record that showers would be documented, and she stated no, a daily shower assignment sheet has been recently implemented but was not in place at the time resident #7 was in the facility.

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The policy entitled, "Activities of Daily Living (ADLs)", was asked for and received 1/26/23. The policy was not dated and reads in part, "Each resident shall receive tub or shower baths as often as needed, but not less than twice weekly or as required by state law. Residents whose preference and/or whose medical conditions prohibit tub or shower baths shall have a sponge bath daily".
These issues were discussed with the acting Administrator, Regional Nurse Consultant and Assistant Director of Nursing on 1/30/23 at 4:02 P.M. and again 1/31/23 at 11:18 A.M. No further information was provided to the surveyor team prior to exit.

3. For Resident #4, the facility staff failed to provide bathing assistance. Resident #4 did not receive a bath/shower in December 2022 and had only received 1 bath/shower in January 2023.

Resident #4's diagnoses included, but were not limited to, unspecified dementia and need for assistance with personal care.

Section C (cognitive patterns) of Resident #4's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/09/22 included a brief interview for mental status (BIMS) summary score of 14 out of a possible 15 points. Indicating the resident was alert and orientated. Section G (functional status) had been coded 3/3 extensive assistance of 2 people for transfers, 3/2 extensive assistance of one person for personal hygiene. Bathing was coded 8/8 activity itself did not occur.

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Resident #4's comprehensive care plan (CCP) included the focus area has activities of daily living (ADL) self-care performance deficit. Interventions included, but were not limited to, physical assist as needed with ADL's and requires staff assistance with personal hygiene and oral care.

A review of Resident #4's clinical record revealed for the month of January 2023, the facility staff had documented Resident #4 had received a shower on 01/17/23, refusals were documented on 01/03, 01/10, 01/13, and 01/25/23. The facility staff had documented not applicable for 01/07, 01/21, and 01/28/23. For the month of December 2022, the facility nursing staff documented Resident #4 had refused a bath on 12/07, 12/10, 12/14, 12/16, and 12/20/22. The nursing staff documented not applicable for 12/03, 12/23, 12/28, 12/30/22. Indicating Resident #4 did not receive any bath/showers in December 2022.

01/30/23 1:45 p.m., Resident #4 was observed up in their wheelchair. When asked if they received baths and/or showers Resident #4 stated they currently had pneumonia and was unable to shower. When asked if they were receiving baths and/or showers prior to being diagnosed with pneumonia Resident #4 stated off and on.

Review of the clinical record revealed that on 01/26/23 the provider began treatment for pneumonia.

01/30/23 4:00 p.m., the Regional Nurse Consultant, Regional Director of Operations, and Assistant Director of Nursing were made aware that Resident #4 did not receive a bath/shower in December 2022 and only received 1 shower in

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F 677	Continued From page 14 January 2023. 01/31/23, the facility provided the surveyor with a copy of their policy titled, "Shower/Tub Bath" this policy read in part, "...At a minimum, the resident will be offered at least 2 full baths or showers per week..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 677		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		2/24/23

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F 812	Continued From page 15 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and facility document review, the facility staff failed to serve food in a manner that would decrease the risk of resident food becoming contaminated for two (2) of 12 sampled residents, Resident #11 and Resident #12. The findings include: On 1/25/23 at 11:58 a.m., the surveyor observed Certified Nurse Aide (CNA) #4 filling up resident drinking cups with ice. CNA #4 held two (2) resident drinking cups against their shirt while using a scoop to fill the cups with ice. On 1/25/23 at 12:02 p.m., the surveyor observed CNA #3 setting up Resident #12's mid-day meal. CNA #3 was observed to touch Resident #12's dinner roll with the their (CNA #3's) bare hands. On 1/25/23 at 12:37 p.m., the surveyor observed CNA #3 setting up Resident #11's mid-day meal. CNA #3 was observed to touch Resident #11's sandwich with their (CNA #3's) bare hands. The following information was found in a facility document titled "Food Preparation and Service" (this document was not dated): "Bare hand contact with food is prohibited. Gloves are worn when handling food directly and changed between tasks." The surveyor discussed the aforementioned meal service observations during a survey team meeting with the Regional Director of Operation, the Director of Nursing (DON), and the Assistant	F 812	F Tag 812 Food Procurement, Store /Prepare/Serve- Sanitary This Plan of Correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the areas cited have been made and the facility is following participation requirements. 1. Water pitchers were swapped out with new and clean pitchers. Resident #12 was offered another roll. Resident #11 was offered another sandwich. 2. All residents have the potential to be affected. ADON/Designee have observed meals and ice pass to ensure there is no cross contamination. 3. DON/Designee has educated all clinical staff on proper food handling for setting up meal trays and proper etiquette for passing ice to ensure no cross contamination. 4. The DON/Designee will continue to observe meal preparation and ice pass weekly x4 and monthly x2. Any issues identified will be addressed immediately. The DON/Designee will identify any trends or patterns and will provide additional education on an ongoing basis. Findings will be presented to QAPI monthly to review compliance. 5. Date of Compliance: 2/24/23	

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F 812	Continued From page 16 Director of Nursing on 1/25/23 at 3:55 p.m. The DON reported the ice should have been scooped into the cups while the cups were sitting on the tray (instead of the staff member holding them against their shirt). The DON reported staff members should wear gloves or use the food item packaging when touching/manipulating a resident food items.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		2/24/23

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F 842	Continued From page 17 (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; (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, clinical record review,	F 842	F Tag 842 Resident Records □	

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F 842	Continued From page 18 and facility document review, the facility staff failed to ensure a complete and accurate clinical record for two (2) of 12 sampled residents, Resident #6 and Resident #10. The findings included: 1. The facility staff failed to document Resident #10's behaviors occurring on 11/6/22. Resident was having behaviors which resulting in a staff member providing one-on-one supervision and attempting to distract the resident. Resident #10 had a minimum data set (MDS) assessment completed, with an assessment reference date (ARD) of 11/18/22. Resident #10 was assessed as usually able to make self understood and as usually able to understand others. Resident #10 Brief Interview for Mental Status (BIMS) summary score was documented as a three (3) out of 15; this indicated severe cognitive impairment. Resident #10 was assessed as requiring assistance with bed mobility, toileting, dressing, transfers, and personal hygiene. On 1/26/23 at 9:10 a.m., the surveyor interviewed Administrative Staff Member (ASM) #6 about Resident #10's documentation. ASM #6 confirmed documented for 11/6/22 and 11/7/22 failed to include evidence of Resident #10 exhibiting behaviors. Resident #10 medication administration records (MARs) included an area for staff members to document the monitoring of behaviors. The staff was to document either: (1) "Y" if monitored and no identified behaviors were observed or (2) "N" if monitored and identified behaviors were	F 842	Identifiable Information This Plan of Correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the areas cited have been made and the facility is following participation requirements. 1. Resident #6 has discharged from the facility. Resident # 10 has a new order as of 1/25/23 for Behavior Monitoring Assessment weekly. 2. All residents have the potential of being affected. An audit of current residents with Behavior Monitoring has been completed by the ADON/Designee. 3. DON/Designee has educated the clinical staff on how to document behaviors and changes in resident condition effectively. 4. The DON/Designee will review the 24-hour report daily in Clinical Meeting 5 days a week for 12 weeks. Unit Managers will ensure all changes in condition and behaviors are documented thoroughly. The DON/Designee will identify any trends and /or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly to review compliance. 5. Date of Compliance: 2/24/23	

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observed. Resident #10's November 2022 MAR was reviewed. No "Y" or "N" were documented for the behavior monitoring; each shift had a check mark documented instead of the directed "Y" or "N".

On 1/30/23 at 3:21 p.m., the surveyor interviewed CNA #5 related to Resident #10's behaviors on 11/6/22. CNA #5 stated Resident #10 was going toward exit doors and becoming agitated. CNA #5 stated the resident was redirected to an office to attempt to decrease the agitation. CNA #5 stated Resident #10 threw a box of tissues at them (CNA #5). CNA #5 reported Resident #10 slammed themselves (Resident #10) back in a chair they were sitting in resulting in the door to the office closing. CNA #5 denied keeping Resident #10 from exiting the office/room. CNA #5 stated they did not document Resident #10's aforementioned behaviors but acknowledged they should have documented the behaviors.

The following information was found in a facility document titled "Charting and Documentation" (this document was not dated):
- "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, will be documented in the resident's medical record. The medical record will facilitate communication between the interdisciplinary team regarding the resident's condition and response to care."
- "Documentation in the medical record will be objective (no opinionated or speculative), complete, and accurate."

The following information was found in a facility document titled "Behavioral Assessment,

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Intervention and Monitoring" (this document was not dated): "The nursing staff and/or (interdisciplinary team) will identify, document, and inform the physician about specific details regarding changes in an individual's mental status, behavior, and cognition, including: a. Onset, duration, intensity, and frequency of behavioral symptoms ..."

On 1/26/23 at 2:45 p.m., the Director of Nursing (DON) confirmed there were no behaviors documented for Resident #10 on 11/6/22.

On 1/31/23 at 11:18 a.m., the survey team met with the facility's Regional Director of Operations, Regional Nurse Consultant, and Assistant Director of Nursing. The failure of facility staff to document Resident #10's behaviors on 11/6/22 was discussed for a final time; no additional information was provided to the survey team.

2. The facility staff failed to document changes in Resident #6's assessment for the time leading up to the resident's death. Resident #6 was reported to have experienced vomiting blood just prior to their death. Resident #6 had a Do Not Resuscitate (DNR) order.

Resident #6's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/25/22, was dated as being completed on 1/3/23. Resident #6 was assessed as being able to make self understood and as being able to understand others. Resident #6's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #6 was documented as requiring supervision with bed mobility, transfers, dressing,

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eating, and personal hygiene. Resident #6 was documented as receiving hospice care.

The following nursing documentation related to Resident #6's death was found in the resident' clinical record: "This nurse called to patient room due to change in condition, upon entering room, patient sitting in (wheelchair), no (respirations) noted, unable to obtain (a blood pressure), and no apical pulse (times three) minutes noted, pronounced at (time of death omitted), charge nurse notified, and will notify hospice." This note did not detail the resident's change in condition.

On 1/27/23 at 8:36 a.m., the facility Social Worker (SW) reported just prior to Resident #6's death, the resident had vomited blood.

On 1/30/23 at 5:01 p.m., the surveyor interviewed Registered Nurse (RN) #1 related to Resident #6's death. RN #1 reported that just prior to Resident #6's death, Resident #6 had vomited a "copious" amount of blood.

The following information was found in a facility document titled "Charting and Documentation" (this document was not dated):
- "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, will be documented in the resident's medical record. The medical record will facilitate communication between the interdisciplinary team regarding the resident's condition and response to care."
- "Documentation in the medical record will be objective (no opinionated or speculative), complete, and accurate."

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F 842	Continued From page 22 On 1/31/23 at 11:18 a.m., the survey team met with the facility's Regional Director of Operations, Regional Nurse Consultant, and Assistant Director of Nursing. The failure of facility staff to document Resident #6's change in condition (vomiting blood) prior to death was discussed; no additional information was provided to the survey team.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		2/24/23

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F 880	Continued From page 23 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, facility	F 880	F Tag 880 Infection Prevention and	

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HIGHLAND RIDGE REHAB CENTER	5872 HANKS STREET DUBLIN, VA 24084

(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 880	Continued From page 24 document review, clinical record review, and during the course of a complaint investigation, the facility staff failed to maintain an infection control and prevention program that ensured a safe, sanitary environment to decrease the risk of the development and/or transmission of communicable diseases and/or infections for three (3) of 12 residents in the survey sample, Resident #1, Resident #5, and Resident #9. The findings include: 1. The facility staff failed to ensure that an insulin pen, used to provide Resident #1's provider ordered insulin, had not been used on another resident. Resident #1's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 10/19/22, was dated as being completed on 10/27/22. Resident #1 was assessed as able to make self understood and as able to understand others. Resident #1's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact and/or borderline cognition. Resident #1 was documented as requiring assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. On 1/25/23 at 9:31 a.m., the facility's Director of Nursing (DON) reported an insulin pen, belonging to another resident, had been used to provide Resident #1 an insulin injection. On 1/25/23 at 12:37 p.m., the facility's DON stated Resident #1's family member reported, on 11/28/22, an insulin pen had been used on 11/25/22 and questioned why the insulin pen had	F 880	Control This plan of Correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the areas cited have been made and the facility is following participation requirements. 1. A new insulin vial was ordered and received 11/29/23 for resident #1. Stat supply was checked in the medication refrigerator and all insulins were available inside 11/28/23 if needed. Resident #5 passed prior to the survey. Glucometer was cleaned with a Sani wipe for resident #10. 2. All residents have the potential to be affected. An audit was conducted to ensure that all diabetics had their ordered insulin labeled in the medication carts. The STAT supply was also audited to ensure that all insulins were available in the locked medication refrigerators. An audit of all infections was conducted to ensure isolation orders have been written as needed and PPE/Biohazard cans available in the room. All glucometers have been thoroughly cleaned with the appropriate Sani wipe. 3. DON/Designee has educated all clinical staff on the importance of not sharing insulin pens, obtaining Isolation orders/providing PPE and biohazard containers, and how to clean the glucometer effectively with a Sani Wipe between residents. 4. DON/Designee will audit medication	

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F 880	Continued From page 25 not been used on 11/28/22. The DON stated they interviewed Registered Nurse (RN) #1 and discovered insulin had been administered to Resident #1 on 11/25/22 by RN #1 using an insulin pen that had not been labeled with a resident's name. (The DON reported on 11/28/22 a new insulin pen was ordered for the resident whose insulin pen was suspected to have been used for Resident #1.) On 1/25/23 at 2:14 p.m., the surveyor interviewed RN #1 via telephone. RN #1 reported they had provided, on 11/25/22, an insulin injection to Resident #1 using an insulin pen that was not labeled with a resident's name. RN #1 reported the insulin pen used was next to Resident #1's other insulin which had been labeled. RN #1 reported the insulin pen's seal had been broken and a small amount of the medication was missing. RN #1 stated they did not label the insulin pen and they did not return the insulin pen to the medication cart. RN #1 stated they placed the insulin pen on a shelf in the medication room (this was a locked room). RN #1 reported they had later discarded the insulin pen into a sharps box. RN #1 was unsure as to when they had discarded the insulin pen into a sharps box; RN #1 stated it could have been a couple of days later. On 1/25/23 at 2:55 p.m., the facility's DON confirmed a document provided to the survey team titled "NovoLog® insulin aspart injection 100 Units/mL" provided information on the type insulin pen referenced in this report. This document included the following information: "Never share a NOVOLOG® FlexPen® or a NOVOLOG® FlexTouch®, PenFill® cartridge or PenFill® cartridge device between patients, even if the	F 880	carts weekly x4 and then monthly x 2 to ensure insulin is available, labeled and stored properly in the medication cart. DON/Designee will conduct an audit of all infections will be completed weekly x4 and then monthly x2 to ensure isolation orders are in place and PPE / biohazard containers are available. DON/Designee will observe med passes weekly x 4 and then monthly x2 to ensure that glucometers are cleaned appropriately with a Sani Wipe. Any issues identified will be addressed immediately. The DON/Designee will identify any trends and/or patterns and additional education will be provided on an ongoing basis. Findings will be presented to QAPI monthly to review compliance. 5. Date of compliance: 2/24/23	

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needle is changed."

The following information was found as part of a Centers for Disease Control and Prevention (CDC) document titled "CDC Clinical Reminder: Insulin Pens Must Never Be Used for More than One Person" (this page was documented as last reviewed on January 4, 2012): "Insulin pens are pen-shaped injector devices that contain a reservoir for insulin or an insulin cartridge. These devices are designed to permit self-injection and are intended for single-person use. In healthcare settings, these devices are often used by healthcare personnel to administer insulin to patients. Insulin pens are designed to be used multiple times, for a single person, using a new needle for each injection. Insulin pens must never be used for more than one person. Regurgitation of blood into the insulin cartridge can occur after injection creating a risk of bloodborne pathogen transmission if the pen is used for more than one person, even when the needle is changed."

On 1/31/23 at 11:18 a.m., the survey team met with the facility's Regional Director of Operations, Regional Nurse Consultant, and Assistant Director of Nursing. The administration of insulin to Resident #1 using a previously used insulin pen which was not labeled with a resident's name was discussed; no additional information was provided to the survey team.

2. For resident #5 the facility staff failed to implement appropriate transmission-based precautions for clostridium difficile (C-Diff).
A complaint referring to resident # 5 reported that

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the resident had C-Diff and that staff were not using PPE while in the room caring for resident and there were no bio-hazard trash and/or laundry bins in the room.

This was a closed record review.

Resident #5's diagnoses included, but were not limited to: C-Diff, dementia, hypertension, chronic anemia, emphysema, atrial fibrillation, generalized weakness and anxiety.

The most recent minimum data set (MDS) with an assessment reference date (ARD) of 12-11-22 assigned a brief interview for mental status (BIMS) score of 6 out of 15 indicating moderate cognitive impairment.

The comprehensive care plan for resident #5 was reviewed. There was no focus for transmission-based precautions or for C-Diff noted in the care plan. Lab results indicating resident was positive for C-Diff were noted in the clinical record and dated 9/25/22, and a second positive result was noted on 12/7/22. There was a physician's order written on 12/7/22 that read, "Contact precautions for C-Diff, every shift". Surveyor was not able to locate a previous order for precautions.

LPN #2 was interviewed on 1/27/23 at 8:37 am and stated that she had been the nurse to put in the order for precautions on 12/7/22. She stated that the lab had called the positive results to the facility and that is what prompted them to put in the order. Surveyor asked about the process for initiating precautions once an order is obtained. LPN #2 stated that as the nurse, they would have then gone to set the room up appropriately with

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PPE, signs, and bio-hazard bins. LPN #2 was asked why precautions were not in place prior to 12/7/22 when resident #5 was first diagnosed in September, they were unable to answer as this was not their normal assignment in the facility. LPN #2 also stated that she felt as though precautions were already in place if the resident had been positive that long but could not definitively recall if that was so. Surveyor asked if precautions were already in place, would there need to be an order put in, they stated the order should have already been there if that was the case.

Regional nurse consultant was interviewed on 1/27/23 at 11:04 A.M. Surveyor asked if they would expect to see a physician's order for contact precautions put in when a resident tests positive for C-Diff, they replied "yes". When asked if they would expect to see precautions on the comprehensive care plan, they replied, "yes".

Administration staff #10 was interviewed on 1/26/23 at 9:45 A.M. Surveyor asked if she recalled resident #5 being on precautions for C-Diff. They replied that they did recall but was unsure when precautions were put in place. Stated that typically as soon as positive results are known the room would then be set up and equipped.

Surveyor received the policy entitled, "Transmission-Precautions" on 1/27/23. The policy is not dated and reads in part, "The facility will ensure systems and processes are in place for the prevention and spread of infectious diseases", and "Contact Precautions may be implemented for residents with known or suspected to be infected with microorganisms

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that can be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident care items in the resident's environment".

This concern was discussed with the acting Administrator, Regional Nurse Consultant and Assistant Director of Nursing on 1/30/23 at 4:02 P.M. and again 1/31/23 at 11:18 A.M. No further information was provided to the surveyor team prior to exit.

3. For resident #9, the facility staff failed to maintain processes to prevent the spread of infection and disease, and to ensure that Point of Care Devices are utilized safely, when used on multiple residents, by properly cleaning a glucose monitor between patients.
On 1/26/23 at 10:48 A.M. and during a medication pass observation for insulin administration, the surveyor observed LPN #4 obtain a blood glucose level on resident #9. LPN #4 utilized an alcohol prep pad to clean the glucose monitor before and after the procedure and then returned the meter to the medication cart.

Surveyor asked for the policy for cleaning glucose meters and received the policy entitled, "Point of Care Devices (Blood Glucose Meters/PT/INR Meters) Use and Cleaning". The policy is not dated and reads in part, "Point of Care Devices will be cleaned /disinfected utilizing an EPA approved chemical disinfectant solution or wipe per the device's manufacturer's recommendation or a solution of 10% bleach. Alcohol wipe will not be used for cleaning or disinfecting a point of care device".

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F 880	Continued From page 30 Surveyor asked for the User Instruction Manual for the device used in the procedure and received the booklet entitled, "Assure Prism Blood Glucose Monitoring System User Manual". The manual read in part, "The meter should be cleaned and disinfected after use on each patient. This blood glucose monitoring system may only be used for testing multiple patients when standard precautions and the manufacturer's disinfection procedures are followed. We have validated Clorox Healthcare Bleach Wipes, Dispatch Hospital Disinfectant Towels with Bleach, CaviWipes1, and PDI Super Sani-Cloth Germicidal Disposable Wipe for disinfecting the Assure Prism multi meter". This concern was discussed with the acting Administrator, Regional Nurse Consultant and Assistant Director of Nursing on 1/30/23 at 4:02 P.M. and again 1/31/23 at 11:18 A.M. No further information was provided to the surveyor team prior to exit.	F 880		