STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 Emergency Preparedness survey was conducted 10/25/2022 through 10/27/2022. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/25/2022 through 10/27/2022. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 69 at the time of the survey. The survey sample consisted of 17 current resident reviews and 3 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to follow physician orders for two (Resident # 64 & #43) of twenty residents in the survey sample. Resident #64 was administered artificial tears solution	F 684		

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Helene Molnar, Administrator 11.11.2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

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CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

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F 684	Continued From page 1	F 684		

instead of the physician ordered medicated eye drops (Refresh Optive solution). The medical devices (protective booties) were not applied to Resident #43's feet, as ordered by the physician.

The findings include:

1. Facility staff failed to administer medication as ordered by the physician. Resident #64 was admitted to the facility with diagnoses that included cerebral infarction, hypertension, dry eyes, anxiety and seizures. The MDS (minimum data set - cms assessment tool) dated 10/6/22 assessed Resident #64 as being cognitively intact for daily decision making.

A medication pass observation was conducted on 10/26/22 at 7:54 a.m. with licensed practical nurse (LPN) #3, administering medications to Resident #64. Among the medications administered was artificial tears labled 0.2%-0.2%-1% (glycerin-hypromellose-PEG 400), of which two drops were instilled in each eye.

Resident #64's clinical record documented a physician's order dated 8/26/22 for Refresh Optive solution 0.5-0.9% (carboxymethylcellul-glycerin) with instructions to instill two drops in each eye four times per day for dry eyes. There was no order for the artificial tears that were administered during the medication pass observation. Neither was artificial tears listed on the MAR (medication administration record).

On 10/26/22 at 8:35 a.m., LPN #3 was interviewed about the eye drops she had administered earlier to Resident #64's. When questioned about what eye drops were ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

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F 684	Continued From page 2	F 684		

by the physician, LPN #3 reviewed the orders and stated, "The order says Optive." When questioned if the eye drops were interchangeable, LPN #3 stated that the Refresh Optive drops and artificial tears were not the same product. When questioned why had she administered the artificial tears, LPN #3 stated that eye drops were "house stock" items and the artificial tears were the only drops in the medication cart.

On 10/26/22 at 10:16 a.m., the director of nursing (DON) was interviewed about Resident #64's eye drops. The DON stated the order should have been clarified and the prescription for Refresh Optive drops sent to the pharmacy. The DON stated the nurse administered the "house stock" artificial tears instead of the ordered Refresh Optive drops.

The facility's policy titled "Medication Reconciliation (revised 9/1/21)" documented that medication reconciliation "refers to the process of verifying that the resident's current medication list matches the physician's orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay..." The policy documented under daily processes, "...Verify medication labels match physician orders and consider 'rights' of medication administration each time a medication is given..."

This finding was reviewed with the administrator, DON and regional director of clinical services during a meeting on 10/26/22 at 4:15 p.m. No additional information was presented to the survey team prior to exiting the facility on 10/27/22 at 12:15pm.

2. The facility staff failed to implement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 684	Continued From page 3	F 684		

interventions for care and prevention of pressure ulcers, which were ordered for Resident #43. On 10/25/22 at 2:41 p.m., Resident #43 was observed seated in a reclining chair in her room. The resident had slipper socks on both feet. Resident #43 was observed again on 10/25/22 at 3:30 p.m. and on 10/26/22 at 10:00 a.m. seated in the reclining chair with slipper socks on both feet. During each of these observations, Resident #43's feet were elevated with heels resting directly on the footrests of the reclined chair, with no protective booties in use.

On 10/26/22 at 10:02 a.m., Resident #43 was observed still seated in the reclined chair without protective booties in use, but was then accompanied by certified nurses' aide (CNA) #1. Interviewed about the protective booties, CNA #1 stated that she sent the booties to the laundry that morning (10/26/22) because they were dirty. CNA #1 was observed searching the room, but did not locate another pair of protective booties.

On 10/26/22 at 10:26 a.m., the licensed practical nurse (LPN #3) caring for Resident #43 was interviewed. LPN #3 stated that the resident had a dressing to a pressure ulcer on the right heel. LPN #3 stated that the protective booties were soiled yesterday (10/25/22) and were sent to laundry for cleaning. Questioned further, LPN #3 responded that there was not another pair of booties to put on the resident, adding that she was not sure if the resident had a spare pair of booties.

On 10/26/22 at 10:30 a.m., LPN #3 was accompanied to observe Resident #43's right heel pressure ulcer. The resident had a circular pressure ulcer on the right heel approximately the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 684	Continued From page 4	F 684		

size of a 50-cent piece. The skin over the wound was dry, scaling with no surrounding redness or signs of infection.

The clinical record documented that Resident #43 received daily treatment for an unstageable pressure ulcer on the right heel. A physician's order dated 8/31/22 documented, "Maintain heel boots to bilat [bilateral] heels every shift." Last revised on 10/18/22, the Comprehensive Care Plan (CCP) documented that the Resident #43 had a right heel pressure ulcer, with interventions to heal and prevent ulcers, which included, "...Administer treatments as ordered and monitor for effectiveness..." The clinical record also documented that Resident #43 was admitted to the facility with diagnoses that included congestive heart failure, anxiety, dementia with behaviors, atrial fibrillation, mood disorder, deep tissue damage of right heel and depression. The MDS (Minimum Data Set - CMS assessment tool) dated 9/5/22 assessed Resident #43 with short and long-term memory problems, as well as moderately impaired cognitive skills.

On 10/26/22 at 2:39 p.m., the unit manager (LPN #1) was interviewed about Resident #43 not having the ordered medical devices in place. LPN #1 stated that the booties were supposed to be on the resident's feet at all times for protection and prevention of ulcers. LPN #1 stated that if the booties were soiled, staff should have obtained another pair. LPN #1 added that additional booties were available and that the resident "...should not have gone without..." [the protective boots].

The National Pressure Injury Advisory Panel (NPIAP) defines a pressure injury as, "localized

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

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F 684	Continued From page 5 damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device...The injury occurs as a result of intense and/or prolonged pressure..." These findings were reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 10/26/22 at 4:15 p.m. No additional information was provided to the survey team prior to exit at 12:15pm on 10/27/22.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 690	Continued From page 6	F 690		

prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interview, record review and facility document review, the facility staff failed to properly place a catheter drainage bag below the bladder for one of 20 residents in the survey sample. Resident #31's catheter drainage bag was observed improperly positioned above the bladder level during the survey.

The findings include:

Resident #31 was admitted to the facility with diagnoses that included neuromuscular dysfunction of the bladder, contractures of the right hand, left and right knee, depression, hypothyroidism, osteoporosis, sacral pressure wound, and multiple sclerosis. The most recent MDS (minimum data set -cms assessment tool) dated 8/24/22 was a Quarterly, which assessed Resident #31 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15, indicating cognitively intact for daily decision making. Under Section H - Bladder and Bowel, the MDS assessed Resident #31 as having a catheter and a colostomy.

Resident #31's clinical record was reviewed, which included physician's orders for the care and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 690	Continued From page 7	F 690		

maintenance of Resident #31's suprapubic catheter. The Comprehensive Care Plans included a focus area for the care and maintenance of suprapubic catheter, with Goals that included: (Resident #31) will be/remain free from catheter-related trauma through review date...." Interventions included "...check tubing for kinks.... Position catheter bag and tubing below the level of the bladder and away from the entrance room door..."

On 10/25/2022 at 1:50 p.m., Resident #31 was observed sitting in an electric wheelchair, in the facility's dayroom Although covered in a privacy bag, Resident #31's catheter drainage bag was positioned above the bladder, hooked onto the right upper side of the chair. Urine was observed in the tubing, which wound under the right arm of the electric wheelchair, towards the resident.

On 10/26/2022 at 12:11 p.m., Resident #31 was again observed sitting in the electric wheelchair, eating lunch in the facility's dining room. The catheter drainage bag was observed in a privacy bag and positioned above the resident's bladder and attached onto the back of the electric wheelchair. The catheter tubing was observed winding under the right arm of the electric wheelchair.

On 10/26/2022 at 3:12 p.m., a third observation of Resident #31 sitting in her electric wheelchair, while reading in her room. Again the catheter drainage bag was observed in a privacy bag and positioned above the resident's bladder, but attached to the back of the wheelchair. The catheter tubing remained winding under the right arm of the electric wheelchair. Resident #31 was asked if she had experienced any discomfort or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

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F 690	Continued From page 8	F 690		

problems with the catheter. Resident #31 stated, "No, I've had this for quite sometime now. The girls know how take care of me."

On 10/26/2022 at 3:20 p.m., along with the unit manager (LPN #1), Resident #31's catheter draining bag was observed in the same position, as last described. Upon observing , LPN #1 stated, "Oh no, this is wrong! That bag is too high!" When asked how was a catheter drainage bag supposed to be positioned, LPN #1 stated the catheter drainage bag was supposed to be positioned below the resident's bladder. LPN #1 explained that the positioning of the built-in hooks on the new electric wheelchair made it difficult to properly position the catheter drainage bag. LPN #1 added, "I guess the staff were trying to be creative, but this bag is too high and the tubing is snaking under the chair arm." LPN #1 was asked if nurses and CNAs were trained and aware of the proper positioning of the drainage bag. LPN #1 replied, "Yes, it's on the Kardex. So I know the CNAs know and I believe it is in our policy." LPN #1 was asked to provide a copy of the Kardex and policy for review.

A review of Resident #31's Kardex (individualized care guide) documented the following under Bladder/Bowel, "...Position catheter bag and tubing below the level of the bladder and away from the entrance room door...."

The policy titled "Catheter Care, Urinary (Revised September 2014)" documented the following: "...Maintaining Unobstructed Urine Flow... 3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder...."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 690	Continued From page 9 On 10/26/2022 at 4:13 p.m., during a meeting with the administrator, director of nursing (DON) and corporate consultants the above findings were discussed. No additional information was received by the survey team prior to exit on 10/27/2022 at 12:15 p.m.	F 690		
F 909 SS=F	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. 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 inspect a bed frame and mattress for one of twenty residents in the survey sample (Resident #43) and failed to implement a facility-wide program for inspecting bed frames, mattresses and bed rails for possible entrapment risks and bed/mattress compatibility for sixty-nine of sixty-nine beds currently in use by residents. The findings include: Resident #43 was admitted to the facility with diagnoses that included congestive heart failure, anxiety, dementia with behaviors, atrial fibrillation, mood disorder, deep tissue damage of right heel	F 909		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 909	Continued From page 10	F 909		

and depression. The MDS (minimum data set - cms assessment tool) dated 9/5/22 assessed Resident #43 with short and long-term memory problems and moderately impaired cognitive skills.

Resident #43's clinical record documented a physician's order dated 8/31/22 for an air mattress to the bed for pressure ulcer treatment/prevention. On 10/26/22 at 10:21 a.m., accompanied by the licensed practical nurse unit manager (LPN #1), Resident #43's mattress was observed. Installed on the resident's bed was a low-air mattress that included bolsters along both sides of the mattress near the corners. LPN #1 stated this was a special mattress in use with the resident due to pressure ulcer treatment/prevention.

On 10/26/22 at 2:11 p.m., the maintenance director (other staff #2) was interviewed about an inspection of Resident #43's bed with the low air loss mattress for compatibility and potential entrapment risks. The maintenance director replied that installed special mattresses and bed rails only when told to do so by therapy. The maintenance director stated that he performed monthly "walk arounds" but had nothing documented about bed and/or mattress inspections. The maintenance director stated that his inspections were focused on bed operation and condition. The survey team requested information from the maintenance director about a bed inspection program for the facility that included bed frames, mattress and/or bed rails for compatibility and potential entrapment risks. The maintenance director stated there was no formal program for checking side rails, mattresses or bed frames. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 909	Continued From page 11	F 909		

maintenance director stated only "grab bars" were used in the facility and these were not considered side rails. Concerning specialty air mattresses such as Resident #43's mattress, the maintenance director stated he installed the mattress and "that's all." The maintenance director stated he did not keep up with which bed had what type of mattress and again stated there was no formal program for inspecting bed frames and/or mattresses. The maintenance director stated he had no inspection records or gap measurements related to potential entrapment zones.

On 10/26/22 at 2:17 p.m., the facility's supply clerk (other staff #3) was interviewed about Resident #43's low-air mattress. The supply clerk stated Resident #43's mattress was a special alternating low-air pressure mattress ordered separately and installed on the existing bed frame.

This finding was reviewed with the administrator, director of nursing and regional director of clinical services during a meeting on 10/26/22 at 4:15 p.m.

On 10/27/22 at 8:00 a.m., the administrator presented a policy about bed maintenance and inspections. The administrator stated documented bed inspections had been done monthly and that the previous communication that the facility had no bed inspection program was inaccurate. The administrator presented a copy of their policy regarding bed maintenance and monthly inspection sheets.

The facility's policy titled "Bed Maintenance and Inspections (revised 9/1/21)" documented, "It is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 909	Continued From page 12	F 909		

the policy of this facility to conduct regular inspections of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify and avoid areas of possible entrapment...The Maintenance Director, or designee, is responsible for keeping records of bed inspections and maintenance...A list of bed frames, mattresses, and bed rails will be maintained, including the manufacturer for each. The Maintenance Director shall be notified of any new equipment brought into the facility...When bed rails and mattresses are used and purchased separately from the bed frame, the facility will ensure that the bed rails, mattress, and bed frame are compatible...Bed frame, mattress, and bed rail inspections will be conducted upon each item entering the facility and then placed on a regularly scheduled inspection and maintenance cycle according to the manufacturer's recommendations..."

Monthly inspection sheets from the facility's preventive maintenance system titled, "Bed & Mattresses: Inspect Bed Rails" were presented by the administrator. Each sheet documented the maintenance check procedure as, "Inspect connectors on rails and tighten as necessary...Remove any burs or rough edges to prevent injury...Verify the function of the spring latch-knob assembly, if applicable. Ensure latch is free of dirt and/or foreign material...Ensure that the rails engage and lock as specified...Tighten, adjust or replace any parts such as end caps, knobs, bolts, screws, etc. that are loose, show sign of wear or are missing..."

The monthly bed and mattress logbook sheets were reviewed for May 2022 through October 2022 and documented the following inspection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495343	A. BUILDING _____ B. WING _____	10/27/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHOICE HEALTHCARE AT GREENE COUNTY	355 WILLIAM MILLS DRIVE STANARDSVILLE, VA 22973

(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 909	Continued From page 13	F 909		

results.

5/2/22 - "no bed rails just grab bars"
6/6/22 - "no bed rail"
7/4/22 - "bed rails ok"
8/3/22 - "do not have bed rail we have grab bars"
9/5/22 - "no bed rails just grab bars"
10/3/22 - "do not have bed rail grab bars only"

The documented inspections included no list of bed frames, mattresses or bed rails for the facility. There was no documentation indicating which beds had rails and of any beds with specialty mattresses purchased separately from the bed frame. There was no documentation regarding the manufacturer of the bed frames, mattresses or bed rails. The inspection procedure and documented inspections made no reference to entrapment risks or bed frame/mattress compatibility. There was no documentation that Resident #43's bed/mattress was inspected for compatibility and safety when installed in August 2022.

On 10/27/22 at 9:47 a.m., the maintenance director (other staff #2) was interviewed again by the survey team about bed/mattress/bed rail program for the facility. The maintenance director stated there was a program in the preventive maintenance system about bed. The maintenance director stated the interview provided yesterday stating there was no formal program was inaccurate because he did not feel well. The maintenance director stated the bed/mattress inspections were included in his preventive maintenance program. The maintenance director again stated the facility used only "grab" rails and he did not feel these were a safety problem. The maintenance director

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	495343	A. BUILDING _____ B. WING _____	10/27/2022

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F 909	Continued From page 14	F 909		

stated he did not have a list of bed frames, mattresses, beds with rails or bed frames with specialty mattresses. The maintenance director stated his monthly sheets documented that beds were checked but there was nothing documented by bed number or room number. The maintenance director stated he had no documentation that Resident #43's bed frame and air mattress were checked for compatibility when installed in August 2022. The maintenance director stated he had no documentation of any gap measurements for beds with rails as the facility only used "grab" bars.

These findings were reviewed with the administrator, director of nursing and regional director of clinical services again on 10/27/22 at 11:55 a.m. No additional information was presented to the survey team prior to exiting at 12:15pm.

Helene Molnar, Administrator 11.11.2022

Plan of Correction F 684

QUALITY OF CARE

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Immediate education was provided to LPN #3, and the correct eye drops were ordered.
   Immediate education was provided to CNA's working on the unit where Resident #43 resides, and protective booties were placed on resident #43's feet.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   DON or designee to provide education to nurses, regarding administration of correct eye drops.
   SDC or designee to provide education to CNA's regarding pressure ulcer prevention protective booties.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing or designee to audit proper administration of eye drops weekly for eight weeks, then monthly for four months.
   UM/ Wound Care Nurse or designee to audit pressure ulcer prevention protective booties use by clinical team for eight weeks, then monthly for four months.
   Results of weekly audits will be submitted to the QAPI Committee monthly.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by November 18th, 2022.

Helene Molnar 11.11.22

Plan of Correction F 690

BOWEL/ BLADDER INCONTINENCE, CATHETER, UTI

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Immediate education was provided to LPN #1, and the catheter drainage bag was relocated below the bladder for resident # 31.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents with catheter drainage bags have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   SDC or designee to provide education to nurses, regarding proper placement of catheter drainage bags.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Director of Nursing (or designee) to audit catheter drainage bag placement weekly for eight weeks, then monthly for four months.
   Results of audits will be submitted to the QAPI Committee monthly.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by November 18th, 2022.

Helene Molnar
11-11-22

Plan of Correction F 990

RESIDENT BED

1. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:**
   Immediate education was provided to the Maintenance Director regarding a monthly facility-wide bed inspection program.

2. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice:**
   Any residents have the potential to be affected.

3. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:**
   Administrator or designee to provide education to the Maintenance Director and Maintenance Assistant regarding a monthly facility-wide bed inspection program, including the inspection of bed frames, mattresses and bed rails, for possible entrapment risks and bed/ mattress compatibility.

4. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:**
   Administrator to create a monthly facility-wide bed inspection program, in addition to monthly TEL's audit.
   Maintenance Director (or designee) to audit monthly facility-wide bed inspection program monthly for eight months.
   Results of audits will be submitted to the QAPI Committee monthly.

5. **Include dates when corrective action will be completed:**
   Corrective actions will be complete by November 18th, 2022.

Helene Molnar 11-11-22