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 02/22/2023

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 2/21/23 through 2/22/23. One complaint (VA00057705 - substantiated with deficiency) was 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 126 at the time of the survey. The survey sample consisted of four current resident reviews and two closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550	F Tag 550: 1. C NA #1, C NA #2, C NA #4, C NA #7 and LPN #7 were educated on providing care in a dignified manner at meal times. The education included sitting at eye level with the resident while assisting with meals, providing clean clothes when residents clothing is soiled, and offering assistance to residents that require assistance and are unable to feed themselves. The term "feeder" was removed from resident #2's meal ticket and dependent on staff for meals was added to the CNA care binder. Resident's #2, #3 and #6 are being treated with dignity during meal times.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/15/2023

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.

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to provide care and services in a manner to promote a dignified existence and maintain resident dignity, for three residents, (Resident #2, #3, and #6) in a survey sample of 6 Residents. The findings included: 1. For Resident #2 the facility staff failed to provide care and services in a manner to promote the resident's dignity and a dignified existence during meals. On 2/21/23, following the survey team's entry to the facility, the facility administration provided the survey team with a list of residents who required assistance with meals. Resident #2 was noted on the list and was therefore put into the survey sample.	F 550	2. All residents have the potential to be affected. Unit Mangers conducted an audit of all residents that are dependent on staff for eating and updated their care plans and Kardex with appropriate interventions. Unit Managers updated the C NA Care Binders at each nurses station to include a list of residents that require staff assistance with meals. 3. DON/Designee will educate all direct care staff on resident rights and providing care and services in a manner to promote dignity. Education will include assisting all residents that require help with meals, providing clothing protection and assist residents with changing soiled clothing and sitting with residents while assisting with meals. 4. DON/Designee will observe 2 residents that require Assistance with meals 3x a week for 4 weeks and then monthly x2 to ensure that all residents that require assistance with meals are receiving assistance in a dignified manner. Any issues identified will be addressed immediately by DON/Designee and appropriate actions will be taken. The DON/Designee will identify any trends or patterns. All findings will be discussed with QAPI monthly x 3. 5. Date of Compliance: 3/15/23	

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F 550	Continued From page 2 On 2/21/23 at 1:03 PM, Resident #2 was visited in their room. Resident #2 was observed in bed and was crying, the Resident said, "I need help, I'm hungry." Resident #2 asked the surveyor if she could get someone to help feed her. The surveyor then approached CNA #4 and CNA #7. CNA's #4 and #7 were made aware that Resident #2 was requesting assistant with her meal and said she needed someone to feed her. Both CNA #4 and #7 reported that Resident #2 could feed herself and stated, "It is behavioral." On 2/21/23 at 1:10 PM, the surveyor returned to Resident #2's room. The Resident asked if the surveyor found someone to help her. When asked if she normally feeds herself, the Resident said, "I usually do but my butt hurts." CNA #4 and #7 then entered the room and told Resident #2, "We are going to get you situated so you can eat." The CNA's then stepped out of the room and CNA #4 told the surveyor, "We got her situated." This writer then entered the room again and observed Resident #2 having difficulty getting her vegetables onto her utensil. The meal tray ticket was observed, and it read, "Note: Feeder". On 2/21/23 at 1:35 PM, Resident #2's meal tray was observed on the tray cart in the hallway and appeared uneaten. On 2/21/23 at 2:05 PM, Resident #2 was visited in her room again. She was observed sitting in her wheelchair with a 1/2 eaten sandwich on her over bed table. When asked if she didn't like the food served at lunch, Resident #2 said, "I liked it, but I couldn't get it on my spoon, I may could have done it on a good day, but not today."	F 550		

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F 550	Continued From page 3 Review of the clinical record revealed Resident #2 had been recorded as having ate 75% of her lunch meal. On 2/21/23 at approximately 5:56 PM, Resident #2 was visited in her room. Resident #2 was in bed, CNA #4 brought in the Resident's food tray, set it up, and prior to leaving told the Resident she would be back after awhile because they had a date. Resident #2 acknowledged this and said, "Yes, with the bathroom." Resident #2 then attempted to feed herself and told this writer that it was hard to eat when she needed to go to the bathroom to have a bowel movement. Resident #2 was observed to have difficulty getting food onto her utensil and started to pick up food items with her fingers. Resident #2 went on to say, "I get real hungry, I just can't get it in my mouth, so I eat cakes and nutty butters, my sister brings me. I'm going to tell her to bring me things I can eat with my hands Parkinson's is doing a number on me." A review of Resident #2's clinical record was conducted. Resident #2 had an active physician order, effective 3/7/22 which read, "CCHO [consistent carbohydrates] diet, Regular texture, Regular/Thin consistency [referring to regular consistency liquids], Directions: FEEDER." Review of Resident #2's most recent MDS (minimum data set) (an assessment tool) with an assessment reference date of 1/12/23, coded Resident #2 as having required extensive assistance of one staff for eating. The facility policy titled, "Dignity" was received and reviewed. This policy had no date with	F 550		

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F 550	Continued From page 4 regards to the origination or revision. The policy read, "...1. Residents will be treated with dignity and respect at all times. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs... 5. When assisting with care, residents are supported in exercising their rights. For example, residents are: ... e. provided with a dignified dining experience... 8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not "labeling" or referring to the resident by his or her room number, diagnosis, or care needs...". On 2/22/23, during an end of day meeting, the facility Administration was made aware of the above findings and concern for Resident dignity/dignified existence with regards to having to eat a sandwich versus a hot well-balanced meal, having to eat while needing to go to the bathroom and being referred to as a "feeder". The Corporate Nurse Consultant acknowledged that they [Administrative staff] had already discussed not referring to Resident's as "feeders". No further information was provided. 2. For Resident #6, the facility staff failed to promote the resident's dignity by failing to provide care in a manner to prevent food from spilling onto the resident and the resident's clothing while eating and failed to assist the resident to clean up at the time the spillage was observed. On 2/22/23 at approximately 8:30 AM, an observation was made of Resident #6 while	F 550		

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F 550	Continued From page 5 eating breakfast. Resident #6 was attempting to feed self but had spilled a significant amount of oatmeal onto her chest and gown. Resident #6 stated to the surveyor, "I'm messy." On 2/22/23 at approximately 8:45 AM, LPN #3 accompanied the surveyor to the room of Resident #6. LPN #3 confirmed that Resident #6 had a significant amount of food spilled onto her chest. LPN #3 made no attempts to clean up Resident #6, nor provide anything to catch the food spillage. On 2/22/23 at approximately 8:46 AM, an interview was conducted with CNA #2. CNA #2 reported that Resident #6 had refused assistance and wanted to feed self. CNA #2 reported that she had not seen any clothing protectors available or in use since she has been working at the facility. The facility policy titled, "Dignity" was received and reviewed. This policy had no date with regards to the origination or revision. The policy read, "...5. When assisting with care, residents are supported in exercising their rights. For example, residents are: ... e. provided with a dignified dining experience...". On 2/22/23, during an end of day meeting, the facility Administration was made aware of the above findings and concern for Resident dignity. No further information was provided. 3. For Resident #3 (R3), the facility staff failed to provide dignity to the resident while assisting the resident with eating. On the most recent MDS (minimum data set), a	F 550		

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F 550	Continued From page 6	F 550		

quarterly assessment with an ARD (assessment reference date) of 2/9/23, the resident was coded as being severely cognitively impaired for making daily decisions, having scored four out of 15 on the BIMS (brief interview for mental status).

On 2/21/23 at 5:15 p.m., R3 was sitting up in bed. CNA (certified nursing assistant) #1 stood at R3's bedside and fed the resident.

On 2/22/23 at 8:45 a.m., CNA #8 was standing beside R3's bed to feed the resident.

On 2/22/23 at 11:23 a.m., CNA #8 was interviewed. When asked if she remembered how she was positioned to feed R3 breakfast earlier in the day, she stated she was standing up beside the resident's bed. When asked if she could think of another way she might have positioned herself to do this, she stated: "I guess I could have sat down. That might have made her more comfortable." When asked if sitting beside the resident would have afforded the resident more dignity, she stated: "Yes, for sure."

On 2/22/23 at 2:37 p.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed. When asked if a CNA standing over a resident to assist with feeding was the most dignified positioning, LPN #2 stated: "A lot of times they do better if you sit down beside them." She added: "It could be taken as a dignity issue."

On 2/2/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

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F 550	Continued From page 7 A review of the facility policy, "Dignity," revealed, in part: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem...Residents will be treated with dignity and respect at all times." No further information was provided prior to exit.	F 550		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-	F 553	F Tag 553: 1. Social Worker was educated that all invitations to attend the Care Plan meeting will be documented in the resident record. The Social Worker offered to review the two care plans that were missed with resident #3 and family member. 2. All residents have the potential to be affected. An audit of all residents with a scheduled care plan review was conducted for the past 30 days. If family or residents were not in attendance than an invitation was sent to review the current plan of care. The care planning process will be reviewed with residents and family members during the admission process. The Social Worker will be responsible for inviting residents and family members to review the plan of care and will document in the resident record.	

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F 553	Continued From page 8 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide evidence that the resident and/or resident representative received an invitation to participate in care plan meetings for one of six residents in the survey sample, Resident #3. The findings include: For Resident #3 (R3), the facility staff failed to invite the resident and/or resident representative to two of four care plan meetings in 2022. R3 was admitted to the facility on 7/13/21. A review of R3's clinical record revealed evidence that the resident and resident representative was invited to participate in care plan meetings held on 9/29/22 and 11/10/22. The record review failed to reveal evidence of invitations to any other care plan meetings in 2022. On 2/22/23 at 9:44 a.m., OSM (other staff member) #4, the social services assistant, was interviewed. She stated she was not employed at the facility during the part of 2022 when R3 should have received two additional care plan meeting invitations. She stated she was not sure how care plan meetings invitations were handled prior to her employment at the facility. She stated currently, the MDS (minimum data set) coordinator provides her with a list of care plan	F 553	3.DON/Designee will educate Social Services that all residents and responsible parties will be invited to a care plan review at least quarterly. It will be documented that the family has been invited and if they plan to attend. Resident /family will schedule this meeting at their convenience and will be made aware that this meeting can be done virtually if needed. 4. DON/Designee will audit the care plan list to confirm that there has been an invitation to meet with the care plan committee to review the plan of care weekly x 4 and monthly x 2. The DON/Designee will identify any trends or patterns and educate as needed. All findings will be discussed with QAPI monthly x3. 5.Date of compliance: 3/15/23	

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F 553	Continued From page 9 meetings that are due for the next few weeks. She states she then reaches out to the resident/representative to invite them to the meeting. She stated sometimes she calls the representative, or sometimes she sees them in person at the facility to issue the invitation. She stated if the resident is their own RP (responsible party), she always reaches out to the first contact designated in the resident's record. She stated she does not document the invitation anywhere in the resident's clinical record. On 2/2/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Care Planning - Interdisciplinary Team," revealed, in part: "The resident, resident's family and/or the resident's legal representative/guardian or surrogate are encouraged to participate in the development of and revisions to the resident's care plan...Every effort will be made to schedule care plan meetings at the best time of the day for the resident and family." No further information was provided prior to exit.	F 553		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655	F Tag 655: 1. Copy of Care Plan provided to resident #4.	

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F 655	Continued From page 10 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview,	F 655	2. All residents have the potential to be affected. Unit Managers audited admissions for the past 30 days to determine if a copy of the Baseline Care Plan was received and reviewed with the resident and/or RP by staff. A copy has been provided if needed. 3. DON/Designee will educate all licensed nurses on the responsibility of completing, reviewing and providing a copy of the baseline care plan at admission. The Unit Manager will ensure this has occurred when completing the admission review. 4. DON/Designee will complete an audit of all admissions 3x a week x 12 weeks to ensure a baseline CP has been completed and reviewed with resident and family with in 72 hours. Any issues identified will be addressed immediately by DON/Designee and appropriate actions will be taken. All findings will be addressed with QAPI monthly x 3. 5. Date of Compliance: 3/15/23	

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F 655	Continued From page 11	F 655		

facility document review, and clinical record review, the facility staff failed to evidence they provided a summary of the baseline care plan to one of six residents in the survey sample, Resident #4.

The findings include:

For Resident #4 (R4), the facility staff failed to provide the resident with a summary of the baseline care plan.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 1/18/23, R4 was coded as having no cognitive impairment for making daily decisions, having scored 14 out of 15 on the BIMS (brief interview for mental status).

On 2/21/23 at 1:35 p.m., R4 was asked if the staff had provided a copy of the resident's baseline care plan to them. The resident stated she could not remember having received a copy of the baseline care plan at any point in time.

On 2/22/23 at 9:44 a.m., ASM (administrative staff member) #1, the administrator, stated she could provide any evidence that R4 had received a copy of the baseline care plan.

On 2/22/23 at 11:31 a.m., RN (registered nurse) #1, the MDS coordinator was interviewed. She stated the admitting nurse is responsible for the baseline care plan. She stated she uses the baseline care plan as a starting point to build the comprehensive care plan.

On 2/22/23 at 2:37 p.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed. She

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F 655	Continued From page 12 stated the baseline care plan is formulated as a part of the admission assessment process. She stated the admitting nurse is responsible for developing the baseline care plan. When asked who is responsible for giving the resident/RR (resident representative) a copy of the baseline copy, she stated: "The nurse who develops it." She stated she did not know if floor nurses are aware of this responsibility. On 2/2/23 at 2:50 p.m., ASM #1, ASM #2, the assistant director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Baseline Care Plans," revealed, "The resident and their representative will be provided a summary of the baseline care plan." No further information was provided prior to exit.	F 655		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692	F Tag 692 1. Facility adjusted the RD position to include 8 additional hours a week for RD services. Resident #1 is no longer an active resident. Resident #3 is dependent with meals. Kardex updated and staff educated. The RD reviewed weights and medical record on 2/22/2023 for resident #3.	

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F 692	Continued From page 13 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to provide care and services to prevent weight loss for two residents (Resident #1 & Resident #3) in a survey sample of six residents. The findings included: 1. For Resident #1, the facility staff failed to implement interventions to prevent further weight decline, following the identification of a significant weight loss. On 2/21/23 and 2/22/23, a record review was conducted of Resident #1's closed electronic health record (EHR). Review of Resident #1's weights revealed that on 3/4/2020, the resident weighed 166.8 lbs., on 3/13/2020, the resident weighed 160.0 lbs., on 3/18/2020, the resident weighed 157.6 lbs., on 3/25/2020, the resident weighed 156.8 lbs., and on 4/1/2020, the resident weighed 155 lbs. The following progress notes were noted: 1. Resident #1 was seen by the registered dietitian (RD) on 3/18/2020, who noted, "CBW: (current body weight) 157.6 lb.- weight loss of 5.5% x ~ 2 weeks (5.5% weight loss in approximately 2 weeks)... Plan: add magic cup with lunch and dinner...	F 692	2. All residents have the potential to be affected. Unit Managers conducted an audit of all residents with significant weight loss to ensure all recommendations have been reviewed and orders written as the providers ordered. Managers reviewed orders and observed meal trays to ensure supplements are received and effective. 3. DON/Designee will educate all clinical management team that RD recommendations will be given to DON/ADON by RD so they may be reviewed with the Provider to determine if the recommendation is appropriate. Once approved the Unit Managers will enter the order into the record. 4. DON/Designee will audit the RD recommendations weekly to ensure orders are written after Provider review. Will review the effectiveness at weekly PAR meeting x 4 weeks then monthly x2. Any patterns or trends will be identified, and education provided. Will review outcomes in QAPI x 3 months. 5.Date of compliance: 3/15/23	

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F 692	Continued From page 14 2. On 4/4/2020, there was a "weight change note" that read, "7% (11.8 pounds) loss x 30 days. CBW- 155.0... Will request magic cup bid (twice a day) for added caloric intake..." 3. On 4/8/2020, an additional "weight change note" was recorded that read, "RD follow up. Sig wt. (significant weight) loss of 7.1% x 30 days, sig wt. loss of 7.7% x 90 days. RD in agreement r/t (related to) adding magic cup BID...". The dietician and dietary manager who made the above entries with regards to Resident #1's significant weight loss, were not employed at the facility at the time of survey and were unable to be interviewed. Review of the physician orders revealed that a physician order for magic cups wasn't ordered until 4/9/2020. There weren't any notes from the provider (physician or nurse practitioner) with regards to the weight loss and/or implementation of any interventions for the weight loss. On 2/22/23, mid-morning, an interview was conducted with the RD (Other Staff #3). The RD explained during this interview, that she sees residents based on priority basis because her time in the facility is limited. When asked about recommendations, the RD stated she sends her report and recommendations to the facility administration and nurse practitioner via email and usually her recommendations are carried out within the week. When asked if she follows up to see if her recommendations are carried out, she stated that her allotted time at the facility doesn't really permit her the time to do such follow-up. On 2/21/23, the facility administrator was asked to provide the survey team with evidence of	F 692		

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F 692	Continued From page 15 Resident #1 being provided the magic cups. The facility provided evidence of Resident #1 being provided magic cups in February 2019 but submitted no evidence for April 2020. Review of the facility policy titled, "Weight Assessment and Intervention" was conducted. The policy read, "Significant Unplanned and Undesired Weight Change will be based on the following criteria... 1 month- 5% weight change is significant; greater than 5% is severe. 3 months- 7.5% weight change is significant; greater than 7.5% is severe. 6 months- 10% weight change is significant; greater than 10% is severe...4. Any weight change of 5% or more since the last weight will be retaken for confirmation. If the weight is verified, nursing will immediately notify the physician/practitioner and dietary team... 7. The physician/practitioner, resident and resident representative will be informed of significant weight change... The policy included: "Interventions: 1. Interventions for undesirable weight change shall be based on careful consideration... 2. The Dietitian/designated interdisciplinary team will discuss undesired weight change with the resident and/or family. 3. The interdisciplinary team may make recommendations for additional evaluations as needed; such evaluation may include referrals to rehabilitative therapy, dental consult... 4. If a Resident declines to accept the recommendations from the interdisciplinary team regarding the unplanned weight change, the Dietitian/designee will educate the resident/resident representative on the risk of the not accepting the recommendation will document the resident's wishes, and those wishes will be respected".	F 692		

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F 692	Continued From page 16 On 2/22/23, an interview was conducted with the facility Administrator and Director of Nursing (DON). When asked how they document the delivery of magic cups, the DON said they document on the MAR [medication administration record]. They were notified that the survey team had not been provided any evidence that Resident #1 was provided with magic cups from 4/9/2020 through his discharge on 4/27/2020. The DON stated they did not have anything further to provide the survey team. 2. For Resident #3, the facility staff failed to implement timely interventions following the identification of a significant weight loss. On 2/21/23 and 2/22/23, observations were made of Resident #3 during meals and the Resident was being fed by staff. Resident #3 was noted to have confusion and not able to be interviewed. Review of the clinical record for Resident #3 revealed the following: Resident #3 was dependent upon facility staff for activities of daily living to include eating. Resident #3 was noted on 9/28/22, to weigh 167.4 lbs. There was a progress note written by the Registered Dietitian (RD) on 9/28/22, that read, "...baseline wt. (weight) 1/13/21 262# (262 lbs.), 95# (95 lbs.) weight loss in 20 months; severe and steady wt. loss...Rsd [Resident] with severe wt loss, likely malnourished with continued risk due to Alzheimer's dx (diagnosis)... Goal: stabilize wt and prevent further loss through next assessment. Recommendation: 1. Add Glucerna 120 cc TID (three times per day) between meals.	F 692		

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F 692	Continued From page 17 2. Weigh weekly x 4 wks or until stable". On 11/1/22, Resident #3 weighed 155.6 lbs., which was an additional loss of 11.8 lbs since the weight obtained 9/28/22. On 11/8/22, the RD made a note that read, "weight change note. Value: 155.6... Add Glucerna 120 cc TID between meals." Review of the physician orders revealed that Resident #3 was not ordered Glucerna, or any other supplements to increase caloric intake, upon the identification of the significant weight loss in September. Glucerna was not ordered until 11/9/22. On 2/22/23, mid-morning, an interview was conducted with the RD (Other Staff #3). The RD explained during this interview, that she sees Residents based on priority basis because her time in the facility is limited. When asked about recommendations, the RD stated she sends her report and recommendations to the facility administration and nurse practitioner via email and usually her recommendations are carried out within the week. When asked if she follows up to see if her recommendations are carried out, she reported that her allotted time at the facility doesn't really permit her the time to do such follow-up. Review of the facility policy titled, "Weight Assessment and Intervention" was conducted. The policy read, "Significant Unplanned and Undesired Weight Change will be based on the following criteria... 1 month- 5% weight change is significant; greater than 5% is severe. 3 months- 7.5% weight change is significant; greater than	F 692		

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F 692	Continued From page 18 7.5% is severe. 6 months- 10% weight change is significant; greater than 10% is severe...4. Any weight change of 5% or more since the last weight will be retaken for confirmation. If the weight is verified, nursing will immediately notify the physician/practitioner and dietary team... 7. The physician/practitioner, resident and resident representative will be informed of significant weight change... The policy included: "Interventions: 1. Interventions for undesirable weight change shall be based on careful consideration... 2. The Dietitian/designated interdisciplinary team will discuss undesired weight change with the resident and/or family. 3. The interdisciplinary team may make recommendations for additional evaluations as needed; such evaluation may include referrals to rehabilitative therapy, dental consult... 4. If a Resident declines to accept the recommendations from the interdisciplinary team regarding the unplanned weight change, the Dietitian/designee will educate the resident/resident representative on the risk of the not accepting the recommendation will document the resident's wishes, and those wishes will be respected". On 2/22/23, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings. No additional information was provided.	F 692		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758	F Tag 758: 1. Resident #5 is no longer an active resident.	

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F 758	Continued From page 19 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758	2.All residents have the potential to be affected. DON/Designee conducted an audit of all psychoactive medications and ensured that there is a side effects monitoring order in place. 3. DON/Designee will educate all clinical staff the importance of monitoring side effects of psychoactive medications to prevent unnecessary medication use. Staff will report any side effects to Provider to determine if further orders are necessary. Side effect monitoring orders have been added on the MAR for all residents receiving a psychoactive medication. 4. DON/Designee will audit order listing report 5x a week for 12 weeks to ensure all ordered psychoactive medications are being monitored for behavior and side effects. Any patterns or trends will be identified and education provided. Outcomes will be reviewed in QAPI x 3 months. 5. Date of Compliance: 3/15/23	

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F 758	Continued From page 20 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to monitor for side effects of a psychoactive medication to prevent unnecessary medication administration for one of six residents in the survey sample, Resident #5. The findings include: For Resident #5 (R5), the facility staff failed to monitor the resident for side effects of Risperdal (1) in December 2022, January 2023, and February 2023. R5 was admitted to the facility with a diagnosis of dementia with behavioral disturbances. A review of the resident's clinical record revealed multiple, frequent episodes of anxious, disruptive, self-injurious behaviors. A review of R5's physician orders revealed, in part: "Risperdal Tablet 0.25 MG (risperidone) Give 0.25 mg by mouth at bedtime for agitation and aggression...Order date 12/29/22." Further review of R5's clinical record revealed no evidence of monitoring for side effects of Risperdal. On 2/22/23 at 2:37 p.m., LPN (licensed practical	F 758		

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F 758	Continued From page 21	F 758		

nurse) #12, a unit manager, was interviewed. When asked how the facility staff prevents a resident from receiving unnecessary psychoactive medications, she stated the nurses should be monitoring for behaviors by the resident, and for any signs or symptoms of medication side effects. She stated these side effects could be sedation, appetite changes, skin irritations, or involuntary movements on the resident's part. She stated nurses should be charting on both behaviors and side effects every shift for any resident receiving an antipsychotic [medication]. LPN #12 reviewed R5's clinical record, including MARs (medication administration records) and TARs (treatment administration records). She stated there was no evidence that R5 was being monitored for side effects of the psychoactive medications the resident had been receiving.

On 2/2/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns.

A review of the facility policy, "Antipsychotic Medication Use," revealed, in part: "Nursing staff shall monitor for and report any of the following side effects and adverse consequences of antipsychotic medications to the Attending Physician/practitioner: General/anticholinergic: constipation, blurred vision, dry mouth, urinary retentions, sedation; Cardiovascular: orthostatic hypotension, arrhythmias; Metabolic: increase in total cholesterol triglycerides, unstable or poorly controlled blood sugar, weight gain; Neurologic: Akathisia, dystonia, extrapyramidal side effects, akinesia, tardive dyskinesia, stroke."

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F 758	Continued From page 22 No further information was provided prior to exit. (1) "Risperidone is used to treat the symptoms of schizophrenia (a mental illness that causes disturbed or unusual thinking, loss of interest in life, and strong or inappropriate emotions) in adults and teenagers 13 years of age and older. It is also used to treat episodes of mania (frenzied, abnormally excited, or irritated mood) or mixed episodes (symptoms of mania and depression that happen together) in adults and in teenagers and children 10 years of age and older with bipolar disorder (manic depressive disorder; a disease that causes episodes of depression, episodes of mania, and other abnormal moods)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a694015.html.	F 758		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to serve food at the physician-ordered consistency for one of six residents in the survey sample, Resident #3. The findings include:	F 805	F Tag: 805: 1. Dietary staff educated that Provider orders are to be followed and that no dietary changes can be made without an order. Diet order was checked with meal ticket for resident #3. 2. All residents have the potential to be affected. Audit conducted by DON/Designee of all dietary orders / meal tickets to ensure accuracy for the last 30 days.	

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F 805	Continued From page 23 For Resident #3 (R3), the facility staff failed to serve pureed eggs at breakfast on 2/22/23. On 2/22/23 at 8:45 a.m., CNA (certified nursing assistant) #8 was observed assisting R3 with eating breakfast. R3's plate contained scrambled eggs which had not been pureed. A review of R3's meal ticket revealed the resident was to receive pureed food. A review of R3's clinical record revealed the following order, dated 11/2/22: "Diet Puree texture, Regular/Thin consistency, fortified food with meals." On 2/22/23 at 10:40 a.m., OSM (other staff member) #3, the registered dietitian, was interviewed. When asked if scrambled eggs are considered to be a pureed food, she stated: "I would have to refer back to the contract the dietary manager is on; they do the menus, and how the food is prepared. That is outside my scope of responsibility." On 2/22/23 at 11:11 a.m., OSM #2, the dietary manager, was interviewed. She stated scrambled eggs are not considered pureed food. She stated if a resident should have pureed food, the scrambled eggs are placed in the blender and pureed before being served to the resident. On 2/2/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the assistant director of nursing, and ASM #3, the regional nurse consultant, were informed of these concerns. A review of the facility policy, "Specialized Diets," revealed, in part: "Diet order should include the	F 805	3. DON/Designee will educate all clinical staff to review meal tickets before serving trays to ensure accuracy. Dietary staff will be educated the importance of following Provider orders when preparing meal Trays. Dietary staff will be educated on diet types and textures that are served. 4. DON/Designee will observe 5 meal trays for accuracy 3x weekly x4 weeks and monthly x 2. Any issues will be identified, and education provided. Will review outcomes in QAPI x 3 months. 5. Date of Compliance: 3/15/23	

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 02/22/2023

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 805	Continued From page 24 type of diet and texture modification if applicable, and the consistency of food and fluids. Meals will be prepared and served according to the prescribed diet." No further information was provided prior to exit.	F 805		