STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 The unannounced Standard Medicaid/Medicare survey was conducted on 03/09/22 through 03/11/22 and 03/14/2 through 03/17/22. Corrections are required for compliance with the Emergency Preparedness requirements and with 42 CFR 483 Federal Long Term Care requirements. . .	E 000		
E 006 SS=C	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The	E 006		4/30/22

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

Electronically Signed | 04/15/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 006	Continued From page 1 plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the	E 006	Upon notification of deficient practice for out of date risk assessment, facility	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 006	Continued From page 2 facility's updated Emergency Preparedness Plan. The findings included: During an interview on 03/11/22 at 10:00 A.M. with the Maintenance Director and the Administrator, the Administrator was asked for documentation of the facility's community based risk assessments that will assist the facility in addressing the needs of their patients. The Administrator stated the facility had not conducted a risk assessment of it's emergency preparedness plan. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 01/09/20. The Plan included the name of a different facility.	E 006	initiated a new assessment of the facility's community based risks and addressing the needs of residents. The Emergency Preparedness Plan was also audited for all references to the other facility's name on the template used to create Courtland's plan.	
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 007	Continued From page 3 plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's patient population and services the facility would be able to provide during an emergency. The findings included: During an interview on 03/11/22 at 10:05 A.M. with the Administrator and the Maintenance Director they were asked for documentation of the facility's patient population and services the facility would be able to provide during an emergency. The Administrator and Maintenance Director stated the facility had not conducted a patient population assessment nor had they reviewed what services would be provided during an emergency. The documentation presented	E 007	Facility updated Emergency Preparedness Plan to include the Patient Population Assessment and reviewed services to be provided to ensure continuity of care for all residents. Administrator, or Designee, will audit assessment and services quarterly for two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 007	Continued From page 4 indicated the Emergency Preparedness Plan had not been updated since 01/09/20. The Plan included the name of a different facility.	E 007		
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.	E 015		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 015	Continued From page 5 (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's updated Emergency Preparedness Plan included policies and procedures to ensure adequate energy sources as well as provide for sewage and waste disposal. The findings included: During an interview on 03/11/22 at 10:27 A.M. with the Administrator and the Maintenance Director they were asked for documentation of the facility's policies and procedures to ensure adequate energy sources were maintained during an emergency as well as provide for sewage and waste disposal. The Maintenance Director and the Regional	E 015	Facility updated Emergency Preparedness Plan to include Policies and Procedures to ensure alternate energy sources as well as sewage and waste disposal. Emergency Preparedness Plan will be reviewed and revised annually and as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 015	Continued From page 6 Nurse Consultant, stated the facility had not developed policies and procedures to ensure alternate energy sources as well as sewage and waste disposal. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 01/09/20. The Plan included the name of a different facility.	E 015		
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] *[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's communication plan which provides a means of sharing information with residents and	E 035	Facility updated Emergency Preparedness plan to include Policies and Procedures for the Communication Plan to provide a means of sharing information	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 035	Continued From page 7 family's. The findings included: During an interview on 03/11/22 at 11:41 A.M. with the Administrator and the Maintenance Director they were asked for documentation of the Emergency Preparedness Communication Plan to provide a means of sharing information about the facility's Emergency Preparedness Plan with residents and family's. The Administrator stated the facility had included the communication notification plan in the admissions package for new admits. However, the facility had not updated policies and procedures of the Emergency Preparedness Communication Plan to include sharing information about the facility's Emergency Preparedness Plan with residents and family's. The documentation presented indicated the Emergency Preparedness Plan had not been updated since 01/09/20. The Plan included the name of a different facility.	E 035	with residents and families. Communication Plan will be reviewed annually and as needed	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at	E 036		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 036	Continued From page 8	E 036		

§484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.

*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 036	Continued From page 9 requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's written training and testing program. The findings included: During an interview on 03/11/22 at 11:58 A.M. with the Administrator and the Maintenance Director they were asked for documentation of the Emergency Preparedness Plan written training and testing program. The Administrator and the Maintenance Director stated the facility had not implemented a written training and testing program. The documentation presented indicated the Emergency Preparedness Plan written training and testing program had not been updated and implemented since July 2020.	E 036	Facility updated Emergency Preparedness Plan to include annual training and testing for all staff. Administrator, or Designee, will audit training records for new hires and current employees monthly x 3 months, then quarterly x 2 quarters to ensure all staff receive EP training and testing upon hire and annually.	
E 037 SS=C	EP Training Program	E 037		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 037	Continued From page 10 CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 037	Continued From page 11	E 037		

expected roles.
(ii) Demonstrate staff knowledge of emergency procedures.
(iii) Provide emergency preparedness training at least every 2 years.
(iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(v) Maintain documentation of all emergency preparedness training.
(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 037	Continued From page 12 (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 037	Continued From page 13	E 037		

with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 037	Continued From page 14 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of the facility's staff receiving annual emergency preparedness training. The findings included: During an interview on 03/02/22 at 12:07 P.M. with the Administrator and the Maintenance Director they were asked for documentation of the staff Emergency Preparedness annual training and testing. The Administrator, stated the facility had not implemented annual training and testing. The documentation presented indicated the Emergency Preparedness Plan written training and testing program had not been updated and implemented since July 2020.	E 037	Facility updated the Emergency Preparedness Plan to include annual training and testing of al staff. Administrator, or Designee, will audit training records for new hires and current employees monthly x 3 months, then quarterly x 2 quarters to ensure all staff receive EP training and testing annually and upon hire.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2),	E 039		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 15	E 039		

§460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2).

*[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:

(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following:

(i) Participate in a full-scale exercise that is community-based every 2 years; or
(A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or
(B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event.
(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 16	E 039		

scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 17 directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]	E 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 18	E 039		

(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]
(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 19	E 039		

annually. The PACE organization must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or
(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]
(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 20	E 039		

emergency procedures. The [LTC facility, ICF/IID] must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.
(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:
(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 21	E 039		

accessible, conduct an annual individual, facility-based functional exercise; or.
(B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]
(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at
least annually. The HHA must do the following:
(i) Participate in a full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.
(B) If the HHA experiences an actual natural or man-made emergency that requires activation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 22	E 039		

of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]
(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:
(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 23 man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility staff failed to have documentation of an annual full scale community based emergency exercise. The findings included: During an interview on 03/11/22 at 12:09 P.M. with the Administrator and the Maintenance Director they were asked for documentation of the facility's annual community based Emergency Preparedness exercise.	E 039	Facility staff is scheduled to participate in a community full scale exercise with Eastern Va Healthcare Coalition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 039	Continued From page 24 The Administrator, stated the facility had not conducted nor participated in a community based emergency exercise. The documentation presented indicated the community Emergency Preparedness exercise was last updated on July 2020.	E 039		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/09/22 through 3/12/22 and 3/14/22 through 3/17/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey: VA00054507-Subtantiated with deficiency. The census in this 90 certified bed facility was 83 at the time of the survey. The survey sample consisted of 35 current Resident record reviews and 9 closed record reviews.	F 000		
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,	F 553		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 553	Continued From page 25 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- (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 resident interview, staff interviews, clinical record review and facility documentation review, the facility staff failed to invite 1 of 44 residents (Resident #64) in the survey sample to participate in her Person-Centered care plan meeting. The findings included: Resident #64 was admitted to the nursing facility on 11/12/21. Diagnosis for Resident #64 included but not limited to Type II diabetes. The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 02/22/22 coded the resident with a 14	F 553	1. Upon notification of deficient practice, resident #64 and RP were issued invitations to a care plan meeting and the meeting was held on 3/16/22. 2. Facility will conduct an audit of current residents to ensure residents have received care plan invitations 3. The Interdisciplinary Team will be re-educated on the care plan process to include invitations. The Social Services Director is responsible for issuing care plan 8invitations to residents and/or their responsible parties and documenting in the medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 553	Continued From page 26 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. During the initial tour on 03/09/22 at approximately 3:27 p.m., an interview was conducted with Resident #64 who stated, "Care plan meetings don't happen here. I was never invited nor did I receive a letter to attend a care plan meeting." An interview was conducted with the Social Worker (SW) on 03/10/22 at approximately 10:35 p.m., who stated, "I invited Resident #64 to attend her care plan meeting verbally, but a care plan letter was not provided to Resident #64." The surveyor requested documentation that the resident was verbally invited to attend her person-centered care plan meeting, she replied, "I can't; it was never documented." On the same day at approximately 3:00 p.m., the (SW) provided a care plan letter addressed to Resident #64 inviting her to attend her care plan meeting on 03/16/22 at approximately 11:00 a.m. An interview was conducted with the MDS Coordinator on 03/17/22 at approximately 1:00 p.m., who stated, a care plan meeting should have been held for Resident #64 by 12/02/21. A debriefing was held with the Administrator and Vice President of Operations on 03/17/22 at approximately 5:45 p.m., who were informed of the above findings; no further information was provided prior to exit. The facility's policy titled Care Planning - Interdisciplinary Team (IDT) - revised on 02/01/22.	F 553	4. The Administrator, or Designee, will audit compliance weekly x 4 weeks, then monthly x 2 months. 5. Results will be brought to QAPI x 3 month or until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 553	Continued From page 27 The policy Interpretation and Implementation read in part: 3. The resident, the 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. 4. The Social Services department will be responsible for inviting residents and family representative via phone, email, postage and other methods deemed practical to schedule care plan meetings. Documentation of invitations will be reflected in medical records. 5. Every effort will be made to schedule care plan meetings at the best of the day for the resident and family.	F 553		
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on record review, staff and individual	F 568	1. Upon notification of deficient practice,	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 568	Continued From page 28 interviews the facility staff failed to provide one resident (Resident #37) in the survey sample of 44 residents with a quarterly financial statement. The findings included: Resident #37 was admitted to the facility on 11/17/2018 with diagnoses of sequela, neuromuscular dysfunction of bladder, paraplegia, hypertension, anxiety disorder, contracture of right hip, contracture of left hip, and depression. The facility staff failed to provide Resident #37 with a quarterly financial statement. Resident #37 was noted to be his own authorized legal representative. A Quarterly Minimum Data Set (MDS) assessed Resident #37 as having a Basic Interview for Mental Status (BIMS) score of 13. In the area of Activity's of Daily Living (ADL's) this resident was assessed as requiring extensive assistance in the area of bed mobility and transfer. A Care Plan Dated: 2/11/2022 indicated: The resident needs a safe environment with: (floors free from spills and/or clutter; adequate light; a working and reachable call light, personal items within reach) The resident uses antidepressant medication r/t Depression-The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT.	F 568	resident #37 was provided a copy of his financial statement. 2. Facility will interview other residents to identify if quarterly statements were received. 3. Business office staff will be re-educated to provide quarterly financial statements to residents and their financial representative 4. Administrator, or Designee, will audit financial statements monthly x 3 months 5. Results of audits will be brought to QAPI x 3 months or until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 568	Continued From page 29	F 568		

Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes.

The resident has depression-The resident will exhibit indicators of depression, anxiety or sad mood less than daily by review date. Administer medications as ordered. Monitor/document for side effects and effectiveness.
Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self, refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness. Monitor/record/report to MD PRN risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons.

During the Resident Council Interview at 10:00 A.M. on 03/11/22 residents were asked if they received quarterly financial statements of their personal fund account. Resident #37 stated, he had not received a quarterly financial statement of his personal funds.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 568	Continued From page 30 During an interview with Resident #37 at 11:58 a.m. on 03/11/22, he stated, at the beginning of the month he goes and get money from his account to purchase items at the store. I do not get a statement telling me how much I have or how much I have spent. During an interview with the Business Office Manager he stated, residents are not provided with Quarterly financial statements. A facility policy indicated: "Deposit of Resident Funds" Policy: Resident personal funds that are held and managed by the facility will be safeguarded. The policy and procedures titled Quarterly and Discharge Statements: 1. Statements will be generated by the facility. Copies are to be made and mailed/given to the resident/authorized legal representative no less than quarterly.	F 568		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or	F 580		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 31 clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, resident interview, staff interviews, facility document	F 580	1. Deficient practice for residents #64, 47, 88, 87, 26 cannot be retroactively	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 32	F 580		

review, and clinical record review, the facility staff failed to notify the physician and or the Resident Representative of a change in condition for 5 of 44 residents (Resident #64, #47, #88, #87 and #26) in the survey sample. For Resident #64, the facility staff failed to notify the physician of blood sugars 400 and greater. For Resident #47, the facility staff failed to notify the physician and resident representative of missed doses of an antibiotic to treat Urinary tract Infection (UTI). For Resident #88, the facility staff failed to inform the physician of the neuropsychologist recommendation to start medication (Luvox 25 mg) daily for behaviors. For Resident #87, the facility staff failed to notify the responsible party timely of an acute change of condition that required the resident to be transferred to the hospital on 2/3/22. The facility staff failed to notify Resident #26's responsible party of unstageable pressure ulcers located on resident's sacrum and right lateral ankle.

The findings included:

1. The facility staff failed to follow physician orders to notify the physician if Resident #64's blood sugars were greater than 400. Resident #64 was admitted to the nursing facility on 11/12/21. Diagnosis for Resident #64 included but not limited to Type II Diabetes Mellitus (DM) with hyperglycemia.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 02/22/22 coded the resident with a 14 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The MDS coded Resident #64 requiring total dependence of one with

corrected.

2. Unit Manager, or designee, will review 24 hour report, incident management, and clinical dashboard for resident changes in condition to ensure proper notifications are made to MD/NP and RP.

3. Licensed nurses will be educated on MD/RP notification regarding missed and/or unavailable medications, following blood sugar parameters, consultant recommendations, acute transfers, and newly identified pressure ulcer.

4. Unit Manager, or designee, will audit 24 hour report and clinical dashboard for resident changes in condition to ensure proper notifications are made to MD/RP x5 weekly for 4 weeks and x3 weekly for 3 weeks.

5. Results from audits will be brought to QAPI for 3 months or until compliance is achieved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 33	F 580		

bathing, extensive assistance of one with dressing, limited assistance of one with toilet use and personal hygiene and supervision with transfer and eating for Activities of Daily Living care. Under Section N for the use of insulin injection was coded as received daily during the last 7 days.

The care plan created on 11/15/21 identified Resident #64 with a diagnosis of DM. The goal set for the resident by the staff to have no complications related to diabetes. Some of the interventions/approaches the staff would use to accomplish this goal is monitor/document/report as needed any signs or symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain and acetone breath (smells fruity).

During the initial tour on 03/09/22 at approximately 3:27 p.m., an interview was conducted with Resident #64 who stated, "I was on sliding scale insulin when I was at home but since I've been here, they have been checking my blood sugar but I'm not always receiving insulin coverage when my blood sugars are high."

Review of Resident #64's physician orders for March 2022 revealed the following order starting on 11/15/21: check blood sugars before meals and at bedtime. Notify the physician for blood sugar less than 60 or greater than 400.

1. Review of November 2021 Medication Administration Record (MAR) revealed blood sugar's greater than 400 on the following days with no notification to the physician: 11/26 @ 513, 11/27 @ 513 and again @ 421, 11/21 @ 433 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 34	F 580		

11/30 @ 475.

2. Review of December 2021 (MAR) revealed blood sugar's greater than 400 on the following days with no notification to the physician: 12/08 @ 508 and 487, 12/09 @ 459 and 482, 12/13 @ 435, 483 and 409.

3. Review of January 2022 (MAR) revealed blood sugar's greater than 400 on the following days with no notification to the physician: 01/25 @ 466 and 01/26 @ 453.

4. Review of February 2022 (MAR) revealed blood sugar's greater than 400 on the following days with no notification to the physician: 02/01 @ 460 and 02/02 @ 407.

An interview was conducted with the Regional Director of Clinical Services on 03/16/22 at approximately 2:53 p.m., who reviewed the documents mentioned above. He stated, the expectations is for all nurses to is follow the physician orders and to inform the physician of elevated blood sugars greater than 400 as instructed.

On 03/16/22 at approximately 3:15 p.m., an interview was conducted with License Practical Nurse (LPN) #1 and the Regional Director of Clinical Services. The LPN was assigned to Resident #64 on the following days when the resident's the blood sugars were greater than 400 and the NP or physician were not notified: 11/26/21 @ 513 and 11/27/21 @ 513, 12/09/21 @459 and 12/13/21 @ 409. The nurse reviewed the documents and stated, "If I did not notify the NP or the Physician of Resident #64's blood sugars greater than 400, I should have." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 35	F 580		

surveyor asked, do you see documentation that the NP or physician were notified of blood sugars greater than 400 on the days mentioned, she replied, "No."

A debriefing was held with the Administrator and Vice President of Operations on 03/17/22 at approximately 5:45 p.m., who were informed of the above findings; no further information was provided prior to exit.

The policy titled: Obtaining a Fingerstick Glucose Level with a revision date of 10/11.
Purpose is to obtain a blood sugar sample to determine the resident's blood glucose level.

Documentation read in part: The person performing this procedure should record the following in the resident's medical record:
6. The blood sugar results. Follow facility policies and procedure for appropriate nursing interventions regarding blood sugar results (if resident is on sliding scale coverage, and/or physician interventions is needed to adjust insulin or oral medication dosages).

2. The facility staff failed to notify the physician and Resident Representative (RR) that Resident #47 missed 12 doses of his antibiotic (Zyvox) as ordered by the physician to treat a Urinary tract infection (UTI).

Resident #47's Minimum Data Set (MDS - an assessment protocol) a PPS 5-day assessment with an Assessment Reference Date of 02/14/22 coded Resident #47's Brief Interview for Mental Status (BIMS) scored a 06 out of a possible score of 15 indicating severe cognitive impairment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 36	F 580		

Resident #47's Minimum Data Set (MDS - an assessment protocol) a PPS 5-day assessment with an Assessment Reference Date of 02/14/22 coded Resident #47's Brief Interview for Mental Status (BIMS) scored a 06 out of a possible score of 15 indicating severe cognitive impairment. The MDS coded Resident #47 requiring total dependence of one with dressing, personal hygiene and bathing, extensive assistance of one with bed mobility and toilet use, supervision with eating for Activities of Daily Living care.

The care plan with a revision date of 03/03/22 identified Resident #47 on antibiotic therapy for UTI. The goal set for the resident by the staff was that the resident's UTI will resolve without complications. Some of the interventions/approaches the staff would use to accomplish this goal is administer antibiotic therapy as ordered and to monitor for side effects and effectiveness.

During the review of Resident #47's hospital discharge summary dated 02/28/22 revealed the following order: start Zyvox 500 mg tablet twice a day for 14 days for UTI.

Review of Resident #47's Medication Administration Record (MAR) for March 2022 revealed the antibiotic Zyvox was not administered as ordered on the following days: 03/01/22-03/07/22.

The facility provided a packing slip which revealed the medication Zyvox (28 tablets) were delivered to the nursing facility on 03/01/22.

On 03/14/22 at approximately 1:00 p.m., the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 37	F 580		

facility provided a copy of the facility's investigation report that indicated the following: "On the evening of 02/28/22, Resident #47 was readmitted to the nursing facility with a new order for Zyvox. The pharmacy was made aware of the new order and according to the manifest, the medication Zyvox was delivered to the facility on 03/01/22. According to License Practical Nurse (LPN) #1 and LPN #2, the medication was not given because it was considered unavailable and was not located in the medication cart."

An interview was conducted with LPN #2 on 03/16/22 at approximately 11:45 a.m. The LPN stated, "Zyvox was not given because the medication was located in another medication cart. The LPN said if I had called the pharmacy, they would have informed me that the Zyvox was delivered on 03/01/22 and Resident #47 wouldn't have missed all those doses of his antibiotic. When asked if the physician or the resident's representative were made aware that Resident #47 had missed 12 doses of his antibiotics from 03/01/22-03/07/22, she replied, "No."

A debriefing was held with the Administrator and Vice President of Operations on 03/17/22 at approximately 5:45 p.m., who were informed of the above findings; no further information was provided prior to exit.

Definitions:
-Zyvox is used to treat infections, including pneumonia, and infections of the skin. Zyvox is in a class of antibacterials called oxazolidinones. It works by stopping the growth of bacteria (https://medlineplus.gov/druginfo/meds).

3. The facility staff failed to inform the physician

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 38	F 580		

of the neuropsychologist recommendation to start medication (Luvox 25 mg) daily for behaviors. Diagnosis for Resident #88 included but not limited to major depressive disorder and Parkinson's Dementia.

Resident #88's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 02/02/22 coded Resident #88's Brief Interview for Mental Status (BIMS) scored a 10 out of a possible score of 15 indicating moderate cognitive impairment. The MDS coded Resident #88 requiring total dependence of one with bathing, extensive assistance of one with bed mobility, transfer, dressing, toilet use and personal hygiene and supervision with limited assistance of one with eating for Activities of Daily Living (ADL) care.

The care plan created on 09/15/20 identified Resident #88 is on an antidepressant medication related to (r/t) depression. The goal set for the resident by the staff to be free from discomfort or adverse reactions related to antidepressant therapy. Some of the interventions/approaches the staff would use to accomplish this goal is administer medications as ordered by the physician, monitor/document/report adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal and decline in ADL ability.

The care plan created on 09/20/19 identified Resident #88 has an alteration in neurological status r/t Parkinson's disease. The goal set for the resident by the staff is for the resident to communicate needs daily. Some of the interventions/approaches the staff would use to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 39	F 580		

accomplish this goal is to give medications as ordered and monitor/document for side effects and effectiveness.

On 12/07/21, a progress note entered by neuropsychologist revealed the following information: "Resident #88 is being seen today because he is frequently defecating and spreading his feces around and urinating all over the place. The resident also intermittently refuse nutrition and medication. The progress note also states that Resident #88 is confused and gets physically violent with staff when trying to assist with ADL care. The recommendation is to consider Luvox 25 mg daily for major depressive disorder with psychotic features."

Review of the physician Order Sheet (POS) for March 2022 and the Medication Administration Record (MAR) was reviewed from 12/21-03/22 revealed the medication Luvox 25 mg was never initiated.

On 03/16/22 at approximately 3:15 p.m., an interview was conducted with the Regional Director of Clinical Services. The progress note entered by neuropsychologist on 12/07/21 and the MAR's from 12/21-03/22 were reviewed with the Regional Director of Clinical Services who acknowledge the recommendation to start Luvox 25 mg was never referred the to the resident primary physician or Nurse Practitioner for approval.

A debriefing was held with the Administrator and Vice President of Operations on 03/17/22 at approximately 5:45 p.m., who were informed of the above findings; no further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 40	F 580		

Definitions:
-Luvox is used to treat obsessive-compulsive disorder (bothersome thoughts that won't go away and the ... front of others that interferes with normal life) (https://medlineplus.gov).
4. The facility staff failed to notify Resident #87's responsible party timely of an acute change of condition that required the resident to be transferred to the hospital on 2/3/22 via 911.

Resident #87 was admitted to the facility on 1/21/22 with diagnoses to include but not limited to Chronic Kidney Disease, Stage 5. Diabetes Mellitus, Anemia, Obesity, and Atrial Fibrillation. Resident #87 was discharged to the hospital on 2/3/22.

The most recent comprehensive Minimum Data Set (MDS) was an Admission Assessment with an Assessment Reference Date (ARD) of 1/27/22. The Brief Interview for Mental Status for Resident #87 was coded as a 15 out of a possible 15, indicating the resident was cognitively intact and capable of daily decision making. Under Section F0400 Interview for Daily Preferences Resident #87 was coded as a 1-Very Important for: How important is it to you to have your family involved in discussions about your care? Under Section M Skin Conditions Resident #87 was coded for being at risk for developing pressure ulcer/injuries. The resident was also coded as having skin tears.

On 3/15/22 at 10:36 a.m. a phone interview was conducted with Resident #87's son/responsible party to discuss a complaint investigation. During the call Resident #87's son began discussing the resident being send to the hospital on 2/3/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 41	F 580		

Resident #87's son stated, "Mom was sent to the hospital on 2/3/22 because she wasn't responding. How I found out my mom was in the emergency room was from a call I received from the hospital billing department around 2 p.m. The lady on the phone asked if it was ok for the hospital to bill my mom's insurance. I asked her what were they billing for. The lady said, "sir were you not aware your mother is in our emergency room. I told her that I was not aware. As soon as I hung up the phone with the hospital a nurse from the facility called me to inform me that she had sent my mom to the hospital that morning."

Resident #87's Progress Notes entered by Licensed Practical Nurse (LPN) #3 were reviewed and are documented in part, as follows:

2/3/2022 12:06 p.m. Orders - Administration Note: hospital.

2/3/2022 14:47(2:47)p.m. Nurses Notes: Resident noted in room hard to arouse and unable to answer simple questions. Call placed to NP (Nurse Practitioner) and order given to send resident out for further evaluation. RP (responsible party) Name (son) made aware, call to ER(emergency room) charge nurse. Med (medication) orders, bed hold policy, and Care plans sent with resident. 911 was called and arrived resident taken to ED (emergency department) via stretcher accompanied by EMS(emergency medical services).

Resident #87's 2/3/22 Emergency Department Record was reviewed and is documented in part, as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 42	F 580		

Admission Information:
Arrival Date/Time: 2/3/22 11:29 a.m.

On 3/14/22 at 1:56 p.m. a phone interview was conducted with LPN #3. LPN #3 was asked when did she call Resident #87's responsible party after she noted a acute change in the residents condition and sent the resident to the hospital via 911. LPN #3 stated, "I called the son. I don't know for sure the time, but I charted it. It couldn't have not even been more than 30 minutes after I sent her out. She went out around 11 a.m.." LPN #3's Nursing Note entry dated 2/3/22 at 14:47(2:47) p.m.
was reviewed with the nurse. LPN #3 stated, "Well that's just when I charted it."

The facility policy titled "Change in a Resident's Condition or Status" revised 2/2021 was reviewed and is documented in part, as follows:

Policy Statement: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status.

Policy Interpretation and Implementation:

4. Unless otherwise instructed by the resident, the nurse will notify the resident's representative when:
b. there is a significant change in the resident's physical, mental, or psychosocial status;
e. it is necessary to transfer the resident to a hospital/treatment center.

On 3/17/22 at 2:50 p.m. an interview was conducted with the Administrator regarding the notification of Resident #87's representative after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 43	F 580		

an acute change of condition requiring 911 transfer to the hospital on 2/3/22. The Administrator was asked when should resident representatives be notified when there is an acute change of condition and who is responsible for the notification. The Administrator stated, "The family should be notified as soon as the emergency has been handled, call immediately. The nurse in charge of the emergency is who is to notify the family and document the time the family was notified."

During a pre-exit debriefing on 3/17/2 at 5:44 p.m. with the Administrator, Vice President of Operations and the Vice President of Clinical Services the above information was shared.

Prior to exit no further information was shared.

5. For Resident #26 the facility staff failed to notify his next of kin (RP/Responsible Party/Brother) of unstageable pressure ulcers located on resident's sacrum and right lateral ankle.

Resident #26 was originally admitted to the facility on 1/11/22 after an acute care hospital stay. The resident has never been discharged from the facility. The current diagnoses included; Pressure Ulcer of Sacral Region, unstageable and Pressure ulcer of the Right Lateral Ankle.

The quarterly revision assessment Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/26/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated Resident #26 cognitive abilities for daily decision making were moderately impaired.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 44	F 580		

In section "G"(Physical functioning) the resident was coded as requiring extensive assistance of two people with bed mobility and personal hygiene. Requiring extensive assistance of one person with dressing. Requiring total dependence of two persons with toilet use and bathing. Requires supervision with set-up help only with eating.

In section "M" (Skin and Ulcer/Injury Treatments) M1200. Turning/repositioning program: coded as No. Pressure ulcer/injury care: coded as No.

In section "M" (Skin Conditions) M0150. Risk of Pressure Ulcers/Injuries. Codes as Yes. M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Left Blank.

The care plan dated 2/04/22 reads: Focus: SKIN INTEGRITY: Resident has potential impairment to skin integrity r/t (relating/ to) cancer, COPD (Chronic Obstructive Pulmonary Disease) heart failure, anemia, Foley catheter, incontinence and need for ADL (Activity of Daily Living) assistance. Goal: The resident will maintain or develop clean and intact skin by the review date. Interventions: Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Keep skin clean and dry. Use lotion on dry skin. Observe location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration etc. to MD (Medical Doctor).

The care plan dated 2/04/22 reads: Focus: ADL self-care performance deficit related to Heart failure, Acute kidney failure, Malignant carcinoma of the lung, Malignant neoplasm of the brain.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 45	F 580		

Goal: Resident to maintain current level of function in (eating) through the next review date. Interventions: BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Avoid scrubbing & pat dry sensitive skin. Provide a tub bath/shower at least 2 days week. Provide a sponge bath if a tub bath/ shower cannot be tolerated. Shave and shampoo hair as needed. BED MOBILITY: Requires (Limited to extensive assistance) of (1-2) staff to turn and reposition in bed Q 2-3 hours and as necessary. PERSONAL HYGIENE: Requires (limited to extensive assistance) of (1-2) staff with personal hygiene and oral care. SKIN OBSERVATION: Observe skin for rashes, redness, open areas, scratches, cuts, bruises and report changes for prompt treatment.

According to the wound evaluation dated 2/08/22 revealed that an unstageable pressure ulcer of the sacrum was acquired in house. Measurements: Length: 5.35 cm. Width: 5.73 cm LxW: 30.66 cm Depth: 0. Observations: %slough/eschar: 100.00

According to the comprehensive skin assessment dated on 2/24/2022 at 6:57 PM a new wound was found on Resident's right lateral ankle as an unstageable pressure ulcer by the wound Nurse Practitioner (NP). % slough/eschar: 100%.

A review of nurses note dated 2/16/22 at 2:22 PM show that family member was called concerning labs and chest xray but did not mention that resident has an unstageable sacral ulcer unstageable pressure ulcer to right ankle. Noted: deep non productive cough. Coarse rhonchi to bilateral upper and lower lobes. Afebrile. 98% via 2L of O2. Call placed to on call provider. Orders

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 46	F 580		

received to obtain CBC, CMP, COVID test and chest X-Ray. Resident own RP and made aware of new orders.

A review of nursing notes show no indication that Resident's family member was notified of his unstageable pressure ulcers.

On 03/11/22 at approximately 9:39 AM an interview was conducted with Resident #26 concerning his wounds on his sacrum and lower extremities. He was asked how he got the wounds. He stated, "I got it since I've been in here. (His Heels were observed resting on the bed." No bunny boots or heel protectors were seen. Resident's heels were not floating but resting on his bed/mattress). Surveyor received permission from resident to observe wound care today.

On 3/11/22 at approximately 6:05 PM a phone call was placed to Resident #26's RP (Responsible Party/Brother) concerning Resident's pressure ulcers. He stated, "He was there 3 days when I was told the facility had many cases of COVID19 in the building. I didn't know he had pressure ulcers. I talked to the nurse the other day and they didn't mention that to me. They have not called me concerning his wounds."

On 03/14/22 at 2:47 PM an interview was conducted with LPN #6 concerning Resident #26. She stated. The area on the sacrum was found on 2/09/22 as an unstageable. If it's covered in slough or eschar it's unstageable because we don't know what's under it. Upon arrival, we look at resident's skin with the Wound NP, then weekly. If the CNA see any issues on resident's skin they will report it to the nurse. Since I've

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 47	F 580		

been looking at his wound every week it's getting better. His sacrum was debrided on 3/10/22. I normally put a note in that I rounded with her but I didn't. She was asked who was Resident #26's RP (Responsible Party) she stated, "His brother is listed as his next of kin. So if anything happens to resident I would call him. Was the RP notified when the unstageable was found? (LPN #6 looking through PCC/electronic medical records). It doesn't look like it. An SBAR (Situation, Background, Assessment and Recommendation) should have been completed and notifications should have been in there. She was asked by surveyor if Resident #26's brother been notified of the unstageable pressure ulcers and notified of the debridement of his sacral ulcer? She stated, " No."

On 03/15/22 at 1:35 PM an interview was conducted with the Wound Nurse Practitioner (OSM) #19 concerning Resident #26's wounds. She stated, "When he first got to the facility he didn't have a wound. When the facility told me to come look at him he was already unstageable. I initially saw him on February 8th, 2022. I only see it once a week. She was asked if the wound was found at an advance stage on his right lateral heel and sacrum. She stated, "Yes because he didn't have it on his initial skin assessment. The staff should have communicated if they saw something open, redness and documented it. I do a skin sweep quarterly on patients that don't have wounds. Most nurses should do weekly skin assessments."

On 3/17/22 at approximately 5:45 PM a Pre-exit interview was conducted with the Administrator, The Vice President of Operations and with the Vice President of Clinical Services concerning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 580	Continued From page 48 Resident #26. The Vice President of Operations Stated, "The DON that was here had a wound care protocol but we can't find it but will re-implement it."	F 580		
F 607 SS=E	COMPLAINT DEFICIENCY Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on employee record review, facility document review and staff interviews the facility staff failed to implement their Abuse/Neglect Prevention Policy for screening of new employees. Criminal Background Checks were not obtained for 12 current employees within 30 days of their hire date, Sworn Statements were not obtained for 16 current employees upon hire, and a Nursing License was not obtained for 2 current employees upon hire. The findings included: On 3/14/22 twenty-five current employee records were reviewed. The employee record review	F 607	1. Current employee files will have criminal background checks, attestation letters, and current license verifications by 4/30/22. 2. The VPO completed an audit of all active employee files on 3/29/22. 3. The BOM was educated by the VPO on 4/12/22 regarding the documents required to be in employee files. The new hire packet was updated to include the attestation statement. Facility has submitted request to be able to run background checks on new employees.	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 49 revealed that 12 current employees did not have a Criminal Background Checks. There were also 16 current employees that had no Sworn Statements upon hire. The employee record review also revealed that Nursing Licenses for 2 current employees were not obtained. On 10/14/22 at 10:30 a.m., an interview was conducted with the Business Office Manager (BOM) regarding the current employees with missing criminal background checks, sworn statements and nursing licenses. The BOM stated, "I have only been here since the end of December and have not been able to look through all of the employee records to make sure they has everything that is required. I promise it will be better the next time you come." The BOM was asked what is the importance of obtaining criminal background checks, sworn statements and licenses on new hires. The BOM stated, "To make sure that we don't have anyone in the building that doesn't have a current license or has a criminal history that could harm the residents." On 3/17/22 at 2:30 p.m. an interview was conducted with the Administrator regarding the current employees without criminal background checks, sworn statements and nursing licenses. The Administrator was asked who in the facility was responsible for completing new employee records and what should be in the employee record upon hire. The Administrator stated, "The Business Office Manager is responsible for ensuring all new employee records are complete at hire. The record should include the sworn statement upon hire, the criminal background check within 30 days of hire and a copy of the current nursing license upon hire. The Administrator was asked what is the importance	F 607	4. The Administrator, or designee, will audit new employee files weekly for 4 weeks and results of the audits taken to QAPI until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 50	F 607		

of obtaining the documents she listed for new employees. The Administrator stated, "To ensure we don't have someone with a history of abuse or violent behavior in the building taking care of the residents. Also we need to ensure the nurses are licensed to practice to also protect the residents. This procedure is in our abuse policy and we were not following it based on your findings."

The facility policy titled "Abuse Prevention" last revised 12/2016 was reviewed and is documented in part, as follows:

Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse.

Policy Interpretation and Implementation: As part of the resident abuse prevention, the administration will:
1. Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, or any other individual.

2. Conduct employee background checks and will not knowingly employ or otherwise engage any individual who has:
a. been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;
c. a disciplinary action in effect against his or her professional license by a state licensure body as a result of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 51 3. Develop and implement policies and procedures to aid our facility in preventing abuse, neglect or mistreatment of our residents. During a pre-exit debriefing on 3/17/2 at 5:44 p.m. with the Administrator, Vice President of Operations and the Vice President of Clinical Services the above information was shared. Prior to exit no further information was shared.	F 607		
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 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-	F 655		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 655	Continued From page 52 (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 staff interviews, and clinical record review, the facility staff failed to complete and implement the baseline care plan within 48 hours of a resident's admission and failed to provide a written baseline care plan summary to one resident representative for 2 of 44 residents (Resident #83 and #67), in the survey sample. The findings included: 1. Resident #83 was originally admitted to the facility 11/19/21, was discharged to acute care 11/26/21. The diagnoses at the time of the resident's 11/19/21 admission included; status post decompression and fusion of the lumbar spine and polymyalgia rheumatic. The admission Minimum Data Set (MDS) assessment with an assessment reference date	F 655	1. Resident #83 no longer resides in the facility. Resident #67 and her RP were provided a copy of her baseline care plan. 2. An audit of all admissions since 3/14/22 was completed by the VPO on 4/13/22 and a copy of the baseline care plan will be provided to the resident and/or RP. 3. IDT was educated by VPO on 4/13/22 and 4/14/22 regarding baseline care plans, and a new process was implemented. The Admissions Director will schedule the baseline care plan meeting upon admission. The baseline care plan will be signed by the IDT and resident/RP, and a copy provided to resident/RP, and scanned into the medical record.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 655	Continued From page 53 (ARD) of 11/26/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #83's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people with transfers, extensive assistance of one person with dressing and toileting, limited assistance of one person with bed mobility and personal hygiene, and supervision after set-up with eating. In section J0500A and B; the resident was coded that pain made it hard to sleep at night and limited day to day activities. At section M1040E; the resident was coded with a surgical wound. On 3/16/22 at approximately 10:30 a.m., an interview was conducted with the resident's listed Responsible party (RP). The RP stated the resident had very specific toileting needs based on a history of urinary problems and the limitation in his physical abilities secondary to the recent back surgery and the severity of his pain. A review of Resident #83's clinical record failed to evidence a baseline care plan which was to provide instructions for the provision of effective and person-centered care to the resident. An interview was conducted with the MDS Coordinator on 3/16/22 at approximately 2:10 p.m. The MDS Coordinator stated she was unable to locate a baseline care plan for Resident #83's 11/19/21 admission. On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, VPCS and the Vice President of Operations	F 655	4. Administrator, or designee, will audit baseline care plans of all new admission weekly for evidence of a baseline care plan meeting, including evidence that it was provided to the resident/RP, weekly for 4 weeks and monthly for 2 months. Results will be brought to QAPI for 3 months or until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 655	Continued From page 54	F 655		

(VPO). The VPCS stated development of the baseline care is a comprehensive approach by all staff to develop and implement.
2. The facility staff failed to provide a written baseline care plan summary to Resident #67's representative.

Resident #67 was admitted to the facility on 2/17/22 with diagnoses to include but not limited to Diabetes Mellitus and Depression.

The most recent comprehensive Minimum Data Set (MDS) was an Admission Assessment with an Assessment Reference Date (ARD) of 2/24/22. The Brief Interview for Mental Status for Resident #67 was coded as a 3 out of a possible 15, indicating the resident was severely cognitively impaired and incapable of daily decision making.

A review of Resident #67 electronic medical record indicated the baseline care plan was completed on 2/17/22 by Licensed Practical Nurse (LPN #3). Resident #67's progress notes were reviewed but revealed no documentation that a copy of the written baseline care plan summary was provided to the patient's representative.

On 3/9/22 at approximately 6:00 p.m. an interview was conducted with Resident #67 daughter who was asked if the facility provided her with a copy of the baseline care plan summary that was completed for her mother. Resident #67's daughter states, "No I never received a copy of any type of care plan for mom, this is the first time hearing about it."

On 3/14/22 at 1:56 p.m. a phone interview was conducted with LPN #3. LPN #3 was asked if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 655	Continued From page 55	F 655		

she completed Resident #67's baseline care plan and did she provide the family with a copy of the written baseline care plan summary. LPN #3 stated, "I remember doing the baseline care plan, but I'm not sure that I gave a copy to her daughter or talked to her about it."

On 3/15/22 at 1:00 p.m. an interview was conducted with the Vice President of Clinical Services regarding Resident #67's baseline care plan summary. The Vice President of Clinical Services stated, "I do not see a note in Name (Resident #67's) chart that the family was given a copy of the baseline care plan summary. The interdisciplinary team meets with the family and resident within the 48 hour window to go over the baseline care plan and a copy is to be given them. It should then be documented in the resident's medical record that the a copy of the baseline care plan summary was given to the resident and family."

The facility policy titled "Care Plans-Baseline" revised 12/2016 was reviewed and is documented in part, as follows:

Policy Statement: A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight ($*) hours of admission.

Policy Interpretation and Implementation:
4. The resident and their representative will be provided a summary of the baseline care plan that includes, but is not limited to the following:
a. The initial goals of the resident;
b. A summary of the resident's medications and dietary instructions;
c. Any services and treatments to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 655	Continued From page 56 administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary. On 3/17/22 at 2:40 p.m. an interview was conducted with the Administrator regarding Resident #67's baseline care plan summary. The Administrator stated, "Based on our policy, Social Services should review the baseline care plan summary and provide a copy of the summary with the resident and family." During a pre-exit debriefing on 3/17/2 at 5:44 p.m. with the Administrator, Vice President of Operations and the Vice President of Clinical Services the above information was shared. Prior to exit no further information was shared.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 657	Continued From page 57 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility staff failed to revise the care plan for one resident, Resident #37, in the survey sample of 44 residents, to include interventions for this resident sharing alcohol with other residents. The findings included: Resident #37 was admitted to the facility on 11/17/2018 with diagnoses of sequela, neuromuscular dysfunction of bladder, paraplegia, hypertension, anxiety disorder, contracture of right hip, contracture of left hip, and depression. The facility staff failed to revise Resident #37 care plan to include interventions for sharing alcohol with other residents. A Quarterly Minimum Data Set (MDS) assessed Resident #37 as having a Basic Interview for Mental Status (BIMS) score of 13. In the area of Activity's of Daily Living (ADL's) this resident was assessed as requiring extensive assistance in the area of bed mobility and transfer.	F 657	1. Resident #37 care plan was revised on 4/14/22. 2. Care plan audit was completed for the residents who consume alcohol with resident #37 to ensure their care plans reflect that their alcohol consumption. 3. Staff was educated on 4/15/22 regarding comprehensive care planning. 4. DON, or designee, will audit 5 care plans weekly for 3 months to ensure known behaviors are captured on the comprehensive care plan. Results will be brought to QAPI for 3 months or until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 657	Continued From page 58	F 657		

A Care Plan Dated: 2/11/2022 indicated:

The resident needs a safe environment with: (floors free from spills and/or clutter; adequate light; a working and reachable call light, personal items within reach)

The resident uses antidepressant medication r/t Depression-The resident will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Administer ANTIDEPRESSANT medications as ordered by physician. Monitor/document side effects and effectiveness Q-SHIFT.

Monitor/document/report PRN adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes.

The resident has depression- The resident will exhibit indicators of depression, anxiety or sad mood less than daily by review date. Administer medications as ordered. Monitor/document for side effects and effectiveness.

Monitor/document/report PRN any risk for harm to self: suicidal plan, past attempt at suicide, risky actions (stockpiling pills, saying goodbye to family, giving away possessions or writing a note), intentionally harmed or tried to harm self,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 657	Continued From page 59	F 657		

refusing to eat or drink, refusing med or therapies, sense of hopelessness or helplessness, impaired judgment or safety awareness.

Monitor/record/report to MD PRN risk for harming others: increased anger, labile mood or agitation, feels threatened by others or thoughts of harming someone, possession of weapons or objects that could be used as weapons.

A Nursing Progress Note dated 02/19/22 at 14:33 indicated: "Resident was reported by another resident and reported to staff that he was drinking alcohol."

A Nursing Progress Note dated 02/17/22 at 13:17 indicated: " Notified RP and Resident about care plan meeting scheduled for 02/23/2022."

A Nursing Progress Note dated 02/23/22 at 13:51 indicated: " Care Plan meeting: Resident and family member invited; resident did attend and sister (via) phone. Care, goals and concerns were addressed.

A Nursing Progress Note dated 12/11/21 at 17:55 indicated: " 50 ml empty bottle of Scotch found in residents trash. Resident admits to drinking it this evening, per staff. Hold melatonin for tonight and resume meds in AM. No behaviors exhibited from resident, monitored for change.

A Nursing Progress Note dated 10/01/21 at 17:26 indicated: " Spoke with family member and informed of resident going to ABC store to purchase alcohol and returning to parking lot to share with other resident. MD notified."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 657	Continued From page 60 During an interview on 03/11/22 at 14:05 PM with Resident #37, he stated, he goes over to the ABC store sometimes and purchase alcohol. Me and some of my friends we have a drink or two. During an interview on 3/11/22 at 15:00 PM with the Social Worker (SW), she stated, the facility staff is aware that Resident #37 goes over to the ABC store and purchase alcohol. The Social Worker stated they have spoken to Resident #37 and his family concerning this behavior. The SW was asked had the concerns of sharing the alcohol with other residents been addressed. The SW stated, no.	F 657		
F 684 SS=G	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 complaint investigation, staff interviews, clinical record review, and facility documentation, the facility staff failed to provide the necessary care and treatment for 5 out of 44 residents (Resident #84, #64, #79, #56, and #71) in the survey sample. For Resident #84, the facility staff failed to follow the Nurse Practitioner (NP) orders to provide parenteral Intravenous (IV) fluids as ordered on 02/04/22 at approximately 10:30 a.m., to start Sodium Chloride Solution	F 684	1. Deficient practices for residents #84, 64, 56 cannot be retroactively corrected. For resident #71 PICC line care changed on 3/17/2022. 2. Review of 24 hour report, clinical dashboard, and new orders will be done to identify other residents at risk for being affected by the same deficient practices.	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 61 0.9%, use 50 ml/hour intravenously (IV) x 24 hours for 2 liters for hydration which was never initiated for a resident who had a decline in oral fluids, decrease appetite and having loose stools. Resident #84 remained in the facility for 28 hours after the order was given on 02/04/22 to start IV fluids. On 02/05/22 at approximately 2:56 p.m., Resident #84 was observed in respiratory distress, unable to obtain blood pressure, and using accessory muscles for breathing. Resident #84 was transferred via 911 (emergent) to the local hospital and admitted on 02/05/22 with a diagnosis of severe metabolic acidosis, severe dehydration, hypothermia at 89.4 degrees, Urinary Tract Infection (UTI), and Acute Kidney Injury (suspect pre-renal due to dehydration), which constituted harm for Resident #84. For Residents #64 and #79, the facility staff failed to obtain blood sugars as ordered by the physician. For Resident #56, the facility staff failed to recognize, assess and intervene on an acute change in condition for a resident presenting with a four-pound weight gain in a week, increased edema to the resident's right leg, left arm, and face, and episodes of shortness of breath without flowing oxygen. For Resident #71, the facility staff failed to follow physician orders for the care of an IV PICC line. The findings included: 1. Resident #84 was admitted to the nursing facility on 11/10/21. The resident was discharged to the local hospital on 02/05/22 and did not return to the nursing facility. Diagnosis for Resident #84 included but not limited to Chronic Kidney Disease (not on dialysis) and Type II	F 684	3. Licensed nurses will be re-educated on establishing IV access, obtaining blood sugar levels, and identifying changes in conditions. 4. Unit Manager, or designee, will audit MARs 5/days a week x 4 to ensure orders are confirmed and executed. Results will be reported to QAPI for 3 months or until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 62	F 684		

Diabetes Mellitus.

The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 11/17/21 coded the resident on the Brief Interview for Mental Status (BIMS) an 11 of 15 indicating moderate cognitive impairment. Resident #84 was coded total dependence of one with toilet use and bathing, extensive assistance of one with bed mobility and transfer, limited assistance of one with dressing and personal hygiene, and supervision with one assist with eating Activities of Daily Living (ADL). Under section H - (Bladder and Bowel) was coded for always incontinent of bladder and bowel.

The care plan created on 11/17/21 and a revision date of 01/11/22 identified Resident #84 with impaired cognitive function or impaired thought process related to an altered mental status. The goal set for the resident by the staff was that the resident will improve their current level of cognitive function through the next review on 03/09/22. One of the interventions/approaches the staff would use to accomplish this goal is to administer medications as ordered. Monitor/document for side effects and effectiveness.

On 02/04/22, the Nurse Practitioner's (NP) progress revealed the following information: "Resident #84 is being seen today for loose stools, decrease intake, and COVID-19. Resident #84 reports having decreased appetite and increased thirst." Under diagnosis, assessment and plan it included but was not limited to start Sodium Chloride Solution at 50 ml/hour x 2 liters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 63	F 684		

The review of Resident #84's Medication Administration Record (MAR) revealed the following order: Sodium Chloride Solution 0.9%, use 50 ml/hour intravenously (IV) x 24 hours for 2 liters for hydration or clysis for 3 days, the order remains in pending confirmation.

An interview was conducted with License Practical Nurse (LPN) #6 on 03/14/22 at approximately 4:12 p.m. When asked, what does it mean with an order that reads pending confirmation? The LPN stated, that the order was put in Point Click Care (PCC) but the nurse never confirmed the order, so the order was never initiated.

A review of Resident #84's clinical record revealed the following documentation entered on 02/05/22 at approximately 2:56 p.m., by LPN #3. Resident #84 noted having respiratory distress, being unable to obtain blood pressure, oxygen saturation of 94% on room air, and heart rate of 102 while using accessory muscles for breathing. A new order was obtained to send to the ER for evaluation and treatment.

A phone interview was conducted with Nurse Practitioner (NP) on 03/15/22 at approximately 2:08 p.m. The NP stated she assessed Resident #84 on 02/04/22 due to the staff reporting the resident was having loose stools and not eating. She said that during her discussion with the resident, he voiced to me that he was really thirsty and has no appetite. The NP said IV fluids were ordered and started on 02/04/22. The NP stated, "IV fluids were ordered for hydration because Resident #84 was having loose stools and not eating" She said the BMP was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 64	F 684		

ordered as STAT (now order) because I needed time for the IV fluids to hydrate the resident to help determine what further treatment was needed. The NP stated, "Unfortunately, his IV fluids were never started and I was never notified."

An interview was conducted with LPN#3 on 03/14/22 at approximately 1:46 p.m. The LPN was assigned to provide care and services to Resident #84 on 02/04/22 and 02/05/22 (7-3 shift), the day Resident #84 was evaluated by the NP with new orders to start IV fluids. The LPN said she remembered Resident #84 was not eating or drinking. She said the NP came in and saw Resident #84 and wrote a bunch of new orders but I was never informed that an order to start IV fluids.

On 03/15/22 at approximately 9:44 a.m., a phone interview was conducted with LPN #5. The LPN was assigned to provide care and services to Resident #84 on 02/04/22 (11-7 shift). The LPN stated, "I don't recall the nurse giving a report that Resident #84 had an order to start an IV to administer IV fluids."

On 03/16/22 at approximately 2:53 p.m., an interview was conducted with the Regional Director of Clinical Services. The Regional Director said the nurse(s) should have activated the order in PCC and the IV fluids should have been started as ordered by the (NP). He stated, "If the nurse assigned was not able to start the IV, there is always someone in house that could have started the IV. He stated clysis could have been used to hydrate the resident.

A phone interview was conducted with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 65	F 684		

Medical Director on 03/17/22 at approximately 5:11 p.m., when asked if the staff should have started the fluids IV or via clysis, he replied, "Absolutely, not receiving the IV fluids could have contributed to his dehydration as well as Acute Renal Failure (AFR)." The Medical Director stated, "The NP or I should have been notified that Resident #84's IV fluids were never started."

A review of the hospital records revealed the following: "Resident #84 presented in the Emergency Room (ER) on 02/05/22 from (name of nursing facility) for further evaluation due to lethargy. The 911 transport revealed the following: "Resident serum glucose was 14. The Emergency Medical Service (EMS) placed an IV, gave glucagon and D10 and his glucose increased to 135." The ER records indicated Resident #84's rectal temperature at 89.4 degrees F (hypothermia - low body temperature) and placed on Bair Hugger for low rectal temperature. The resident's blood pressure was 89/40 (normal = 120/80). He was found to be in severe metabolic acidosis and septic shock. The urinalysis with reflex showed large leukocyte esterase, positive nitrites, and a moderate amount of blood with 3+ bacteria. The urine culture revealed more than 100,000 colonies and was positive for Kiebsiella pneumoniae. The resident had a high blood creatinine of 7.2 (0.59-1.04 = normal range). The creatinine test is a measure of how well your kidneys as performing their job of filtering waste from your blood (www.mayoclinic.org). The resident was started on IV sodium bicarbonate, given D50, and admitted to the Intensive Care Unit (ICU). Intravenous Fluids (IV), and IV antibiotic (Zyvox and Zosyn) was also started. Resident #84 is in the ICU, on a ventilator, sedated and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 66	F 684		

unresponsive. The resident will need dialysis per nephrology but is pending due to his acute kidney injury. Resident #84 is being transferred to a higher level of care on 02/12/22. The resident is hemodynamically unstable for conventional hemodialysis and will benefit from continuous renal replacement therapy (CRRT), which this facility doesn't provide. At the time of discharge, resident remains on a mechanical ventilator."

A review of the hospital records revealed the following: Resident #84 presented in the Emergency Room (ER) on 02/12/22 as a transfer from the originated hospital for further evaluation due to hypoglycemia and Altered Mental Status (AMS). The resident was sent here for continuous renal replacement therapy (CRRT), which the previous hospital doesn't provide. The hemodialysis catheter placement was placed and (CRRT) was started on 02/13/22.

A debriefing was conducted with the Administrator, Vice President of Clinical Services, and Regional Director of Clinical Services on 03/17/22 at approximately 5:45 p.m., Resident #84's issues were presented again. The facility did not present any further information about the findings prior to survey exit.

Definitions:
-Metabolic acidosis develops when too much acid is produced in the body. It can also occur when the kidneys cannot remove enough acid from the body. Some causes of metabolic acidosis include but are not limited to severe diarrhea and severe dehydration. Treatment is aimed at the health problem causing acidosis. In some cases, sodium bicarbonate may be given to reduce the acidity of the blood. Often, you will receive lots of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 67	F 684		

fluids through the vein (https://medlineplus.gov).

-Dehydration occurs when you use or lose more fluid than you take in, and your body doesn't have enough water and other fluids to carry out its normal functions. If you don't replace lost fluids, you will get dehydrated. You can usually reverse mild to moderate dehydration by drinking more fluids, but severe dehydration needs immediate medical treatment. Many people, particularly older adults, don't feel thirsty until they're already dehydrated. That's why it's important to increase water intake when you're ill. Other dehydration causes include but are not limited to diarrhea and or acute diarrhea - that is, diarrhea that comes on suddenly and violently - can cause a tremendous loss of water and electrolytes in a short amount of time. Dehydration can lead to serious complications, including urinary and kidney problems. Prolonged or repeated bouts of dehydration can cause urinary tract infections, kidney stones, and even kidney failure.

The only effective treatment for dehydration is to replace lost fluids and lost electrolytes. The best approach to dehydration treatment depends on age, the severity of dehydration, and its cause. Adults who are severely dehydrated should be treated by emergency personnel arriving in an ambulance or in a hospital emergency room. Salts and fluids delivered through a vein (intravenously) are absorbed quickly and speed recovery.

-Hypothermia is a medical emergency that occurs when your body loses heat faster than can produce heat, causing a dangerously low body temperature. Normal body temperature is around 98.6. Hypothermia occurs as your body

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 68	F 684		

temperature falls below 95 degrees Fahrenheit (https://www.mayoclinic.org).

-Urinary tract infection occurs when there is a compromise of host defense mechanisms and a virulent microbe adheres, multiplies, and persists in a portion of the urinary tract. Most commonly, UTIs is caused by bacteria, but fungi and viruses are possible. Urine culture and sensitivity are the gold standards for the diagnosis of bacterial UTIs (https://www.ncbi.nlm.nih.gov).

-Acute Kidney Injury occurs when your kidneys suddenly become unable to filter waste products from your blood. When your kidneys lose their filtering ability, dangerous levels of waste may accumulate, and your blood's chemical makeup may get out of balance. Acute kidney failure - also called acute renal failure or acute kidney injury - develops rapidly, usually in less than a few days (https://www.mayoclinic.org/diseases-conditions/kidney-failure/symptoms-causes).

-Sodium Chloride Solution 0.9%, solution is used to supply water and salt (sodium chloride) to the body. Sodium chloride solution may also be mixed with other medications given by injection into a vein (https://www.webmd.com/drugs).

-Clysis or hypodermoclysis is a relatively safe and effective procedure in a nursing home. The use of clysis in the nursing home is an alternative to intravenous hydration. The use of clysis for short-term hydration has the potential to reduce costs and transfers to the hospital (https://pubmed.ncbi.nlm.nih.gov).

-A basic metabolic panel (BMP) is a test that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 69	F 684		

measures eight different substances in your blood. It provides important information about your body's chemical balance and metabolism. Metabolism is the process of how the body uses food and energy. A BMP is used to check different body functions and processes, including kidney function, fluid and electrolyte balance, blood sugar levels, and acid and base balance (https://medlineplus.gov).

-Klebiella pneumoniae is one of the bacteria most frequently causing healthcare-associated urinary tract infections (https://www.ncbi.nlm.nih.gov).

-Bair hugger system is a temperature management system used in a hospital or survey center to maintain a patient's core body temperature (https://www.bairhugger.com).

-Mechanical ventilation is a form of life support. A mechanical ventilator is a machine that takes over the work of breathing when a person is not able to breathe enough on their own. The mechanical ventilator is also called a ventilator, respirator, or breathing machine (https://www.continued.com/resp-therapy/courses).

2. The facility staff failed to follow physician orders to obtain blood sugars as ordered by the physician. Resident #64 was admitted to the nursing facility on 11/12/21. Diagnosis for Resident #64 included but not limited to Type II Diabetes Mellitus (DM) with hyperglycemia.

The current Minimum Data Set (MDS), a quarterly assessment with an Assessment Reference Date (ARD) of 02/22/22 coded the resident with a 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 70	F 684		

out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. The MDS coded Resident #64 requiring total dependence of one with bathing, extensive assistance of one with dressing, limited assistance of one with toilet use and personal hygiene and supervision with transfer and eating for Activities of Daily Living care. Under Section N for the use of insulin injection was coded as received daily during the last 7 days.

The care plan created on 11/15/21 identified Resident #64 with a diagnosis of diabetes mellitus. The goal set for the resident by the staff is to be without complications related to diabetes. Some of the interventions/approaches the staff would use to accomplish this goal is monitor/document/report as needed any signs or symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain and acetone breath (smells fruity).

During the initial tour on 03/09/22 at approximately 3:27 p.m., an interview was conducted with Resident #64 who stated, "The nurses do not always check my blood sugar." The resident stated my blood sugar is to be check everyday before my meals and at bedtime.

Review of Resident #64's physician orders for March 2022 revealed the following order starting on 11/15/21: check blood sugars before meals and at bedtime. Notify the physician for blood sugar less than 60 or greater than 400.

1. Review of January 2022 Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 71	F 684		

Administration Record (MAR) revealed blood sugar's
were not obtained as ordered by the physician on the following days: 01/18 (before breakfast, 01/19 (at bedtime), 01/20 (before breakfast) and 01/24 (before breakfast).

2. Review of February 2022 Medication Administration Record (MAR) revealed blood sugar's were not obtained as ordered by the physician on the following days: 02/04 (before breakfast), 02/07 (at bedtime), 02/17 (before breakfast, before dinner and at bedtime).

An interview was conducted with the Regional Director of Clinical Services on 03/16/22 at approximately 2:53 p.m., who reviewed the documents mentioned above. He stated, the expectations is for all nurses are to obtain blood sugars as ordered by the physician. The Regional Director stated, "If it's not documented, it didn't happen."

A debriefing was held with the Administrator and Vice President of Operations on 03/17/22 at approximately 5:45 p.m., who were informed of the above findings; no further information was provided prior to exit.

The policy titled: Obtaining a Fingerstick Glucose Level with a revision date of 10/11.
Purpose is to obtain a blood sugar sample to determine the resident's blood glucose level.

Documentation read in part: The person performing this procedure should record the following in the resident's medical record:
5. If the resident refused the procedure, the reason(s) why and the intervention taken.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 72	F 684		

6. The blood sugar results. Follow facility policies and procedure for appropriate nursing interventions regarding blood sugar results (if resident is on sliding scale coverage, and/or physician interventions is needed to adjust insulin or oral medication dosages).

3. The facility staff failed to follow physician orders and obtain blood sugars for Resident #79.

The quarterly Minimum Data Set (MDS) assessment dated 3/4/22 coded Resident #79 was assessed as a 15 on the BIMS assessment.

A Care Plan dated 2/28/22 indicated:

Potential for complications from Diabetes Mellitus diagnosis. Blood Sugar as ordered by doctor. Check all of body for breaks in skin and treat promptly as ordered by doctor. Diabetes medication as ordered by doctor.
Monitor/document for side effects and effectiveness. Dietary consult for nutritional regimen and ongoing monitoring.
Consult and notify doctor of any changes in diabetic medications. Inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness.

Monitor/document/report PRN any s/sx of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, and pain, Kussmaul breathing, acetone breath (smells fruity), stupor, coma.

Monitor/document/report PRN any s/sx of hypoglycemia: Sweating, Tremor, Increased heart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 73	F 684		

rate (Tachycardia), Pallor, Nervousness, Confusion, slurred speech, lack of coordination, Staggering gait.

Monitor/document/report PRN any s/sx of infection to any open areas: Redness, Pain, Heat, swelling or pus formation.
Monitor/document/report PRN compliance with diet and document any problems. Offer substitutes for foods not eaten.

Resident is at risk for injuries from falls related to history of falls, possible side effects from medications, diagnosis of Epilepsy, HTN, Diabetes Mellitus, Atrial Fib.

A 01/04/2022 physician order indicated: Blood sugar check daily 4 times a day. Notify MD less 60 or greater than 400.

A review of the Medication Administration Record (MAR) indicated: Blood sugars were not taken at the 0600 and the hour on February 17 and 18. Blood sugars were not taken at the 1700 and 2100 hour on the 25th. Blood sugars were not taken at the 0600 hour on the 26th.

Resident #79 was noted to have the following physician orders:
Insulin Aspart Flexpen 100 unit/ML solution pen injector
Inject as per sliding scale:
if 0 - 199 = 0 units
200 -250 = 2 units
251- 300 = 4 units
301- 350 = 6 units
351- 400 = 8 units - if over 400 call MD,
subcutaneously before meals and at bedtime for DM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 74	F 684		

During an interview on 3/17/22 at 10:10 a.m. with the Corporate Clinical Nurse (CCN), he was asked what did the blank areas of the MAR indicate. The CCN stated that the blank areas indicated the blood sugars were not taken.

4. The facility staff failed to recognize, assess and intervene on an acute change in condition for a resident presenting with a four pound weight gain in a week, increased edema to the resident's right leg, left arm and face and episodes of shortness of breath without flowing oxygen for Resident #56.

Resident #56 was originally admitted to the facility 9/19/16 and readmitted 1/30/22 after an acute care hospital stay. The current diagnoses included; COPD, congestive heart failure (CHF), and respiratory failure with hypoxia.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/15/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #56's cognitive abilities for daily decision making was intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with personal hygiene, bathing, dressing, and toileting, extensive assistance of two people with bed mobility and supervision of one person after set-up with eating.

Resident #56 was observed seated in a wheel chair in her room. She was wearing a slipper to the right foot and her right lowered leg was with plus two edema and redness. The resident's left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 75	F 684		

arm was also with plus two edema and her face appeared fuller than it was the prior evening. The resident had a portable oxygen tank on the back of her wheel chair but it was on empty and she had a nasal cannula in her nostrils.

An interview was conducted with Resident #56 in her room on 3/10/22 at approximately 2: 30 p.m. Resident #56 stated she participated in the Resident Council meeting earlier on 3/10/22 and was waiting for the nurses to put her back in bed. Resident #56 stated she felt heavy as well as a little short of breath and it troubled her for in January 2022 she was hospitalized twice for shortness of breath caused by COPD and congestive heart failure. The resident stated her doctor always told her to weigh daily and if there was a change of three pounds or more to contact the office and to be sure she monitored her intake of fluids. Resident #56 stated she asked Certified Nursing Assistant CNA) #6 to weight her on 3/10/22 and she weighed was 194.5 pounds. Resident #56 stated she's supposed to wear a TED hose to her right leg but the CNA wasn't able to locate one that morning. The resident also stated she received a fluid pill, a heart pill and oxygen to manage her breathing problems caused by COPD and congestive heart failure.

The Physician's Order Summary (POS) revealed an order dated 3/1/22 which read; weekly weights to be completed one time a day every Monday related to heart failure. The resident's weight was 190.7 pounds on 3/7/22.

Additional orders on the POS read; 8/25/21 Lasix Tablet 40 MG (Furosemide) Give 1 tablet by mouth two times a day for CHF. 08/17/2021- apply TED hose in AM and off in PM two times a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 76	F 684		

day. 12/31/21 Oxygen 2 liters per minute by nasal cannula as needed for oxygen saturations below 92 percent.

The resident's diet order dated 8/17/21 read, regular diet, regular texture, thin consistency, no added sodium; 1200 milliliters/24 hour fluid restriction. Fluid Restriction: 1200 cc (720cc with Meals and 480CC provided by Nursing) 7-3 = may give 240 cc 3-11 = may give 120 cc 11-7 = may give 120 cc.

The current care plan had a problem dated 2/24/22 which read; resident has altered cardiovascular status r/t hypertension, CHF and cardiomyopathy. The goal read; the resident will be free from complications of cardiac problems through the review date. The interventions included; Assess lung and heart sounds as needed. Medications as ordered. Oxygen at 2 liters per minute via nasal cannula. Vital signs as ordered. Resident is a daily weight

An interview was conducted with Licensed Practical Nurse (LPN) #10 on 3/10/22 at approximately 4:35 p.m. LPN #10 stated the resident's portable oxygen tank was empty but she connected the resident to the concentrator and her oxygen saturation was 8 percent. LPN #10 stated she didn't assess or obtain the resident's saturation prior to attaching her tubing to the concentrator. LPN #10 didn't acknowledge the resident's shortness of breath, increased weight or edema to her extremities but she stated the resident offered no concerns. LPN #10 stated she signed off for the resident's TED hose because she relied on the CNA to apply them as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 77	F 684		

An interview was also conducted with LPN #8 on 3/10/22 at approximately 5:00 p.m. LPN #8 stated the resident's weights are charted and if they flagged, other actions would be taken.

An interview was also conducted with the Director of Nursing (DON) on 3/10/22 at approximately 5:10 p.m. The DON stated the resident would be assessed and the physician/designee would be contacted for further instructions.

On 3/11/22, Resident #56 was evaluated by the rounding Nurse Practitioner (NP). The NP assessment revealed the following; 3/11/22 staff reported 4.2 pounds weight gain over one week. Plus one edema to the right lower extremity with redness and warmth and fluid filled blisters and plus one edema to the left upper arm. Plan Keflex 500 milligram every twelve hours for seven days, complete blood count, basic metabolic panel, brain natriuretic peptide, chest x-ray and urinalysis and culture and sensitivity.

The chest x-ray results findings dated 03/12/22 were as follows; there is cardiomegaly. There is interstitial edema. There is pulmonary venous hypertension. There is no pneumonia, mass, or adenopathy. There is no effusion. There is congestive heart failure. There is no pneumothorax. There is a right base infiltrate increased from 02/23/2022. There is no tuberculosis.

On 3/12/22 a new order was received to start for Duoneb every 6 hours for SOB and/or wheezing.

On 3/15/22, an order was received to start Furosemide Tablet 20 MG; Give 1 tablet by mouth one time a day for CHF for 5 Days. This was in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 78	F 684		

addition to the previously ordered Lasix 40 mg two times each day.

On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, VPCS and the Vice President of Operations (VPO). No additional information was offered and no concerns were voiced.

Heart failure signs and symptoms may include: Shortness of breath with activity or when lying down, fatigue and weakness, swelling in the legs, ankles and feet, rapid or irregular heartbeat, swelling of the belly area (abdomen), very rapid weight gain from fluid buildup ... (https://www.mayoclinic.org/diseases-conditions/heart-failure/symptoms-causes/syc-20373142). The above information was obtained 3/24/22.

5. The facility staff failed to follow physician orders for the care of a IV PICC line.

Resident #71 was originally admitted to the facility 1/11/22 and readmitted 2/21/22 after an acute care hospital stay. The current diagnoses included; Incision and drainage of the right knee and placement of antibiotic beads.

The five day Medicare Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/28/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #71's cognitive abilities for daily decision making were intact.

In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 79	F 684		

with bed mobility, extensive assistance of one person with personal hygiene, dressing, toileting limited assistance of one person with eating and limited assistance of one after set-up with eating.

Resident #71 was observed sitting in a wheel chair in her room on 3/9/22 at approximately 4:45 p.m. The resident stated she had surgery to the right knee and the physician had to go back in it and clean it out because of an infection; as a result she needed to have extensive antibiotic therapy intravenously. The resident further stated some of staff act like they have no idea how to administer the antibiotic.

The resident had a PICC to the right upper arm and it was dated 3/9/22. Resident #71 stated the PICC dressing was supposed to be changed 3/5/22 but it wasn't changed until 3/9/22 and it was supposed to be changed again on 3/12/22 but it was now 3/17/22 and it hadn't been changed. Resident #71 stated she was concerned the PICC site may become infected and cause a delay in her going home.

The physician order summary revealed the following orders;
2/25/22 IV PICC change needleless connector on admission, weekly every day shift/ Saturday for and as needed thereafter and change after every blood draw.

2/25/22 IV-PICC Measure catheter length on admission and with each dressing change thereafter. 2/25/22 IV-PICC change transparent dressing on admission, then weekly every day shift/Saturday and as needed thereafter.

2/21/22 Ceftriaxone Sodium Solution

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 80 Reconstituted 2 Grams - Use 2 gram intravenously in the evening for infection related to infection and inflammatory reaction due to internal right knee prosthesis. An interview was conducted with Licensed Practical Nurse (LPN) #15, on 3/17/22 at approximately 1:15 p.m. LPN #15 stated she would take care of the dressing change today. On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, VPCS and the Vice President of Operations (VPO). The VPSC stated he had spoken to the nurse caring for Resident #71 and the dressing was to be changed today. The below information was obtained from the following web site on 3/25/22 (https://medlineplus.gov/ency/patientinstructions/000462.htm#:~:text=You%20should%20change%20the%20dressing,you%20with%20the%20dressing%20change.) A dressing is a special bandage that blocks germs and keeps your catheter site dry and clean. You should change the dressing about once a week. You need to change it sooner if it becomes loose or gets wet or dirty. COMPLAINT DEFICIENCY	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F 686		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 81 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and clinical record review, the facility staff failed to provide services to prevent pressure ulcers and promote healing for 2 of 9 Residents with pressure ulcers, the facility staff failed to properly classify, assess, and institute an appropriate treatment/care to Resident #8's pressure ulcer to the left hip to prevent deterioration to unstageable, presenting with 70 percent granulation tissue/30 percent slough (dead tissue) over four days, which constituted harm. For Resident #26, the facility staff failed to provide care and services to prevent pressure ulcer development in two areas prior to identification at an advanced stage; the sacrum with 100% slough/eschar and the right lateral ankle with 100% slough/eschar which constituted harm. The findings included: 1. Resident #8 was originally admitted to the facility on 5/11/12 and was discharged from the facility for an acute care hospital stay, returning on 3/29/14. The current diagnoses included; dementia, high blood pressure, and adult failure to thrive.	F 686	1. For resident # 8, assessment, measurements, and treatment plan including recommended air mattress put in place. 03/31/2022 wound status documented as improving as evidence by a decrease in measurements. For resident # 26, assessments and measurements cannot be corrected retroactively since resident no longer resides at facility. 2. Weekly skin observations for all residents are up to date. Review wounds reports and recommendations to ensure carried out accordingly. 3. In-service unit managers and licensed nurses on requirements to complete weekly skin observations. Unit managers will review new admissions to ensure complete and accurate capture of skin conditions. DON or designee shall audit on weekly basis, the house acquired wounds, treatment plans, and resolutions to Wound Practitioner recommendations. 4. DON or designee shall report on cases of pressure ulcers to QAPI committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 82	F 686		

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 12.25/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 0 out of a possible 15. This indicated that Resident #8's cognitive abilities for daily decision-making were severely impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with bed mobility, transfers, total care of one person with dressing, eating, toileting, personal hygiene, and bathing.

A review of the facility's matrix revealed Resident #8 was coded for having a facility-acquired unstageable pressure ulcer.

A review of the clinical record revealed a nurse progress note authored by LPN #10 on 3/8/22 at 3:05 p.m., which read; that the Wound Care Nurse Practitioner (WCNP) was noted in the facility and was made aware that the resident's left hip was worsening.

The clinical record offered no evidence that Resident #8 had an opened area to the left hip and there was no assessment and/or documentation of a left hip open area. This was the first documentation of a left hip open area.

An interview with LPN #10 on 3/10/22 at approximately 4:15 p.m. revealed the left hip was being treated with; normal saline, dry and apply Triple-antibiotic ointment (TAO) and a border gauze. This was the order for the left buttock scratches.

The clinical record revealed a "change in condition document" dated 3/4/22 which identified

monthly x 3, or until satisfactory compliance is achieved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 83	F 686		

a reopened area to the left buttock due to observed self-inflicted and witnessed scratching on more than one occasion. An order was obtained to cleanse the scratches to the left buttock open area with normal saline, dry, and apply Triple-antibiotic ointment (TAO) and a border gauze every day until healed. The left buttock scratches were documented as healed on 3/8/22.

An interview was conducted with Licensed Practical Nurse (LPN) #6 on 3/17/22 at approximately 12:05 p.m. LPN #6 stated LPN #16 stated she obtained the left buttock treatment order from the primary Nurse Practitioner (NP) for self-inflicted and witnessed scratches to the left buttock, not a pressure ulcer, just as she documented on the "change in condition" form

The left hip wound was assessed for the first time by the WCNP on 3/8/22 and the assessment revealed an etiology of pressure. The pressure ulcer measured; length 3.03 centimeters by a width of 2.17 centimeters, with no depth. It contained 70 percent granulation tissue/30 percent slough, had a scant amount of serosanguinous drainage, and no odor. The left hip pressure ulcer was classified as unstageable. The WCNP stated to discontinue the previous treatment to cleanse the left buttock open area with normal saline, dry, apply Triple-antibiotic ointment (TAO), and apply a border gauze every day until healed and to start to cleanse the left hip pressure ulcer with wound cleanser, pat dry and apply Medi-honey with a border dressing every day. The WCNP also recommended an air mattress for pressure reduction and provided the following; Plan of Care Assessment and Plan - resident has a pressure injury; pressure reduction

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 84	F 686		

and turning precautions discussed with staff at the time of visit recommended, including heel protection and pressure reduction to bony prominences. Staff educated on all aspects of care.

An observation was made on 3/10/22 at approximately 4:45 p.m., of the resident in bed lying to face the doorway. The resident was lying on a pressure-reducing reducing mattress, not the recommended low air loss mattress. A pair of pressure-reducing reducing boots were observed in the Broda chair (a special chair used for prevention and seating comfort) at the foot of the bed. The resident spoke nonsensically and rocked repetitively.

Another observation was made on 3/14/21 at approximately 11:30 a.m., again the resident was in bed lying on a standard pressure-reducing mattress on her right side and facing the doorway. The recommended low air loss mattress was not on the bed. She was talking and rocking repetitively, asking what do you have to eat? The green pressure-reducing boots were on her lower extremities, but there was no low air loss bed.

An interview was conducted with the WCNP on 3/15/22 at approximately 2:20 p.m. The WCNP stated she was asked on 3/8/22 to see Resident #8 because of a worsening left hip wound. The WCNP stated she had not seen the resident's wound prior to 3/8/22 and her assessment of the left hip wound revealed a pressure ulcer because it was over a bony prominence surrounded by old scar tissue and unstageable because it was comprised of granulation tissue and slough.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 85	F 686		

Further review of Resident #8's clinical record revealed that weekly skin assessments had not been conducted since 12/31/21.

During an interview with the Vice President of Operation (VPOC) on 3/17/22 at approximately 12:40 p.m., she stated she was aware skin assessments were only conducted sporadically and inconsistently. The VPOC stated a best practice would be to conduct skin assessment weekly on a shower day and ideally the CNAs should look at resident skin each time care is provided to identify changes. The VPOC also stated skin assessments should be completed upon admission as well as a Braden scale for Prediction of Pressure Sores. The VOP stated that although the resident had been under comfort care measures for many years it didn't relieve the staff of assuring necessary basic care was rendered including prevention of skin breakdown and early recognition of skin breakdown if it did occur. The VPO also stated recommendations from the WCNP should have been instituted along with the treatment orders therefore the low air loss bed should have been ordered for Resident #8.

Resident #8 was also observed on 3/17/22 in bed at approximately 11:00 a.m., seated in the Broda chair waiting to have her hair cut. The lower extremities were contracted at the knees. At approximately 4:00 p.m., an observation was made of the resident's left hip pressure ulcer with Licensed Practical Nurse (LPN) #12. The wound was to the bony prominence of the left hip and it was surrounded by scar tissue. The left hip pressure ulcer was without odor or drainage but slough was present.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 86	F 686		

The 3/17/22 WCNP assessment of the left hip pressure ulcer read; measured; length 3.54 centimeters by width 1.88 centimeters and no depth. It contained 70 percent granulation tissue/30 percent slough, had a scant amount of serosanguinous drainage and had no odor. The WCNP stated the wound was showing improvement and the treatment order remained as ordered on 3/8/22.

On 3/11/22 at approximately an interview was conducted with Certified Nursing Assistant (CNA) #6. CNA #6 stated Resident #8 for many years enjoyed sitting in the common areas wearing a purple cap, greeting all who passed her, or simply napping. CNA #6 also stated the resident had a history of falling from the bed but the episodes had decreased over time. CNA #6 also stated the resident required total care with all activities of daily living and frequently asks for something to eat, and consumes approximately 75-100 percent of most meals. CNA #6 also stated that until this recent pressure sore of the resident's left hip she had only had scratches to her ankles and legs.

An interview was conducted with the MDS Coordinator on 3/16/22 at approximately 2:10 p.m. The MDS Coordinator stated Resident #8 had been a comfort care resident since 2015 and it included no intravenous (IV) medications, no IV fluids, no hospitalizations, no tube feeding, no laboratory testing, no monthly vitals, no height, and no weights. The MDS Coordinator further stated that prior to the most recent skin impairment the resident had been with skin breakdown for many years.

An interview was conducted with Licensed Practical Nurse (LPN) #6 on 3/17/22 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 87	F 686		

approximately 3:20 p.m. LPN #6 stated the resident had been on comfort care for many years yet her condition remained stable except for some falls. LPN #6 also stated that the low air loss bed had been ordered.

The Braden Scale for Prediction of Pressure Sores was completed on 11/2/21. It revealed that the resident; responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness or has a sensory impairment which limits the ability to feel pain or discomfort over half of the body, skin is occasionally moist, requiring an extra linen change approximately once a day, confined to bed, never eats a complete meal. Rarely eats more than half of any food offered. Takes fluids poorly. Does not take a liquid dietary supplement, requires moderate to maximum assistance in moving, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction, and the resident scored nine, indicating a very high risk for pressure ulcer development.

The active care plan had a problem dated 3/15/22 which read; (name of the resident) has impaired skin integrity (left hip pressure injury) and is at risk for further skin breakdown related to a history of pressure injuries, immobility, incontinence, dementia, anemia, adult failure to thrive and contracture. The goal read; the left hip pressure injury will show improvement by the review date. The interventions included; a concave mattress, out of bed in a Broda chair, position resident as needed, and treatment per orders.

A Dietary/Nutrition dated 4/9/2021 at 5:05 p.m., revealed the resident's current body weight is 90

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 88	F 686		

pounds, reflective of weight loss -22.0% x 3 months. The Resident is under comfort care services. The Resident's usual body weight (UBW) is 90-100 pounds for 2 years. Weight in comparison on 1/4/21 of 115.4 pounds is an outlier from the resident's UBW. The resident is currently receiving a pureed texture diet with thin liquids. The resident is dependent on staff for the provision of meals and her PO intake was largely 76-100 percent per documentation. No open areas were noted to the skin. Considering resident's PO intake of meals is good and resident is under comfort care with no weight order in place - no new recommendations at this time. Continue Plan of Care to ensure the resident remains comfortable in accordance with wishes for comfort care.

The clinical record revealed the following recent weight for Resident #8, 12/16/21 91.0 pounds; 2/4/22, 91.2 pounds and 3/9/22, 91.5 pounds.

On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, Vice President of Clinical Services and the Vice President of Operations. No additional information was provided or concerns voiced.

Triple-antibiotic ointment (TAO) is a medication used is used to prevent minor skin injuries such as cuts, scrapes, and burns from becoming infected.
(https://medlineplus.gov/druginfo/meds/a601098.html)

Medi-honey is used to clean and remove necrotic tissue to promote wound healing.
(https://mms.mckesson.com/product/699433/McKesson-Brand-31515)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 89	F 686		

The below information was obtained 3/23/22 from (https://medlineplus.gov/ency/patientinstructions/000740.htm#:~:text=Stage%20II%20pressure%20sores%20should,They%20can%20damage%20the%20skin.)

Caring for a Pressure Sore

Stage I or II sores will often heal if cared for carefully. Stage III and IV sores are harder to treat and may take a long time to heal.

Here's how to care for a pressure sore:

Relieve the pressure on the area.

Use special pillows, foam cushions, booties, or mattress pads to reduce the pressure. Some pads are water or air-filled to help support and cushion the area. The type of cushion used depends on the wound and whether the individual is in bed or in a wheelchair.

Change positions often. If in a wheelchair, try to change position every 15 minutes. If in bed, repositioning should be about every 2 hours.

Care for the sore as directed by physician or specialist. Keep the wound clean to prevent infection.

Clean the sore with every dressing change.

For a stage I sore, wash the area gently with mild soap and water. If needed, use a moisture barrier to protect the area from bodily fluids.

Stage II pressure sores should be cleaned with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 90	F 686		

salt water (saline) rinse to remove loose, dead tissue. Or a specific cleanser as ordered by a physician.

Do not use hydrogen peroxide or iodine cleansers. They can damage the skin.

Keep the sore covered with a special dressing. This protects against infection and helps keep the sore moist so it can heal.

Types of dressngs used may depend on the size and stage of the sore; may use a film, gauze, gel, foam, or other type of dressing.

Most stage III and IV sores to include those with slough and necrosis will require specific orders from a physician.

Avoid further injury or friction.
2. a. Resident #26 was originally admitted to the facility on 1/11/22 after an acute care hospital stay. The resident was never been discharged from the facility. According to the comprehensive skin assessment dated 2/08/2022 at 8:12 PM a new wound was found on the resident's Sacrum. Acquired in-house. With 100% slough/eschar.

The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 1/26/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 11 out of a possible 15. This indicated that Resident #26 cognitive abilities for daily decision-making were moderately impaired.

In section "E" (Rejection of Care) did the resident reject evaluation or care, marked "O" behavior not exhibited.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 91	F 686		

In section "G"(Physical functioning) the resident was coded as requiring extensive assistance from two people with bed mobility and personal hygiene. Requiring extensive assistance of one person with dressing. Requiring total dependence of two persons with toilet use and bathing. Requires supervision with set-up help only with eating.

In section "M" (Skin Conditions) M0150. Risk of Pressure Ulcers/Injuries. Codes as Yes. M0300. Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage. Left Blank.

In section "M" (Skin and Ulcer/Injury Treatments) M1200. Turning/repositioning program: coded as No. Pressure ulcer/injury care: coded as No.

The care plan dated 2/04/22 reads: Focus: SKIN INTEGRITY: Resident has potential impairment to skin integrity r/t (relating/ to) cancer, COPD (Chronic Obstructive Pulmonary Disease) heart failure, anemia, Foley catheter, incontinence and need for ADL (Activity of Daily Living) assistance. Goal: The resident will maintain or develop clean and intact skin by the review date. Interventions: Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Keep skin clean and dry. Use lotion on dry skin. Observe location, size, and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs/symptoms) of infection, maceration, etc. to MD (Medical Doctor).

The care plan dated 2/04/22 reads: Focus: ADL self-care performance deficit related to Heart failure, Acute kidney failure, Malignant carcinoma

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 92	F 686		

of the lung, Malignant neoplasm of the brain. Goal: Resident to maintain the current level of function in (eating) through the next review date. Interventions: BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Avoid scrubbing & pat dry sensitive skin. Provide a tub bath/shower at least 2 days a week. Provide a sponge bath if a tub bath/ shower cannot be tolerated. Shave and shampoo hair as needed. BED MOBILITY: Requires (Limited to extensive assistance) of (1-2) staff to turn and reposition in bed Q 2-3 hours and as necessary. PERSONAL HYGIENE: Requires (limited to extensive assistance) of (1-2) staff with personal hygiene and oral care. SKIN OBSERVATION: Observe skin for rashes, redness, open areas, scratches, cuts and bruises and report changes for prompt treatment.

A review of the Braden Scale assessment for predicting pressure sore risk was completed on 1/11/22 with a score of 18 which indicates Resident #26 is at risk for pressure sore. The remainder of the admission screening was incomplete.

A review of the admission screening dated 1/11/22 at 6:36 PM reads: Pressure Ulcers: Is a pressure ulcer present? No.

A review of the TAR (Treatment Administration Record) for February 2022 reads: 02/09/2022 00:12 Order Summary: Santyl Ointment 250 UNIT/GM (Collagenase) Apply to sacrum topically everyday shift for wound care.

A review of the TAR (Treatment Administration Record) for March 2022 reads: Sacrum: Clean with wound cleanser, apply

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 93	F 686		

Dakin's wet-to-dry, and cover with bordered gauze.

A review of nursing notes reveal the following:
On 1/11/2022 at 6:53 PM resident was admitted to the Long Term Care facility from acute care via stretcher. No distress or complaints.

A comprehensive wound evaluation for all new admits was completed by the Wound Care Nurse Practitioner (WCNP) on 1/13/22 at approximately 9:47 PM. The skin evaluation reads: Patient reports no rashes or known dermatologic conditions at the time of this exam. The dermatologic evaluation reads: Patient's skin is intact with no rashes. There are no open wounds on today's comprehensive skin examination. Wound plan of care: Recommend moisturizing bilateral legs and feet for *xerosis. Plan of Care Assessment & Plan explained all necessary basic foot care aspects. "Patient understands that proper foot care is key to improved health, based on patient's comorbidities proper foot care is key to promoting the health of limbs. Other elements of Patient Evaluation: Wound rounds completed and reconciled with facility wound nurse today. All questions and concerns answered for staff and patient as applicable. Staff made aware that wound rounds were completed and of any changes in treatment plan."

A review of the WCNP's Tissue Analytics (TA) weekly wound assessments revealed the following:
Wound evaluation dated 2/08/22 revealed that an unstageable pressure ulcer of the sacrum was acquired in house. "Measurements: Length: 5.35 cm. Width: 5.73 cm LxW: 30.66 cm Depth: 0. Observations: %slough/eschar: 100.00. Wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 94	F 686		

Status: New. Drain amount: Serosanguinous. No odor. Dressing change frequency: Daily. Cleanse wound with wound cleanser. Apply Santyl dressing with bordered gauze. Pressure Reduction/Offloading: Ensure compliance with turning protocol, wedges/foam cushion for offloading, wheelchair cushion, mattress overlay, and specialty bed."

A review of the WCNP's weekly wound evaluation revealed resident's wound is stable dated 2/24/22: "Unstageable Sacral Pressure Ulcer measurements: Length: 5.88 cm, Width: 6.02 cm, LxW: 35.40 cm, Depth: 0. Observations: % Granulation: 30.00. %Slough/eschar: 100.00. Wound Status: Stable. Drain Amount: Serosanguinous. Odor: Malodorous. Dressing Change Frequency: Daily. Pressure Reduction/offloading: Ensure compliance with turning protocol, wedge/foam cushion for offloading, wheelchair cushion, mattress overlay, specialty bed. Cleanse wound with: Wound cleanser. Apply Dakins moist-to-dry dressings. Bordered gauze."

Another review of the WCNP's weekly wound evaluation revealed that the resident's wound is improving dated 3/03/22: "Unstageable Sacral Pressure Ulcer of the sacrum. Measurements: Length: 5.94 cm, Width: 5.14 cm. LxW: 30.53 cm. Depth: 0. Observations: % granulation: 20.00. % slough/eschar: 80.00. Wound Status: Improving. Drain amount: Moderate. Drain Description: Serosanguinous. Odor: No odor. Dressing change frequency: Daily. Cleanse wound with: Wound Cleanser. Dakins moist-to-dry dressings and bordered gauze. Pressure Reduction/Offloading: Ensure compliance with turning protocol, wedge/foam/cushion for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 95	F 686		

offloading, wheelchair cushion, mattress overlay, specialty bed."

A continued review of WCNP's weekly wound evaluation revealed that the resident had debridement of the sacrum dated 3/10/22: "Sacrum unstageable pressure injury. Post (after)-debridement length (cm): 1. 63 as per ulcer noted. width (cm) 0. 96 as per ulcer noted. 100% debrided. Wound plan of care: Recommend obtaining an air mattress and applying foot protectors/heel boots. I am recommending an air mattress for pressure reduction. Plan of Care Assessment & Plan - Patient has a pressure injury; Pressure reduction and turning precautions discussed with staff at the time of visit recommended, including heel protection and pressure reduction to bony prominences. Staff educated on all aspects of care. Explained all aspects of necessary basic foot care. Patient understands that proper foot care is key to improved health, based on patient' s comorbidities proper foot care is key to promoting health of limbs."

Factors Affecting Healing: "Patient has frequent incontinence which can decrease healing rate of wound. Recommend providing incontinence care as needed, PRN. Increased moisture at wound site can promote poor prognosis of wound healing. Please keep wound site covered and avoid contamination with feces at all times. Other elements of Patient Evaluation: Wound rounds completed and reconciled with wound nurse today. All questions and concerns answered for staff and patient as applicable. Patient was left as requested, lowest locked position with call bell within reach, no restraints in place. Staff made aware that wound rounds were completed and of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 96 any changes in treatment plan." A review of the weekly WCNP evaluation reveals Residents wound is improving dated 3/17/22: "Unstageable sacral pressure ulcer of the sacrum. Measurements: Length: 7.66 cm. Width: 5.62 cm. LxW; 43.05 cm. Observations: % granulation: 20. % slough/eschar: 80.00. Other: Apply Santyl to necrosis. Wound Stasis: Improving. Draining: Moderate. Drainage description: Serosanguinous. Odor: Malodorous. Dressing Change Frequency: Daily. Cleanse wound with: Wound Cleanser. Dressings: Santyl, Dakin's moist-to-dry. Bordered gauze. Pressure Reduction/offloading: Ensure compliance with turning protocol, wedge/foam cushion for offloading, wheelchair cushion, mattress overlay, specialty bed." On 03/11/22 at approximately 9:39 AM, an interview was conducted with Resident #26 concerning his wounds on his sacrum and lower extremities. He was asked how he got the wounds. He stated, "I got it since I've been in here." His heels were observed resting on the bed. No bunny boots or heel protectors were in place. The resident's heels were not floating but resting on his bed/mattress. Surveyor received permission from the resident to observe wound care. On 3/11/22 at approximately 10:45 AM., a wound care observation was made while LPN (Licensed Practical Nurse) #2 administered wound care/treatment to the resident's sacrum. Slough and eschar were present on the wound bed with moderate serosanguinous drainage. The resident tolerated the procedure without difficulty. No issues were noted.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 97 On 03/14/22 at 2:47 PM an interview was conducted with LPN #6 concerning Resident #26. She stated, "He had an admission screen Braden scale. There's an admission assessment in here (PCC/Point Click Care/ electronic medical records) but it's not complete. It should have been completed. The area on the sacrum was found on 2/09/22 as unstageable. If it's covered in slough or eschar it's unstageable because we don't know what's under it. Upon arrival, we look at the resident's skin with the Wound Care Nurse Practitioner, then weekly. If the CNA sees any issues on the resident's skin they will report it to the nurse. Since I've been looking at his wound every week it's getting better. His sacrum was debrided on 3/10/22. I normally put a note in that I rounded with her but I didn't." On 03/14/22 at 2:47 PM an interview was conducted with LPN #6 (Unit Manager) concerning Resident #26. She stated, "He had an admission screening Braden scale on 1/11/22. There's an admission assessment in here [PCC/Point Click Care (electronic medical records)] but it's not complete. It should have been completed." According to LPN#6, the area on the sacrum was found on 2/08/22 as unstageable with slough and eschar. She said, "If it's covered in slough or eschar it's unstageable because we don't know what's under it. Upon arrival, we look at the resident's skin with the WCNP, then weekly if any pressure ulcer/wound issues. If the CNAs see any issues on the resident's skin they should report them to the nurse." The LPN continued to say that on 3/10/22 she failed to document that she rounded with the WCNP when the sacrum pressure ulcer was debrided.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 98	F 686		

On 03/15/22 at 1:35 PM an interview was conducted with the WCNP concerning Resident #26's wounds. She stated, "When he first got to the facility (1/11/22) he didn't have a wound. My admission skin sweep for the resident was on 1/13/22. When the facility told me to come to look at him he was already unstageable. I initially saw him on February 8th, 2022 (sacrum). I only see it once a week. For prevention: He needs to be turned every (q) 2 hours, heels floated, heel protectors, and an air mattress. The staff says he refuses to be turned and repositioned. I have had a nurse lately that does the dressings as I'm charting." She was asked was the wound found at an advanced stage on his right lateral ankle (2/24/22)? She stated, "Yes because he didn't have it on his initial skin assessment. The staff should have communicated if they saw something open, redness, and documented it. I do a skin sweep quarterly on patients that don't have wounds. Most nurses should do weekly skin assessments."

A review of the nurse's notes and or skin assessments from 1/31/22 through 2/8/22 did not reveal any skin integrity issues on the sacrum. Although there were no nurse's notes from this timeframe, the WCNP, per the above interview on 3/15/22, was asked by the nursing staff to come to look at his sacrum, which was identified as unstageable.

A review of the resident's care plan shows no refusal of care.

A review of the resident's care plan and nurse's notes showed no refusal of care to include skin assessments, bed baths, and or incontinence

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 99	F 686		

care.

A review of ADL documentation records for January, February, and March 2022 show no refusal of care.

On 03/15/22 at approximately 2:33 PM two CNAs were observed transferring Resident #26 back to bed via Hoyer lift. The resident was placed in a supine position. CNA #7 was asked if Resident #26 wears bunny boots or heel protectors when in bed. She stated, "He has a regular mattress. You would think he would have a specialty mattress because of the pressure sores."

On 03/16/22 at approximately 1:39 PM., an interview was conducted with LPN (Licensed Practical Nurse) #2. Concerning Resident #26. She stated, "I keep resident off his bottom, turn and reposition him every two hours. His sacral wound looks about the same as when I first interacted with him.

On 03/17/22 at approximately 11:38 AM., an interview was conducted with LPN #6/Unit Manager concerning communication with the WCNP. She stated, "She would normally email us a spreadsheet of everybody that we saw during wound rounds. The orders either stay the same or change, then we update orders." During the interview, LPN#6 was asked about the following recommendations that the WCNP made after completing her rounds at each assessment that included foot protectors or heel protectors, bunny boots, pressure reduction devices to bony prominences, and air mattress. The original recommendation for the air mattress for pressure reduction was made on 2/8/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 100	F 686		

On 3/10/22 and 3/17/22 during the WCNP's wound care assessment, these recommendations were still not implemented and were reiterated in her notes. LPN #6 stated, "I would consult with the facility Nurse Practitioner (OSM #1) if the WCNP gives me an order (recommendations) and I will put the orders in. It (the previous recommendations) was an oversight."

On 3/17/22 at approximately 12:15 PM., an interview was conducted with Vice President of Operations concerning Resident #26. She stated, "The skin assessments are done sporadically by nurses they are not consistent. The best time is on the shower days at least once a week. If not getting showers they should be getting the skin assessments weekly. There should be an admission assessment done to include your Braden scale.

On 3/17/22 at approximately 5:45 PM a Pre-exit interview was conducted with the Administrator, The Vice President of Operations, and the Vice President of Clinical Services concerning Resident #26. The Vice President of Operations Stated, "The DON that was here had a wound care protocol but we can't find it but will re-implement it."

*(1) Xerosis-Dry skin makes the skin look and feel rough, itchy, flaky, or scaly. The location where these dry patches form vary from person to person. It's a common condition that affects people of all ages. Dry skin, also known as xerosis or xeroderma, has many causes, including cold or dry weather, sun damage, harsh soaps, and overbathing. You can do a lot on your own to improve dry skin, including moisturizing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 101	F 686		

and practicing sun protection year-round. Try various products and skincare routines to find an approach that works for you. This information was taken from https://www.mayoclinic.org/diseases-conditions/dry-skin/symptoms-causes/syc-20353885.

*(2) Unstageable pressure ulcer- "Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Further description:
Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as "the body's natural (biological) cover" and should not be removed." National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm

*(3) The Braden Scale for Predicting Pressure Sore Risk is a clinically validated tool that allows nurses and other health care providers to reliably score a patient/client's level of risk for developing pressure ulcers. It measures functional capabilities of the patient that contribute to either higher intensity and duration of pressure or lower tissue tolerance for pressure. Lower levels of functioning indicate higher levels of risk for pressure ulcer development ...The Braden Scale is a summated rating scale made up of six subscales scored from 1-4 (1 for low level of functioning and 4 for the highest level or no impairment). Total scores range from 6-23 (one subscale is scored with values of 1-3, only). The subscales measure functional capabilities of the patient that contribute to either higher intensity and duration of pressure, or lower tissue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 102	F 686		

tolerance for pressure. A lower Braden Scale Score indicates lower levels of functioning and, therefore, higher levels of risk for pressure ulcer development. This information is taken from the website https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_BRADEN

*(4.) Dakin's solution is used to prevent and treat skin and tissue infections that could result from cuts, scrapes, and pressure sores. This information was obtained from: https://www.webmd.com/drugs/2/drug-62261/dakins-solution/details.

*(5) SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>)

The facilitity's Policy: Prevention of Pressure Injuries reads: Purpose: The purpose of this procedure is to provide information regarding the identification of pressure injury risk factors and interventions for specific risk factors. Preparation: Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. Risk assessment: Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. Skin Assessment: Conduct a comprehensive skin assessment upon (or soon after) admission, with each risk assessment, as indicated according to the resident's risk factors,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 103	F 686		

and prior to discharge. Inspect the skin when performing or assisting with personal care or ADLs (Activity of Daily Living). Inspect pressure points (sacrum, heels, buttocks, coccyx etc. Wash the skin after any episodes of incontinence. Reposition resident as indicated on the care plan. Mobility/Repositioning: Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Monitoring: Evaluate, report, and document potential changes in the skin.

b. According to the comprehensive skin assessment conducted by the Wound Care Nursing Practitioner (WCNP) on 2/24/22, another pressure injury was first identified in-house on Resident #26's right lateral ankle as unstageable. The ankle was assessed by the WCNP as 100 percent (%) slough/eschar.

A review of the Nursing Admission Screening listed under Skin Integrity dated 1/11/2 at 6:36 PM reads Color: Normal. Temperature: Warm and Equal. Turgor: Normal. Comments: Both heels are very dry with a thick coat of yellow crust. Pressure Ulcers: Is a pressure ulcer present? No.

A review of the TAR (Treatment Administration Record) reads:
Right Lateral Ankle: Cleanse with wound cleaner, apply Santyl, cover with bordered gauze everyday shift for wound care. Active 2 /25/2022 7:00 AM.

A review of nursing notes reveal the following:
On 1/11/2022 at 6:53 PM resident was admitted to the Long Term Care facility from acute care via stretcher. No distress or complaints.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 104	F 686		

A comprehensive wound evaluation for all new admits was completed by the Wound Care Nurse Practitioner (WCNP) on 1/13/22 at approximately 9:47 PM. The skin evaluation reads: "Patient reports no rashes or known dermatologic conditions at the time of this exam. The dermatologic evaluation reads: Patient's skin is intact with no rashes. There are no open wounds on today's comprehensive skin examination. Wound plan of care: Recommend moisturizing bilateral legs and feet for xerosis.
Plan of Care Assessment & Plan explained all necessary basic foot care aspects. "Patient understands that proper foot care is key to improved health, based on patient's comorbidities proper foot care is key to promoting the health of limbs. Other elements of Patient Evaluation: Wound rounds completed and reconciled with facility wound nurse today. All questions and concerns answered for staff and patient as applicable. Staff made aware that wound rounds were completed and of any changes in treatment plan."

Based on the WCNP Tissue Analytics (TA) weekly wound assessments for the sacrum pressure ulcer, on 2/24/22 a new pressure ulcer on the right lateral ankle was identified as acquired in-house. The WCNP documented this area as follows: " ... Unstageable. Measurements: Length: 1.56 cm, Width: 1.37 cm LXW: 2.14 cm, Depth: 0. Observations: % slough/eschar: 100.00. Treatment: Wound Cleanser daily, Santyl dressing."

3/03/22 Right Lateral Ankle: " ...Length: 1.24 cm, Width: 0.94 cm, LXW: 1.17 cm, Depth: 0. Observations: %slough/eschar: 100.00. Wound Status: Improving. Cleanse wound with wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 105	F 686		

cleanser daily. Santyl dressing and Bordered Gauze."

3/10/2022 Right Lateral Ankle: " ... Post debridement Length: 1.63 cm. Width: 0.96 cm. LXW: 1.56 cm. Depth: 0. Observations: %Slough/eschar: 100.00. Wound status: Stable. Cleanse with wound cleanser daily. Apply Santyl dressing and bordered gauze."

3/17/22 Right Lateral ankle: " ...Length: 1.77 cm, Width: 1.95 cm. LXW: 3.45 cm. Depth: 0. Observations: %slough/eschar: 100.00. Wound status: Stable. Cleanse daily with wound cleanser apply Santyl dressing and bordered gauze."

On 03/11/22 at approximately 9:39 AM an interview was conducted with Resident #26 concerning his wounds on his sacrum and lower extremities. He was asked how he got the wounds. He stated, "I got it since I've been in here." His heels were observed resting on the bed. No bunny boots or heel protectors were in place. The resident's heels were not floating but resting on his bed/mattress.

Surveyor received permission from the resident to observe wound care.

On 3/11/22 at approximately 10:45 AM., pressure ulcer treatment observation was made while LPN (Licensed Practical Nurse) #2 administered wound care/treatment to resident's right lateral ankle. The resident tolerated the procedure without difficulty. No issues were noted.

On 03/14/22 at 2:47 PM an interview was conducted with LPN #6 (Unit Manager) concerning Resident #26. She stated, "He had an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 106	F 686		

admission screening Braden scale on 1/11/22. There's an admission assessment in here [PCC/Point Click Care (electronic medical records)] but it's not complete. It should have been completed." During the interview, LPN #6 said the resident had an unstageable pressure ulcer on his ankle identified on 2/24/22. If it's covered in slough or eschar it's unstageable because we don't know what's under it. She stated, "Upon arrival, we look at resident's skin with the WCNP, then weekly if any pressure ulcer/wound issues. If the CNAs see any issues on resident's skin they should report them to the nurse."

On 03/15/22 at 1:35 PM an interview was conducted with the WCNP concerning Resident #26's wounds. She stated, "When he first got to the facility (1/11/22) he didn't have a wound. My admission skin sweep for the resident was on 1/13/22. When the facility told me to come to look at him he was already unstageable. I initially saw him on February 8th, 2022 (sacrum). I only see it once a week. For prevention: He needs to be turned every (q) 2 hours, heels floated, heel protectors, and an air mattress. The staff says he refuses to be turned and repositioned. I have had a nurse lately that does the dressings as I'm charting." She was asked was the wound found at an advanced stage on his right lateral ankle (2/24/22)? She stated, "Yes because he didn't have it on his initial skin assessment. The staff should have communicated if they saw something open, redness, and documented it. I do a skin sweep quarterly on patients that don't have wounds. Most nurses should do weekly skin assessments."

A review of the nurse's notes and or skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 107	F 686		

assessments from 1/31/22 through 2/24/22 did not reveal any skin integrity issues on the right lateral ankle. Although there were no nurse's notes from this timeframe, the WCNP, per the above interview on 3/15/22, discovered a new unstageable pressure ulcer to the right lateral ankle.

A review of the resident's care plan and nurse's notes showed no refusal of care to include skin assessments, bed baths, and or incontinence care.

A review of ADL documentation records for January, February, and March 2022 showed no refusal of care.

On 03/15/22 at approximately 2:33 PM two CNAs were observed transferring Resident #26 back to bed via Hoyer lift. The resident was placed in a supine position. No bunny boots or heel protectors were placed on the resident's lower extremities. CNA #7 was asked if Resident #26 wears bunny boots or heel protectors when in bed. She stated, "Therapy will let us know if he needs bunny boots, heel protectors, and float his heels. That would help with his heels, He has a regular mattress. You would think he would have a specialty mattress because of the pressure sores."

On 03/16/22 at approximately 1:39 PM., an interview was conducted with LPN #2. Concerning Resident #26. She stated, "I keep resident off his bottom, turn and reposition him every two hours. His sacral wound looks about the same as when I first interacted with him. His ankle requires skin prep to the right lateral side."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 686	Continued From page 108 On 03/17/22 at approximately 11:38 AM., an interview was conducted with LPN #6/Unit Manager concerning communication with the WCNP. She stated, "She (WCNP) would normally email us a spreadsheet of everybody that we saw during wound rounds. The orders either stay the same or change, then we update orders." During the interview, LPN#6 was asked about the following recommendations that the WCNP made after completing her rounds at each assessment that included foot protectors or heel protectors, bunny boots, pressure reduction devices to bony prominences, and air mattress. The original recommendation for the air mattress for pressure reduction was made on 2/8/22. On 3/10/22 and 3/17/22 during the WCNP's wound care assessment, these recommendations were still not implemented and were reiterated in her notes. LPN #6 stated, "I would consult with the facility Nurse Practitioner (OSM #1) if the WCNP gives me an order (recommendations) and I will put the orders in. It (the previous recommendations) was an oversight." On 3/17/22 at approximately 5:45 PM a Pre-exit interview was conducted with the Administrator, The Vice President of Operations, and with the Vice President of Clinical Services concerning Resident #26. The Vice President of Operations Stated, "The DON that was here had a wound care protocol but we can't find it but we will re-implement it."	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that -	F 689		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 109 §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, staff interviews and facility document review the facility staff failed to ensure 1 of 44 Residents (Resident #61) was provided an assistive device to prevent accidents, Resident #61. The facility staff failed to ensure Resident #61's wanderguard device was in place to prevent elopement. The findings included: Resident #61 was admitted to the facility on 11/14/21 with diagnoses to include but not limited to Alzheimer's Disease, Anxiety and Dementia. The most recent comprehensive Minimum Data Set (MDS) was an Admission Assessment with an Assessment Reference Date (ARD) of 11/20/2. The Brief Interview for Mental Status for Resident #61 was coded as a 3 out of a possible 15, indicating the resident was severely cognitively impaired and incapable of daily decision making. Under Section E Behavior; E0900 Wandering-Presence and Frequency, Resident #61 was coded as a 3=Behavior of this type occurred daily. Under E1000 Wandering-Impact, Resident #61 was coded Yes=Does the wandering place the resident at significant risk of getting to a potentially dangerous place and Yes=Does the wandering significantly intrude on the privacy or activities of others.	F 689	1. The wander guard for resident #61 was discontinued on 4/14/22. 2. An audit of residents with wander guards was completed by VPO on 4/14/22. 3. Staff were educated on safety and supervision of residents on 4/15/22. 4. DON, or designee, will audit 5 residents weekly for 4 weeks to verify wander guard placement. Results of the audits will be taken to QAPI until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 110	F 689		

Resident #61's current Physician Orders were reviewed and are documented in part, as follows:

1. Check Wanderguard placement Q (every) shift. Start Date: 11/15/21
2. Wanderguard bracelet to alert staff of attempted elopement. Every shift for wanders. Start Date: 11/15/21
3. Wanderguard bracelet-check function weekly, every Wednesday for check function, weekly. Start Date: 11/17/21

Resident #61 Admission Elopement Risk Form dated 11/15/21 was reviewed and is documented in part, as follows:

Score: 7
Category: Low Risk
A. Orientation: Has short or long term memory loss.
C. Mobility: Is ambulatory with or without assistive devices.
E. History of Elopement: Has a history of wandering.
F. Wandering/Exit Seeking: Is expressing desire to go home, go to work or leave the facility.
H. Comments: Wanders in facility, states he needs to go home and check on his sister, elopement risk.
I. Interventions: Personal security device.

Resident #61's Comprehensive Care Plan dated 11/22/21 was reviewed and is documented in part, as follows:

Focus: The resident is an elopement risk/wanderer r/t (related to) wandering the facility aimlessly. Resident has previously tried to elope. Date initiated: 11/22/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 111	F 689		

Interventions: Wanderguard as ordered. Check placement every shift. Date Initiated: 11/22/21.

On 3/9/22 at 4:00 p.m. Resident #61 was observed in his room. No wanderguard device was observed on the resident's arms or legs.

On 3/10/22 at 9:48 a.m. Resident #61 was observed in his room standing up looking out the window. No wanderguard device was observed on the resident's arms or legs.

On 3/10/22 at 10:30 a.m. Resident #61 walked with this surveyor down the hall and through the facility front door. Upon nearing the facility front door and after passing through the door, no wanderguard alarm activated to alert the staff that the resident had exited the facility. Resident #61 was escorted back to his room by the surveyor.

On 3/10/22 at 10:45 a.m. Certified Nursing Assistant (CNA) #6 accompanied this surveyor to Resident #61's room and was asked to show me where the resident's wanderguard device was placed. CNA #6 examined both of Resident #61's arms and legs with no wanderguard device detected. CNA #6 stated, "He doesn't have his wanderguard on. I will have to let the nurse know it's missing."

On 3/10/22 at 11:00 a.m. an interview was conducted with Unit Manager Licensed Practical Nurse (LPN) #8 regarding Resident #61's wanderguard bracelet. LPN #8 was asked if Resident #61 was supposed to have a wanderguard in place and if so why. LPN #8 stated, "I have only been the Unit Manager for 2 weeks. I just checked and Name (Resident #61)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 112	F 689		

is supposed to have a wanderguard in place because he is an elopement risk. The CNA just told me he didn't have one on. I have to get him a new one and put it on him."

On 3/17/22 at 2:45 p.m. an interview was conducted with the Administrator regarding Resident #61 being observed without his wanderguard device. The Administrator was asked who was responsible for ensuring the wanderguard device was on the resident and what is the purpose of the device for Resident #61. The Administrator stated, "The nurses are responsible to make sure the wanderguard is on the resident and functional. Name (Resident #61) is an elopement risk, the purpose is to keep him safe and from eloping from the facility.

The facility policy titled "Safety and Supervision of Residents" revised 7/2017 was reviewed and is documented in part, as follows:

Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.

Policy Interpretation and Implementation:
Individualized, Resident-Centered Approach to Safety:

1. Our individualized, resident-centered approach to safety addressed safety and accident hazards for individual residents.
2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 113 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4. Implementing interventions to reduce accident risks and hazards. During a pre-exit debriefing on 3/17/2 at 5:44 p.m. with the Administrator, Vice President of Operations and the Vice President of Clinical Services the above information was shared.	F 689		
F 694 SS=G	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on complaint investigation, staff interviews, clinical record review, and facility documentation, the facility staff failed to provide the necessary care and services for 2 of out 44 residents (Resident #84 and #71) in the survey sample. For Resident #84, the facility staff failed to provide parenteral intravenous (IV) fluids as ordered by the Nurse Practitioner on 02/04/22 at approximately 10:30 a.m., to start Sodium Chloride Solution 0.9%, use 50 ml/hour intravenously (IV) x 24 hours for 2 liters for hydration which was never initiated. Resident #84 remained in the facility for 28 hours after the order was given to start IV fluids before the resident was noted as being in respiratory distress, unable to obtain blood pressure, and	F 694	1. For resident # 84, MD order for intravenous (IV) fluids on 2/4/2022 cannot be administered or corrected retroactively. For resident # 71, dressing changed to peripherally inserted central catheter (PICC) on 03/17/2022. 2. There is no active medication or fluids order requiring use of intravenous administration. 3. Licensed nurses will be re-educated on establishing IV fluid administration and the care of IV site as per physician orders and protocol.	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 114 using his accessory muscles for breathing. Resident #84 was transferred via 911 (emergent) to the local hospital and admitted on 02/05/22 with main diagnoses to include severe metabolic acidosis, severe dehydration, hypothermia at 89.4 degrees, Urinary Tract Infection (UTI), and Acute Kidney Injury (suspect pre-renal due to dehydration), which constituted harm for Resident #84. For Resident #71, the facility staff failed to change the peripherally inserted central catheter (PICC) dressings every seven days for site maintenance and prevention of infection. The findings included: 1. Resident #84 was admitted to the nursing facility on 11/10/21. The resident was discharged to the local hospital on 02/05/22 and did not return to the nursing facility. Diagnosis for Resident #84 included but not limited to Chronic Kidney Disease (not on dialysis) and Type II Diabetes Mellitus. The most recent Minimum Data Set (MDS) was an admission assessment with an Assessment Reference Date (ARD) of 11/17/21 coded the resident on the Brief Interview for Mental Status (BIMS) an 11 of 15 indicating moderate cognitive impairment. Resident #84 was coded total dependence of one with toilet use and bathing, extensive assistance of one with bed mobility and transfer, limited assistance of one with dressing and personal hygiene, and supervision with one assist with eating Activities of Daily Living (ADL). Under section H - (Bladder and Bowel) was coded for always incontinent of bladder and bowel. The care plan created on 11/17/21 and a revision	F 694	4. DON, or designee, shall audit IV orders and care monthly x 3, or until satisfactory compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 115	F 694		

date of 01/11/22 identified Resident #84 with impaired cognitive function or impaired thought process related to an altered mental status. The goal set for the resident by the staff was that the resident will improve current level of cognitive function through the next review on 03/09/22. One of the interventions/approaches the staff would use to accomplish this goal is to administer medications as ordered. Monitor/document for side effects and effectiveness.

On 02/04/22, the Nurse Practitioner (NP) progress revealed the following information: "Resident #84 is being seen today for loose stools, decrease intake, and COVID-19. Resident #84 reports having decreased appetite and increased thirst." Under diagnosis, assessment and plan it included but was not limited to start Sodium Chloride Solution at 50 ml/hour x 2 liters.

The review of Resident #84's Medication Administration Record (MAR) revealed the following order: Sodium Chloride Solution 0.9%, use 50 ml/hour intravenously (IV) x 24 hours for 2 liters for hydration or clysis for 3 days, the order remains in pending confirmation.

An interview was conducted with License Practical Nurse (LPN) #6 on 03/14/22 at approximately 4:12 p.m. When asked, what does it mean with an order that reads pending confirmation? The LPN stated, that the order was put Point Click Care (PCC) but the nurse never confirmed the order, so the order was never initiated.

A review of Resident #84's clinical record revealed the following documentation entered on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 116	F 694		

02/05/22 at approximately 2:56 p.m., by LPN #3. Resident #84 noted having respiratory distress, being unable to obtain blood pressure, oxygen saturation of 94% on room air, and heart rate of 102 while using accessory muscles for breathing. A new order was obtained to send to the ER for evaluation and treatment.

A phone interview was conducted with Nurse Practitioner (NP) on 03/15/22 at approximately 2:08 p.m. The NP stated she assessed Resident #84 on 02/04/22 due to the staff reporting the resident was having loose stools and not eating. She said that during her discussion with the resident, he voiced to me that he was really thirsty and has no appetite. The NP said IV fluids were ordered and started on 02/04/22. The NP stated, "IV fluids were ordered for hydration because Resident #84 was having loose stools and not eating" She said the BMP was not ordered as STAT (now order) because I needed time for the IV fluids to hydrate the resident to help determine what further treatment was needed. The NP stated, "Unfortunately, his IV fluids were never started and I was never notified."

An interview was conducted with LPN#3 on 03/14/22 at approximately 1:46 p.m. The LPN was assigned to provide care and services to Resident #84 on 02/04/22 and 02/05/22 (7-3 shift), the day Resident #84 was evaluated by the NP with new orders to start IV fluids. The LPN said she remembered Resident #84 was not eating or drinking. She said the NP came in and saw Resident #84 and wrote a bunch of new orders but I was never informed that an order to start IV fluids.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 117	F 694		

On 03/15/22 at approximately 9:44 a.m., a phone interview was conducted with LPN #5. The LPN was assigned to provide care and services to Resident #84 on 02/04/22 (11-7 shift). The LPN stated, "I don't recall the nurse giving a report that Resident #84 had an order to start an IV to administer IV fluids."

On 03/16/22 at approximately 2:53 p.m., an interview was conducted with the Regional Director of Clinical Services. The Regional Director said the nurse(s) should have activated the order in PCC and the IV fluids should have been started as ordered by the (NP). He stated, "If the nurse assigned was not able to start the IV, there is always someone in house that could have started the IV. He stated clysis could have been used to hydrate the resident.

A phone interview was conducted with the Medical Director on 03/17/22 at approximately 5:11 p.m., when asked if the staff should have started the fluids IV or via clysis, he replied, "Absolutely, not receiving the IV fluids could have contributed to his dehydration as well as Acute Renal Failure (AFR)." The Medical Director stated, "The NP or I should have been notified that Resident #84's IV fluids were never started."

A review of the hospital records revealed the following: "Resident #84 presented in the Emergency Room (ER) on 02/05/22 from (name of nursing facility) for further evaluation due to lethargy. The 911 transport revealed the following: "Resident serum glucose was 14. The Emergency Medical Service (EMS) placed an IV, gave glucagon and D10 and his glucose increased to 135." The ER records indicated Resident #84's rectal temperature @ 89.4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 118	F 694		

degrees F (hypothermia - low body temperature) and placed on Bair Hugger for low rectal temperature. The resident's blood pressure was 89/40 (normal = 120/80). He was found to be in severe metabolic acidosis and septic shock. The urinalysis with reflex showed large leukocyte esterase, positive nitrites, and a moderate amount of blood with 3+ bacteria. The urine culture revealed more than 100,000 colonies and was positive for Kiebsiella pneumoniae. The resident had a high blood creatinine of 7.2 (0.59-1.04 = normal range). The creatinine test is a measure of how well your kidneys as performing their job of filtering waste from your blood (www.mayoclinic.org). The resident was started on IV sodium bicarbonate, given D50, and admitted to the Intensive Care Unit (ICU). Intravenous Fluids (IV), and IV antibiotic (Zyvox and Zosyn) was also started. Resident #84 is in the ICU, on a ventilator, sedated and unresponsive. The resident will need dialysis per nephrology but is pending due to his acute kidney injury. Resident #84 is being transferred to a higher level of care on 02/12/22. The resident is hemodynamically unstable for conventional hemodialysis and will benefit from continuous renal replacement therapy (CRRT), which this facility doesn't provide. At the time of discharge, resident remains on a mechanical ventilator."

A review of the hospital records revealed the following: Resident #84 presented in the Emergency Room (ER) on 02/12/22 as a transfer from the originated hospital for further evaluation due to hypoglycemia and Altered Mental Status (AMS). The resident was sent here for continuous renal replacement therapy (CRRT), which the previous hospital doesn't provide. The hemodialysis catheter placement was placed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 119	F 694		

(CRRT) was started on 02/13/22.

A debriefing was conducted with the Administrator, Vice President of Clinical Services, and Regional Director of Clinical Services on 03/17/22 at approximately 5:45 p.m., Resident #84's issues were presented again. The facility did not present any further information about the findings.

Definitions:
-Metabolic acidosis develops when too much acid is produced in the body. It can also occur when the kidneys cannot remove enough acid from the body. Some causes for metabolic acidosis included but not limited to severe diarrhea and severe dehydration. Treatment is aimed at the health problem causing acidosis. In some cases, sodium bicarbonate may be given to reduce the acidity of the blood. Often, you will receive lots of fluids through the vein (https://medlineplus.gov).

-Dehydration occurs when you use or lose more fluid than you take in, and your body doesn't have enough water and other fluids to carry out its normal functions. If you don't replace lost fluids, you will get dehydrated. You can usually reverse mild to moderate dehydration by drinking more fluids, but severe dehydration needs immediate medical treatment. Many people, particularly older adults, don't feel thirsty until they're already dehydrated. That's why it's important to increase water intake when you're ill. Other dehydration causes include but are not limited to diarrhea and or acute diarrhea - that is, diarrhea that comes on suddenly and violently - can cause a tremendous loss of water and electrolytes in a short amount of time. Dehydration can lead to serious complications, including urinary and kidney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 120	F 694		

problems. Prolonged or repeated bouts of dehydration can cause urinary tract infections, kidney stones, and even kidney failure.

The only effective treatment for dehydration is to replace lost fluids and lost electrolytes. The best approach to dehydration treatment depends on age, the severity of dehydration, and its cause. Adults who are severely dehydrated should be treated by emergency personnel arriving in an ambulance or in a hospital emergency room. Salts and fluids delivered through a vein (intravenously) are absorbed quickly and speed recovery.

-Hypothermia is a medical emergency that occurs when your body loses heat faster than can produce heat, causing a dangerously low body temperature. Normal body temperature is around 98.6. Hypothermia occurs as your body temperature falls below 95 degrees Fahrenheit (https://www.mayoclinic.org).

-Urinary tract infection occurs when there is a compromise of host defense mechanisms and a virulent microbe adheres, multiplies, and persists in a portion of the urinary tract. Most commonly, UTI is caused by bacteria, but fungi and viruses are possible. Urine culture and sensitivity are the gold standards for the diagnosis of bacterial UTI (https://www.ncbi.nlm.nih.gov).

-Acute Kidney Injury occurs when your kidneys suddenly become unable to filter waste products from your blood. When your kidneys lose their filtering ability, dangerous levels of wastes may accumulate, and your blood's chemical makeup may get out of balance. Acute kidney failure - also called acute renal failure or acute kidney

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 121	F 694		

injury - develops rapidly, usually in less than a few days (https://www.mayoclinic.org/diseases-conditions/kidney-failure/symptoms-causes).

-Sodium Chloride Solution 0.9%, solution is used to supply water and salt (sodium chloride) to the body. Sodium chloride solution may also be mixed with other medications given by injection into a vein (https://www.webmd.com/drugs).

-Clysis or hypodermoclysis is a relatively safe and effective procedure in a nursing home. The use of clysis in the nursing home is an alternative to intravenous hydration. The use of clysis for short-term hydration has the potential to reduce cost and transfers to the hospital (https://pubmed.ncbi.nlm.nih.gov).

-A basic metabolic panel (BMP) is a test that measures eight different substances in your blood. It provides important information about your body's chemical balance and metabolism. Metabolism is the process of how the body uses food and energy. A BMP is used to check different body functions and processes, including: kidney function, fluid and electrolyte balance, blood sugar levels, and acid and base balance (https://medlineplus.gov).

-Klebiella pneumoniae is one of the bacteria most frequently causing healthcare-associated urinary tract infections (https://www.ncbi.nlm.nih.gov).

-Bair hugger system is a temperature management system used in a hospital or survey center to maintain a patient's core body temperature (https://www.bairhugger.com).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 122	F 694		

-Mechanical ventilation is a form of life support. A mechanical ventilator is a machine that takes over the work of breathing when a person is not able to breathe enough on their own. The mechanical ventilator is also called a ventilator, respirator, or breathing machine (https://www.continued.com/resp-therapy/courses).

2. Resident #71 was originally admitted to the facility 1/11/22 and readmitted 2/21/22 after an acute care hospital stay. The current diagnoses included; Incision and drainage of the right knee and placement of antibiotic beads.

The five day Medicare Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/28/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #71's cognitive abilities for daily decision making were intact.

In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people with bed mobility, extensive assistance of one person with personal hygiene, dressing, toileting limited assistance of one person with eating and limited assistance of one after set-up with eating.

Resident #71 was observed sitting in a wheel chair in her room on 3/9/22 at approximately 4:45 p.m. The resident stated she had surgery to the right knee and the physician had to go back in it and clean it out because of an infection; as a result she needed to have extensive antibiotic therapy intravenously. The resident further stated some of staff act like they have no idea how to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 123	F 694		

administer the antibiotic.

The resident had a PICC to the right upper arm and it was dated 3/9/22. Resident #71 stated the PICC dressing was supposed to be changed 3/5/22 but it wasn't changed until 3/9/22 and it was supposed to be changed again on 3/12/22 but it was now 3/17/22 and it hadn't been changed. Resident #71 stated she was concerned the PICC site may become infected and cause a delay in her going home.

The physician order summary revealed the following orders;
2/25/22 IV PICC change needleless connector on admission, weekly every day shift/ Saturday for and as needed thereafter and change after every blood draw.

2/25/22 IV-PICC Measure catheter length on admission and with each dressing change thereafter. 2/25/22 IV-PICC change transparent dressing on admission, then weekly every day shift/Saturday and as needed thereafter.

2/21/22 Ceftriaxone Sodium Solution Reconstituted 2 Grams - Use 2 gram intravenously in the evening for infection related to infection and inflammatory reaction due to internal right knee prosthesis.

An interview was conducted with Licensed Practical Nurse (LPN) #15, on 3/17/22 at approximately 1:15 p.m. LPN #15 stated she would take care of the dressing change today.

On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, VPCS and the Vice President of Operations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 694	Continued From page 124 (VPO). The VPSC stated he had spoken to the nurse caring for Resident #71 and the dressing was to be changed today. The below information was obtained from the following web site on 3/25/22 (https://medlineplus.gov/ency/patientinstructions/000462.htm#:~:text=You%20should%20change%20the%20dressing,you%20with%20the%20dressing%20change.) A dressing is a special bandage that blocks germs and keeps your catheter site dry and clean. You should change the dressing about once a week. You need to change it sooner if it becomes loose or gets wet or dirty.	F 694		
F 695 SS=D	COMPLAINT DEFICIENCY Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff interviews, and clinical record review, the facility staff failed to ensure a resident who receives oxygen therapy for COPD and CHF had oxygen flowing for 1 of 44 residents (Resident #56), in the survey sample.	F 695	1. For resident # 56, a full oxygen machine was provided, oxygen saturation level recorded at 91%, post oxygen administration at 95%. 2. Residents with oxygen orders were checked and tanks/cylinders had	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 695	Continued From page 125 The findings included: Resident #56 was originally admitted to the facility 9/19/16 and readmitted 1/30/22 after an acute care hospital stay. The current diagnoses included; COPD, congestive heart failure (CHF), and respiratory failure with hypoxia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 2/15/22 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #56's cognitive abilities for daily decision making was intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with personal hygiene, bathing, dressing, and toileting, extensive assistance of two people with bed mobility and supervision of one person after set-up with eating. Resident #56 was observed seated in a wheel chair in her room. She was wearing a slipper to the right foot and her right lowered leg was with plus two edema and redness. The resident's left arm was also with plus two edema and her face appeared fuller than it was the prior evening. The resident had a portable oxygen tank on the back of her wheel chair but it was on empty and she had a nasal cannula in her nostrils. An interview was conducted with Resident #56 in her room on 3/10/22 at approximately 2: 30 p.m. Resident #56 stated she participated in the Resident Council meeting earlier on 3/10/22 and was waiting for the nurses to put her back in bed. Resident #56 stated she felt heavy as well as a little short of breath and it troubled her, for in	F 695	adequate supply of oxygen for use. 3. Licensed nurses will be educated on oxygen administration. 4. Unit manager, or designee, will randomly audit oxygen cylinders and concentrators weekly for 4 weeks and monthly for 2 months. Results will be brought to QAPI for 3 months or until compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 695	Continued From page 126	F 695		

January 2022 she was hospitalized twice for shortness of breath caused by COPD and congestive heart failure (CHF). The resident stated her doctor always told her to weigh daily and if there was a change of three pounds or more to contact the office and to be sure she monitored her intake of fluids. Resident #56 stated she asked Certified Nursing Assistant CNA) #6 to weight her on 3/10/22 and she weighed was 194.5 pounds. Resident #56 stated her weight was 190.7 pounds of 3/7/22. The resident also stated she received a fluid pill, a heart pill and oxygen to manage her breathing problems caused by COPD and congestive heart failure.

The Physician's Order Summary (POS) revealed the following order; 12/31/21 Oxygen 2 liters per minute by nasal cannula as needed for oxygen saturations below 92 percent.

The current care plan had a problem dated 2/24/22 which read; resident has altered cardiovascular status r/t hypertension, CHF and cardiomyopathy. The goal read; the resident will be free from complications of cardiac problems through the review date. The interventions included; Assess lung and heart sounds as needed. Medications as ordered. Oxygen at 2 liters per minute via nasal cannula. Vital signs as ordered. Resident is a daily weight

An interview was conducted with Licensed Practical Nurse (LPN) #10 on 3/10/22 at approximately 4:35 p.m. LPN #10 stated the resident's portable oxygen tank was empty but she connected the resident to the concentrator and her oxygen saturation was 8 percent. LPN #10 stated she didn't assess or obtain the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 695	Continued From page 127 resident's saturation prior to attaching her tubing to the concentrator. LPN #10 didn't acknowledge the resident's shortness of breath, increased weight or edema to her extremities but she stated the resident offered no concerns. On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, VPCS and the Vice President of Operations (VPO). No additional information was offered and no concerns were voiced.	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on information gleaned during a complaint investigation, family interview, staff interviews, and a clinical record review, the facility staff failed to admit and transcribe orders to obtain crucial pain medications for over forty-five hours to manage the pain for a resident two days post-surgery after a serious and complex lumbar fusion of the spine, resulting in severe pain which limited participation in day to day activities, the ability to sleep at night and physical decline which constituted harm for 1 of 44 residents (Resident #83), in the survey sample. The findings included: Resident #83 was originally admitted to the facility	F 697	1. For resident # 83 staff failure to admit and transcribe orders on 11/19/2021 cannot be corrected retroactively since resident # 83 was discharged to acute care on 11/26/2021. 2. Admissions report from 03/01/2022 to date is reviewed and all admissions and orders were transcribed, and medications received. 3. Licensed nurses and unit managers re-educated on admission and orders transcription proficiency. Unit managers will utilize an admission check list to verify completeness of admission and orders process within 24 hours and shall immediately address any concerns.	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 697	Continued From page 128 on 11/19/21, was discharged to acute care on 11/26/21, returned to the facility on 12/30/21, and discharged again on 1/1/22, and succumbed on 1/4/22. The diagnoses at the time of the resident's 11/19/21 admission included; status post decompression and fusion of the lumbar spine and polymyalgia rheumatic. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/26/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #83's cognitive abilities for daily decision-making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people with transfers, extensive assistance of one person with dressing and toileting, limited assistance of one person with bed mobility and personal hygiene, and supervision after set-up with eating. In sections J0500A and B; the resident was coded that pain made it hard to sleep at night and limited day-to-day activities. At section M1040E; the resident was coded with a surgical wound. On 3/16/22 at approximately 10:30 a.m., an interview was conducted with the resident's listed Responsible party (RP). The RP stated they were familiar with the facility under different ownership for their mother had short stays after a number of hospitalizations. The RP further stated Resident #83 chose the facility for rehabilitation after surgery to regain strength and return home. The RP stated the resident was an eighteen-wheel truck driver and looked forward to getting back in the truck. The RP also stated the night of 11/19/21, Resident #83 arrived at the	F 697	Licensed nurses have been granted access to STAT medication machine to access medications as needed on emergency basis. 4. The Interdisciplinary Team will review new admissions at Clinical start up meeting to ensure admission is completed, and will ensure admission medications are available to the resident as an ongoing process. 4. Unit managers or designee shall report on the admission process to monthly QAPI x 3 months, or until satisfactory compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 697	Continued From page 129	F 697		

facility at approximately 6:00 p.m., by stretcher from a local hospital. She stated the resident was with significant functional limitations including transfers, walking, toileting, and other activities of daily living (ADL) and back pain secondary to surgical decompression and lumbar fusion of the spine. The RP stated the unit the resident was assigned to was staffed with one nurse, no other staff, and the nurse was overwhelmed and told her she had no orders to provide care to the resident.

During the interview, the RP assured the facility's nurse that wasn't accurate for she had spoken with the hospital's Discharge Planner multiple times to ensure all necessary orders and instructions were provided to the facility prior to the resident leaving the hospital because she was aware of how interruptions in service may occur if all information wasn't provided timely to the facility. The RP stated the nurse told the family upon request for pain medication that she had no orders for medications therefore she couldn't administer any medications to the resident but they could go home and get his medications and they could administer them to the resident. The RP stated that the same evening, the day of admission 11/19/21, Resident #83 experienced severe pain and needed to void but because of a history of voiding only in a specific position it was necessary for him to get out of bed to void and there was no one to assist the resident. It was the family who had to assist the resident to get out of bed to void. The RP stated the only service the resident received the day of admission was to receive a bedside commode, no medications, no physical assistance.

The RP further said during the above interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 697	Continued From page 130	F 697		

that over the course of the first two days her brother had to come into the facility and transfer the resident to the commode because the staff wouldn't. She stated the staff's rationale was rehabilitation services hadn't assessed the resident and he was experiencing severe pain on movement. The RP stated on one occasion the resident lay in feces for four hours because he feared the pain which would be inflicted on him by staff yanking on him to clean him up, therefore the resident called for his son to come to the facility and assist him to clean up. The RP also stated on 11/20/21 the nurse staff stated it would be three to four days before the resident's pain medications would arrive to the facility, and it was a relief when they finally arrived almost two days after his admission to the facility.

Review of the hospital's discharge summary dated 11/19/21 included the following discharge medication orders; Percocet 5/325 milligrams; one tablet by mouth every six hours as needed for pain, Norco 7.5/325 mg; one tablet by mouth every six hours as needed, Prednisone 5mg one tablet by mouth daily and Zanaflex 4mg; one tablet by mouth three times daily as needed.

A record review revealed on 11/20/21 at 10:07 a.m., (name of the on-call Nurse Practitioner) called to have a hard prescription sent to the pharmacy for Percocet. The Nurse Practitioner (NP) stated she would send an electronic prescription to the pharmacy and the resident's son was informed when he arrived at the facility. A nurse's progress note dated 11/21/21 at 5:19 p.m. revealed that Resident #83's family members were in the facility demanding to speak with the Director of Nursing because the resident wasn't receiving two medications (a steroid and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 697	Continued From page 131	F 697		

an antispasmodic) instrumental in treating polymyalgia rheumatic; an inflammatory disorder that causes muscle pain, muscle stiffness, and muscle spasms in various parts of the body which could easily be treated with steroids and an antispasmodic. A progress note was also in the clinical record stating on 11/21/21 at 9:21 p.m., the on-call NP was notified that Resident #83's family desired to have the Prednisone and Zanaflex resumed but the NP deferred the orders to the order until the resident was visited by the in-house Practitioner.

During the interview with the RP on 3/16/22 at approximately 10:30 a.m., the RP stated when the resident's medications arrived at the facility from the pharmacy on 11/21/21 the steroid and antispasmodic weren't included and they were the exact medications the hospital Discharge Planner was asked to ensure was included in the orders to the facility for they were required to treat the debilitating symptoms of polymyalgia rheumatic. The RP stated as a result of not receiving the steroid and antispasmodic the resident suffered additional pain, spasms and other rebound symptoms of polymyalgia rheumatic along with the pain related to the spinal surgery. The RP stated the poor care in the facility resulted in her father's unnecessary pain and physical decline.

An interview was conducted with Licensed Practical Nurse (LPN) #9 on 3/17/22 at approximately 9:52 a.m. LPN #9 stated she remembered Resident #83 and she was the nurse on duty the evening the resident arrived. She further stated the staff knew she wasn't proficient in admissions and she always worked the overnight shift to avoid admitting residents. LPN #9 stated she had never admitted a resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 697	Continued From page 132	F 697		

and the day Resident #83 arrived she was the only direct care staff on the unit; without any other nurses or Certified Nursing Assistants (CNA). LPN #9 stated the front office staff was also aware she was the only caregiver for the shift therefore they came to the unit to assist with answering call lights and providing limited care for the residents prior to going home for the night, but that was all. LPN #9 stated no one told her they were not going to admit Resident #83 to the facility and she didn't. LPN #9 stated she provided the Resident with a bedside commode and a son who was present and very involved in the resident's care assisted him to the toilet. LPN #9 also stated she was aware the resident was experiencing pain and she informed the resident's family that she had no orders to administer any medications to the resident.

An interview was conducted with the facility's Admission Director on 3/17/22 at approximately 2:30 p.m. The Admission Director stated she doesn't have a clinical background, therefore, all clinical concerns are reviewed by the Director of Nursing prior to admissions arrival to the facility. The Admission Director stated there were no specific clinical concerns with Resident #83's 11/19/21 admission therefore all of the admission documents were given to the nursing staff for the unit to the resident was to be admitted and the nursing staff didn't ask her to obtain any specific documents from the hospital's Discharge Planner and no concerns were voiced by the nursing staff.

Two other staff nurses were telephoned on 3/16/22 and 3/17/22 for interviews regarding the status of Resident #83 during the 11/19/21 admission but the calls were not answered and/or returned. One of the nurses assumed care of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 697	Continued From page 133	F 697		

resident on 11/20/21 and telephoned the Nurse Practitioner for a pain medication order and the other was the nurse who opened a Braden Scale for Predicting Pressure Sore Risk assessment but didn't complete any of it or any other admission paperwork on 11/19/21.

An interview was conducted on 3/17/21 at approximately 1:30 p.m., with the facility's Vice President of Clinical Services (VPCS). The VPCS stated he was unable to provide evidence that the resident received any type of pain management prior to 11/21/21 at 3:50 p.m. when Vicodin 5/325 milligrams (mg) was delivered and administered. The VPCS stated the pain medication Percocet 5/325 mg was included in the resident's orders on 11/19/21, as a hospital discharge medication and it was available in the facility's stat medication box, yet it wasn't withdrawn and administered to the resident and neither was the Norco administered at the time of obtaining the order for it on 11/20/21 for the 5/325 mg dose was also available in the stat box but not the 7.5/325 mg dosage. The VPCS further stated both drugs were in the stat box and could have been given. The VPCS

On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, VPCS, and the Vice President of Operations (VPO). The VPCS stated the nurses working at the facility are competent and there is a resource book available for reference when needed therefore he was unable to explain why there was a delay in the resident's care. The VPO stated she too had reviewed the pain medication delays and felt the resident pain wasn't managed appropriately but she was unable to offer any insight into why the care wasn't provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 697	Continued From page 134 promptly. COMPLAINT DEFICIENCY	F 697		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on a family interview, staff interviews, and review of facility documents, the facility staff failed to have on duty sufficient nursing staff with the	F 725	1. The facility has increased staffing ratio for 3-11pm shift on unit B to 2 nurses and 3 CNAs budgeted	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 725	Continued From page 135 appropriate skills sets to provide nursing services during the 3:00 p.m. - 11:00 p.m., shift on 11/19/21. The findings included: Resident #83 was originally admitted to the facility 11/19/21, was discharged to acute care 11/26/21. The resident's diagnoses included status post decompression and fusion of the lumbar spine and polymyalgia rheumatic. The admission Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 11/26/21 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #83's cognitive abilities for daily decision making were intact. In section "G" (Physical functioning) the resident was coded as requiring total care of one person with bathing, extensive assistance of two people with transfers, extensive assistance of one person with dressing and toileting, limited assistance of one person with bed mobility and personal hygiene, and supervision after set-up with eating. In section J0500A and B; the resident was coded that pain made it hard to sleep at night and limited day to day activities. At section M1040E; the resident was coded with a surgical wound. On 3/16/22 at approximately 10:30 a.m., an interview was conducted with the resident's listed Responsible party (RP). The RP stated, they were familiar with the facility under a different ownership for their mother had short stays after a number hospitalization. The RP further stated Resident #83 chose the facility for rehabilitation after surgery to regain strength and return home.	F 725	2. Staffing levels for all shifts are sufficient for resident ratios and care 3. Staffing coordinator will be educated on staffing pattern. Licensed nurses will be educated on completing an admission 4. HR will continue efforts to recruit staff according to safe ratio levels. HR will report on staffing ratios on the 3-11 pm shift daily to the Administrator. 5. HR/staff coordinator shall report to QAPI meeting monthly x 3 staff levels on the 3-11pm shift	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 725	Continued From page 136	F 725		

The RP stated the resident was an eighteen wheel truck driver and looked forward to getting back in the truck. The RP also stated the night of 11/19/21, Resident #83 arrived to the facility at approximately 6:00 p.m., by stretcher from a local hospital. She stated the resident was with significant functional limitations including transfers, walking, toileting and other activities of daily living (ADL) and back pain secondary to surgical decompression and lumbar fusion of the spine. The RP stated the unit the resident was assigned to was staffed with one nurse, no other staff and the nurse was overwhelmed and told her she had no orders to provide care to the resident. The RP assured the facility's nurse that wasn't accurate for she had spoken with the hospital's Discharge Planner multiple times to ensure all necessary orders and instructions were provided to the facility prior to the resident leaving the hospital because she was aware of how interruptions in service may occur if all information wasn't provided timely to the facility.

During the interview, the RP stated the nurse told the family upon request for pain medication that she had no orders for medications therefore she couldn't administer any medications to the resident but they could go home and get his medications and they could administer them to the resident. The RP stated that same evening, the day of admission 11/19/21, Resident #83 experienced severe pain and needed to void but because of a history of voiding only in a specific position it was necessary for him to get out of bed to void and there was no one to assist the resident. It was the family who had to assist the resident to get out of bed to void. The RP stated the only service the resident received the day of admission was to receive a bedside commode,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 725	Continued From page 137	F 725		

no medications, no physical assistance.

An interview was conducted with Licensed Practical Nurse (LPN) #9 on 3/17/22 at approximately 9:52 a.m. LPN #9 stated she remembered Resident #83 and she was the nurse on duty the evening the resident arrived. She further stated the staff knew she wasn't proficient in admissions and she always worker the overnight shift to avoid admitting residents. LPN #9 stated she had never admitted a resident and the day Resident #83 arrived she was the only direct care staff on the unit; no other nurses or Certified Nursing Assistants (CNA). LPN #9 stated the front office staff was also aware she was the only caregiver for the shift therefore they came to the unit to assist with answering call lights, and providing limited care for the residents prior to going home for the night, but that was all. LPN #9 stated no one told her they were not going to admit Resident #83 to the facility and she didn't. LPN #9 stated she provided the Resident with a bedside commode and a son who was present and very involved in the resident's care assisted him to toilet. LPN #9 also stated she was aware the resident was experiencing pain and she informed the resident's family that she had no orders to administer any medications to the resident.

An interview was conducted with Licensed Practical Nurse (LPN) #6 on 3/14/22 at approximately 3:30 p.m. LPN #6 stated Unit B daily census ranged of 26 - 30 residents each day and appropriate staffing for the 3:00 p.m. - 11:00 p.m. shift is one licensed nurse and three Certified Nursing Assistants (CNA). LPN #6 stated having the one nurse with an admission is difficult but doable, working with two CNAs is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 725	Continued From page 138 challenging but very difficult, and having no CNAs is simply unsafe. An interview was conducted with the Staffing Coordinator on 3/14/22 at approximately 4:05 p.m. The Staffing Coordinator stated she was new to the position but based on the formula for staffing she was trained with; on the 3:00 p.m. - 11:00 p.m. shift, one nurse is scheduled and another is on duty for admissions from 3:00 p.m. - 6:00 p.m., and three CNAs. On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, VPCS and the Vice President of Operations (VPO). The VPCS stated the nurses working at the facility are competent and currently they are staffing an additional nurse to complete admissions making this event likely never to occur again. The VPO stated they have a nurse recruiter coming on board soon and the company has restructured nurse staff salary and benefits to increase the potential for obtaining facility staff as opposed to agency staff.	F 725		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required	F 726		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 726	Continued From page 139 at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility staff failed to ensure Agency Staff completed appropriate competencies and skill sets to provide nursing related services to meet resident needs. The findings included: A review of the facility's as work staffing schedule for the prior two weeks (February 20 through March 5th 2022) of the unannounced Medicaid/Medicare survey which started (March 09, 2022) indicated: 86 % of the direct care nursing staff were as needed agency staff. The facility utilized two separate agencies. During an interview on 03/17/2022 at 10:45 A.M. with the Corporate Vice President of Operations,	F 726	1. Agency nursing staff that routinely work in the facility have been identified and competencies for IVs, initiating and care of, accuchecks and documentation, medication administration and pharmacy contact information, noting of physician recommendation and orders, and baseline care plan, have been initiated and are ongoing. 2. Competency files for agency staff have been initiated and will be maintained by the ADON/SDC. 3. The ADON/SDC will be educated regarding need to maintain competency files on agency staff. A nursing competency book from Med Pass has been provided to the facility for use. All agency staff will complete a competency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 726	Continued From page 140 she stated, the facility was operating on 14% company licensed nursing staff with the remaining staff from the two agencies. During an interview on 03/17/2022 at 10: 47 A.M. with the administrator she stated, the facility had a contracted agreement with two agencies for staffing. Agency staff agreement #1 was signed and dated (11/18/21). Agency staff agreement #2 was signed and dated 10/26/21. The facility was noted to have two (2) signed and dated contracted agreements for agency staffing. A review of the agency staffing contracts did not indicate that the agencies had to provide their staff competencies (training) as a part of the agreement. A random selection of 7 agency staff's competencies, which included the two agencies that facility utilized, were requested of the Administrator for review. The administrator provided to the survey team a letter signed and dated 03/17/22 regarding agency staffing competencies. The letter was noted to include the following: "Nursing Competency The facility utilizes nursing staff from (named staff agency) and (named staff agency). Both agencies reported to us that they do not complete or have on file any nursing competencies." The following issues were identified where the agency staff were responsible to provide care and services to the residents in the nursing facility: The agency staff utilized by the facility failed to	F 726	course upon first visit to the facility. 4. The DON or Designee will audit 5 agency competency files weekly x 3 months to ensure competencies have been completed. 5. Results will be brought to QAPI meeting x 3 months or until compliance is achieved	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 726	Continued From page 141	F 726		

exhibit competencies in the skill necessary to admit a resident to the facility. During an interview with Licensed Practical Nurse (LPN) #9 on 3/17/22 at approximately 9:52 a.m. LPN #9 stated she remembered Resident #83, she was the nurse on duty for the specific unit the evening the resident arrived. LPN #9 stated the staff knew she wasn't competent and had not demonstrated the ability to perform the necessary activities to safely complete an admission (writing orders, assessing a new resident, obtaining medications from the pharmacy) therefore she always worked the overnight shift to avoid admission process. LPN #9 stated no one told her they were not going to admit Resident #83 to the facility and she didn't. LPN #9 also stated she was aware the resident was experiencing pain and she informed the resident's family that she had no orders to administer any medications to the resident. As a result of LPN #9's lack of competencies to admit and transcribe orders to obtain crucial pain medications this contributed to poor outcomes for the resident. Resident #83 suffered severe pain which limited participation in day to day activities, the ability to sleep at night and resulted in physical decline .

The agency staff utilized by the facility failed to exhibit competencies in the skills and techniques necessary to care for the resident's needs in the area of identifying pressure ulcers before becoming unstageable.

The agency staff utilized by the facility failed to exhibit and techniques necessary to care for the resident's needs in the area of transcribing an administering parenteral Intravenous (IV) fluids

The agency staff utilized by the facility failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 726	Continued From page 142	F 726		

exhibit competencies in the skills and techniques necessary to care for the resident's needs in the area of notifying and following the physician/Nurse Practitioner (NP) orders to administer parenteral Intravenous (IV) fluids, obtain blood sugar checks as ordered and to notify when check blood sugars are greater than 400.

The agency staff utilized by the facility failed to inform the physician of a progress note written by the neuropsychologist with the recommendation to start the medication (Luvox 25 mg) daily for behaviors.

The agency staff utilized by the facility failed to investigate the location of a significant medication (Zyvox) for one resident whose medication was located inside another medication cart resulting in the resident not receiving his scheduled medication from 03/01/22-03/07/22.

The agency staff utilized by the facility failed to exhibit competencies in the skills and techniques necessary to care for Resident 87's needs in the area of change of condition timely notification . LPN #3 failed to notify Resident #87's responsible party timely of an acute change of condition that required the resident to be transferred to the hospital on 2/3/22 via 911.

The agency staff utilized by the facility failed to exhibit competencies in the skills and techniques necessary to care for Resident 67's needs in the area of baseline care plan. LPN #3 failed failed to provide a written baseline care plan summary to Resident #67's representative.

No further information was provided prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 726	Continued From page 143 survey exit.	F 726		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on information obtained during the Sufficient and Competent Nurse Staffing task, the facility staff failed to use the services of a Registered Nurse (RN) for at least 8 consecutive hours a day, 7 days a week. The findings included: A review of RN staffing for April 3, 2021 through March 13, 2022 the facility staff was unable to provide evidence that an RN provided services in the facility for at least 8 consecutive hours on 5/15/21, 5/29/21, 5/30/21, 6/27/21, 7/17/21, 7/24/21, 10/2/21, 11/27/21, 12/25/21, 1/9/22, 1/15/22, 1/16/22, 3/5/22, 3/6/22, 3/12/22 and 3/13/22. An interview was conducted with the Staffing	F 727	1. Facility is unable to correct previous dates with no RN scheduled 2. Staffing Coordinator will be educated regarding the requirement for an 8 hour/day /7 days a week RN to be scheduled. Attempts ongoing to recruit and hire Full TIme RNs on staff 3. Administrator will audit daily staffing sheets weekly x 4 weeks and monthly x two months 4. Results will be brought to the monthly QAPI meeting x 3 months or until compliance is achieved	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 727	Continued From page 144 Coordinator on 3/14/22 at approximately 4:05 p.m. The Staffing Coordinator stated she was new to the position but based on the formula for staffing she not instructed to staff a RN for at least 8 consecutive hours each day. The Staffing Coordinator stated there are few RNs other than the Director of Nursing, the Assistant Director of Nursing and maybe the MDS Coordinator who work in the facility at least 8 consecutive hours each day. On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, VPCS and the Vice President of Operations (VPO). The VPO stated they have a nurse recruiter coming on board soon and the company has restructured nurse staff salary and benefits to increase the potential for obtaining facility staff as opposed to agency staff enabling RN staffing at least 8 consecutive hours each day.	F 727		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility documentation, the facility staff failed to administer a significant medication for 1 out of 44 residents (Resident #47) in the survey sample. The findings included: 1. The facility staff failed to administer 12 doses of the significant medication (Zyvox) as ordered by the physician to treat a Urinary tract infection	F 760	1. For resident # 47 Zyvox administration was continued per MD order to cover the missed doses. 2. Reviewed Medication Administration Records for the month of 03/01/2022-03/31/2022, found no significant medication errors. 3. Educated licensed nurses on how to deal with situations of unavailable medications. Instructions include calling	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 760	Continued From page 145 (UTI) for Resident #47. Resident #47's Minimum Data Set (MDS - an assessment protocol) a PPS 5-day assessment with an Assessment Reference Date of 02/14/22 coded Resident #47's Brief Interview for Mental Status (BIMS) scored a 06 out of a possible score of 15 indicating severe cognitive impairment. Resident #47's Minimum Data Set (MDS - an assessment protocol) a PPS 5-day assessment with an Assessment Reference Date of 02/14/22 coded Resident #47's Brief Interview for Mental Status (BIMS) scored a 06 out of a possible score of 15 indicating severe cognitive impairment. The MDS coded Resident #47 requiring total dependence of one with dressing, personal hygiene and bathing, extensive assistance of one with bed mobility and toilet use, supervision with eating for Activities of Daily Living care. The care plan with a revision date of 03/03/22 identified Resident #47 on antibiotic therapy for UTI. The goal set for the resident by the staff was that the resident's UTI will resolve without complications. Some of the interventions/approaches the staff would use to accomplish this goal is administer antibiotic therapy as ordered and to monitor for side effects and effectiveness. During the review of Resident #47's hospital discharge summary dated 02/28/22 revealed the following order: start Zyvox 500 mg tablet twice a day for 14 days for UTI. Review of Resident #47's Medication Administration Record (MAR) for March 2022 revealed the antibiotic Zyvox was not administered as ordered on the following days:	F 760	pharmacy services, checking other medication carts, accessing STAT medication machine, notifying unit managers/and or the Director of Nursing, notifying the prescribing practitioner for further instructions should the above steps fail. Significant medication errors must be investigated by the Director of Nursing, notifying patient's family representative, attending physician, and pharmacy consultant.t. 4. Director of Nursing or designee shall report significant medication error(s) monthly to QAPI committee meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 760	Continued From page 146	F 760		

03/01/22-03/07/22.

On 03/14/22 at approximately 1:00 p.m., the facility provided a copy of the facility's investigation report that indicated the following: "On the evening of 02/28/22, Resident #47 was readmitted to the nursing facility with a new order for Zyvox. The pharmacy was made aware of the new order and according to the manifest, the medication Zyvox was delivered to the facility on 03/01/22. According to License Practical Nurse (LPN) #1 and LPN #2, the medication was not given because it was considered unavailable and was not located in the medication cart."

The facility provided a packing slip which revealed the medication Zyvox (28 tablets) were delivered to the nursing facility on 03/01/22.

An interview was conducted with LPN #2 on 03/16/22 at approximately 11:45 a.m. The LPN stated, "Zyvox was not given because the medication was located in another medication cart. The LPN said if I had called the pharmacy, they would have informed me that the Zyvox was delivered on 03/01/22 and Resident #47 wouldn't have missed all those doses of his antibiotic.

A debriefing was held with the Administrator and Vice President of Operations on 03/17/22 at approximately 5:45 p.m., who were informed of the above findings; no further information was provided prior to exit.

Definitions:
-Zyvox is used to treat infections, including pneumonia, and infections of the skin. Zyvox is in a class of antibacterials called oxazolidinones. It works by stopping the growth of bacteria

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 760	Continued From page 147 (https://medlineplus.gov/druginfo/meds).	F 760		
F 804 SS=F	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations during the tray line service, resident interview, staff interviews, and clinical record review, the facility staff failed to serve proper meat portions and mashed potatoes per recipe to provide person-centered determined nutritional needs based on the Registered Dietitian's assessment for 71 of 83 residents in the facility. The findings included: On 3/1/22 at approximately 12:05 p.m., an observation of the midday meal service was observed. The general meal served was 3 ounces (oz.) of ham, 1 twist of an orange, 1 ounce of pineapple sauce, herb roasted red potatoes, mashed potatoes for mechanically altered diets, garden blended vegetables, corn bread, and peach crisp. The alternate was cube steak with brown gravy, and spiral noodles. During the tray line observation on 3/1/22 at approximately 12:05 p.m., the Cook was asked to	F 804	1. Facility is unable to retroactively correct deficient practices noted on 3/1/22. 2. Facility will audit supply of 8oz mugs to ensure they are available as specified on the tray cards. 3. Dietary staff educated on following portion sizes and special diet orders. 4. Administrator, or designee, will audit for compliance daily for 5 days, weekly for 4 weeks, and monthly for 2 months. 5. Results of audit will be brought to QAPI x 3 months or until compliance is achieved	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 804	Continued From page 148 weigh the portion of ham slices served. The ham slice weighed between 1 oz and 1.5 oz. The Cook stated she cut the ham slices at over 3 ounces to account for loss of water during cooking but it never occurred the portion sizes would result in one half to one third of the size to be served. On 3/1/22 at approximately 12:45 p.m., the Dietary Manager stated the mashed potatoes were fortified; which meant they are made with half and half, dried nonfat milk and three cups of margarine. The Dietary Manager stated all residents who received mashed potatoes receives the same product, fortified mashed potatoes. The Dietary Manager stated she understood serving the fortified potatoes to all the resident wasn't what was recommended or in the best interest of all resident's who received them but going forward the two recipes would be followed and served as recommended by the RD. Review of the recipes stated the regular mashed potatoes are prepared with water, instant mashed potatoes and two cups of margarine. Also during the tray line observation the dietary staff provided containers of 6 oz of water instead of 8 oz as the tray card read. On 3/17/22 at approximately 5:45 p.m., the above findings were shared with the Administrator, VPCS and the Vice President of Operations (VPO). The VPO stated she was aware of the identified concerns and voiced no concerns.	F 804		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)	F 868		4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 868	Continued From page 149 §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility record review, and review of the facility's policy, the facility staff failed to consistently have the Medical Director or Designee present for 1 of 4 quarterly meetings. The findings included: An interview was conducted with the Administrator on 03/17/22 at approximately 2:10 p.m. The facility's signature sheets were reviewed for their Quality Assurance (QA) meetings held on 02/28/22, 11/05/21, 07/12/21 and 03/10/21, which revealed the Medical Director or his designee were not present for the quarterly QA meeting held on 02/28/22. A debriefing was held with the Administrator and Vice President of Operations on 03/17/22 at approximately 5:45 p.m., who were informed of the above findings; no further information was	F 868	1. Facility is unable to retroactively correct deficient practice of Medical Director not being present for QAA meeting on 2/28/22. 2. A new Medical Director was brought onboard as of 4/4/22 and a standing appointment made for QAA meetings to ensure compliance moving forward. 3. Administrator has been educated by the VP of Operations regarding the QAPI committee 4. Vice President of Operations, or designee, will audit compliance monthly for 3 months and quarterly for 2 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 868	Continued From page 150 provided prior to exit. The facility's policy titled Quality Assurance and Performance Improvement (QAPI) Program with a revision date of 02/2020. Authority: The Administrator is responsible for assuring that this facility's QAPI program complies with federal, state, and local regulatory agency requirements.	F 868		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and review of facility documents, the facility's staff failed to have an ongoing review of antibiotic stewardship and monitor the effectiveness of the resident's antibiotic therapy. The findings included: On 3/17/22 at approximately 2:30 PM an interview was conducted with ASM (Administrative Staff Member) #3 and via telephone with ASM #6 concerning the antibiotic Stewardship Program. ASM #3 stated, "The DON (ASM #4) has the book with the line listings but	F 881	1. The antibiotic sterwardship program for January, February, and March was completed on 4/12/22. 2. The Infection Preventionist was educated on 4/12/22 by the Vice President of Operations on the antibiotic stewardship program and its components including maintaining an ongoing program 3. The Director o Nursing, or Designee, will audit the Antibiotic Stewardship program for evidence of an ongoing program weekly x 4 weeks then monthly for two months 4. Results will be brought to QAPI x 3	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 881	Continued From page 151 he is no longer here. I only have the education book." An observation of the education book was made. There were no line listings for the months of January, February and March of 2022. ASM #6 stated the DON was working on the book but never finished it. On 3/17/22 at approximately 5:45 PM a Pre-exit interview was conducted with the Administrator, The Vice President of Operations and with the Vice President of Clinical Services. No comments were voiced at this time.	F 881	months or until compliance is achieved	
F 925 SS=D	. Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview the facility staff failed to maintain an ongoing pest control program to ensure the facility is free of insects. The findings included: During the Resident Council meeting on 03/10/22 at 10:00 A.M. Resident #73 stated he had ants in his room. Resident #73 was admitted to the facility on 06/16/21 and had a Brief Interview of Mental Status (BIMS) score of 14.	F 925	1. Resident #73's room was treated for ants. No further ants visualized 2. Eco Lab into facility on 3/11/22 and treated the perimeter of the facility, and spot checked areas within the facility for evidence of pests. 3. Staff education will be completed to include reporting visualization of pests via a work order in TELS 4. Maintenance Director, or designee, will audit facility grounds weekly for any visualization of pests. Audit results will be brought to QAPI for 3 months or until compliance is achieved.	4/30/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 03/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COURTLAND REHABILITATION AND HEALTHCARE CENTER	23020 MAIN STREET COURTLAND, VA 23837

(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 925	Continued From page 152	F 925		

During an interview on 03/10/22 at 11:05 a.m.. with Resident #73. He stated, ants have been crawling all over the room. Observations made in Resident #73's room indicated that a 3 inch by 4 inch by one half inch deep area of the right corner of the room flooring was missing. During this observations, ants were noted to be coming in from the outside under the window and air/heating unit area.

Ants were observed to be under a night stand. Ants were observed to be on the bed and covers of Resident #73 bed. Resident #73. stated, he has been fortunate that the ants had not bitten him.

During an interview on 3/10/22 at 11:43 a.m. with the Maintenance Director, he stated, he was not aware of the ants but would get the pest control company out as soon as possible.

A Pest Control Policy indicated: " Policy Statement-Our facility shall maintain an effective pest control program.
Policy Interpretation and Implementation:
1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.
5. Maintenance services assist, when appropriate and necessary, in providing pest control services."