DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495246	A. BUILDING _____ B. WING _____	C 05/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODMONT CENTER	11 DAIRY LANE FREDERICKSBURG, VA 22405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 5/30/23 through 5/31/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey (VA00058835-substantiated with deficiency). The census in this 118 certified bed facility was 92 at the time of the survey. The survey sample consisted of three current residents and one closed record.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of practice for one of four residents in the survey sample, Resident #1. The findings include: 1.a. For Resident #1 (R1), the facility staff failed to properly transcribe a physician's order in the electronic medical record on 5/16/23 for a left arm and hand x-ray. The x-ray was never obtained. A review of R1's clinical record revealed a note signed by the nurse practitioner on 5/16/23 that	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: N. Threatt, Adm. | TITLE | (X6) DATE: 6/21/23

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

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			will be corrected immediately and brought to QAPI. Beginning 6/21/23 the DON, UM or designee will review all skin checks three times a week for 4 weeks then randomly thereafter to ensure they include monitoring of bruises. 5.Date of compliance: 6/23/23	

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

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

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F 658	Continued From page 1 documented, "Incident over the weekend where pt (patient) was found on the floor in his room. Seen today for assessment of injury...Musculoskeletal: Generalized weakness, Non-ambulatory, Left arm contractures and Left sided weakness-c/o (complains of) L (left) shoulder/arm pain when attempting to turn on L side...Will order x-ray of L arm to hand-scheduled tylenol in place." A physician's order dated 5/16/23 documented an order for an x-ray of the left shoulder to hand. Further review of R1's clinical record failed to reveal the x-ray was obtained. A review of an order/results list from the mobile x-ray company revealed the order for R1's x-ray on 5/16/23 was never submitted to the mobile x-ray company. On 5/31/23 at 8:24 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the nurse practitioner enters orders for x-rays directly into the computer system then the nurses have to go under pending orders in the computer system, confirm the order, schedule the order, and contact the mobile x-ray company online or via phone. On 5/31/23 at 9:48 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated there is a glitch in the computer system that cannot be fixed. ASM #2 stated that if a provider or nurse puts an order into the system, staff must schedule the order for it to populate onto the MAR (medication administration record) or TAR (treatment administration record). ASM #2 stated sometimes the nurse managers will confirm and schedule orders so the orders will transcribe onto the MAR or TAR, then usually, the	F 658		

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F 658	Continued From page 2 floor nurses will review the MAR or TAR and complete the order, such as scheduling an x-ray appointment with the mobile x-ray company. ASM #2 stated she has a new nurse manager who confirmed R1's x-ray order in the computer system but the new nurse manager did not know she had to schedule the order so it would transcribe to the MAR or TAR. ASM #2 stated the new nurse manager thought that by confirming the order, the order automatically translated to the MAR or TAR. On 5/31/23 at 10:20 a.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Physician/Advanced Practice Provider (APP) Orders" documented, "Admission, Interim, Re-admission, and Renewal Orders: Must be entered into the electronic order management system..." 1.b. For Resident #1 (R1), the facility staff failed to document and monitor the resident's left arm bruise. R1 sustained a fall on 5/14/23, was transferred to the emergency room, and returned to the facility on that same date. A review of R1's clinical record (including nurses' notes and skin assessments from 5/14/23 through 5/24/23) failed to reveal any documentation regarding a left arm bruise. A nurse's note dated 5/25/23 documented, "Resident with a fall on 5/14/23 c/o (complained of) left hand at time of the fall x-ray 3 views done negative. Today bruising noted to left axillary area and upper left arm axillary area yellow/light purple, back of left arm with deep purple bruise in linear shape."	F 658		

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F 658	Continued From page 3 On 5/30/23 at 5:00 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 stated she worked the Monday after (5/15/23) R1 sustained the 5/14/23 fall. CNA #1 stated that on that date, she observed a dark purple bruise located towards R1's shoulder and around the resident's under arm. On 5/30/23 at 5:11 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated she took a vacation in May and her first day back to work was on 5/20/23. LPN #4 stated that on that date, she observed a yellow bruise on R1's left upper arm between the resident's elbow and bicep. On 5/31/23 at 10:13 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated she was not aware of R1's left arm bruise until 5/25/23. ASM #2 stated it was difficult to see the bruise because of the location and R1's contracture. ASM #2 stated CNAs should report bruises to nurses and nurses should document and monitor bruises. ASM #2 stated that the staff said R1 had a fall on 5/14/23, went to the hospital and got checked out, but the staff still should have documented the bruise and continue to monitor. On 5/31/23 at 10:20 a.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Skin Integrity and Wound Management" documented, "5. The nursing assistant will observe skin daily and report any changes or concerns to the nurse. 6. The	F 658		

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F 658	Continued From page 4 licensed nurse will: 6.1 Evaluate any reported or suspected skin changes or wounds; 6.2 Document newly identified skin/wound impairments as a change in condition..."	F 658		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure a bed rail assessment was completed for one of four residents in the survey sample, Resident #1. The findings include:	F 700	F700 1.Resident #1 a bedrail assessment was completed on 5/15/23. 2.All residents are at risk for not having a bedrail assessment present. An audit was performed for all current residents and completed on 6/20/23, no further residents were found to be at risk. 3.Beginning 6/20/23 the DON, UM or designee will in-service all licensed nursing staff on ensuring a bedrail assessment is complete upon admission, re-admission, quarterly, change in bed or mattress and with a significant change in condition. 4.Beginning 6/21/23 the DON, UM or designee will complete a bedrail assessment audit three times a week for 4 weeks then randomly thereafter of all current residents to ensure the bedrail assessment is present. Variances will be corrected immediately and brought to QAPI. 5.Date of compliance: 6/23/23	

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F 700	Continued From page 5 For Resident #1 (R1), the facility staff failed to assess the resident for risk of entrapment when bed rails were installed on the resident's bed on 3/27/23. A review of R1's clinical record revealed a bed rail evaluation list that documented a bed rail evaluation was completed on 3/3/23 and, "No Bed Rail(s) to be used." A nurse's note dated 3/25/23 documented, "Resident daughter, (name), came to this nurse with some concerns as followed: No bed rails on bed. Daughter educated about bedrail policy and bed rails will be reassessed and placed if appropriate. RP (Responsible Party) (name) on facetime with daughter and requested for bed rails to be placed on bed. Work order for bed rails put in for Monday morning." A maintenance work order created on 3/25/23 documented bed rails were installed on R1's bed on 3/27/23. Further review of R1's clinical record failed to reveal a bed rail evaluation (including an assessment to determine the risk of entrapment) was completed at that time. On 5/30/23 at 4:05 p.m., an interview was conducted with LPN (licensed practical nurse) #3 (the nurse who signed the above nurse's note). LPN #3 stated that on 3/25/23 she was the supervisor and was working on the medication cart that was located on the unit opposite of R1's unit. LPN #3 stated she spoke with R1's family regarding concerns that included a desire for bed rails. LPN #3 stated she would have to check the computer to see if the nurse caring for R1 on that date completed a bed rail evaluation.	F 700		

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F 700	Continued From page 6 On 5/31/23 at 8:24 a.m., an interview was conducted with LPN #2. LPN #2 stated that nurses have to complete an assessment to make sure bed rails are appropriate and aren't going to cause a risk. On 5/31/23 at 10:20 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Bed Rails" documented, "The Bed Rail Evaluation will be completed upon admission, re-admission, quarterly, change in bed or mattress, and with a significant change in condition."	F 700		
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 776	F776 1.Resident #1 was sent to the ER on 5/25/2023 where the x-ray was obtained. 2.All resident with x-ray orders are at risk. An audit of all current residents who have x-ray orders in the last 3 months have been audited and no further residents are found to be at risk. 3.Beginning 6/20/23 the DON, UM or designee will in-service all licensed nursing staff on scheduling and obtaining x-rays. 4.Beginning 6/21/23 the DON, UM and or designee will complete an audit 3 times a week for 4 weeks then randomly thereafter to ensure all x-ray orders are fulfilled. All variances will be corrected immediately and brought to QAPI. 5.Date of compliance: 6/23/23	

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F 776	Continued From page 7 and clinical record review, the facility staff failed to obtain a physician ordered x-ray for one of four residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to obtain a left arm and hand x-ray that was ordered by the nurse practitioner on 5/16/23. A review of R1's clinical record revealed a note signed by the nurse practitioner on 5/16/23 that documented, "Incident over the weekend where pt (patient) was found on the floor in his room. Seen today for assessment of injury...Musculoskeletal: Generalized weakness, Non-ambulatory, Left arm contractures and Left sided weakness-c/o (complains of) L (left) shoulder/arm pain when attempting to turn on L side...Will order x-ray of L arm to hand-scheduled tylenol in place." A physician's order dated 5/16/23 documented an order for an x-ray of the left shoulder to hand. Further review of R1's clinical record failed to reveal the x-ray was obtained. A review of an order/results list from the mobile x-ray company revealed the order for R1's x-ray on 5/16/23 was never submitted to the mobile x-ray company. On 5/31/23 at 8:24 a.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the nurse practitioner enters orders for x-rays directly into the computer system then the nurses have to go under pending orders in the computer system, confirm the order, schedule the order, and contact the mobile x-ray company online or via phone.	F 776		

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F 776	Continued From page 8 On 5/31/23 at 10:20 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. On 5/31/23 at 11:40 a.m., ASM #2 stated the facility did not have a specific policy regarding x-rays.	F 776		