STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD** **YORKTOWN, VA 23692**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/13/23 through 06/15/23. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/13/23 through 6/15/23 and continued 6/27/23 - 6/29/23. An extended survey was conducted 6/27/23 - 6/29/23. Immediate Jeopardy was identified in the area of Quality of Life at a Scope and Severity Level 4, isolated, Past non-compliance and in the area of Resident Rights at a Scope and Severity Level 4 isolated, Past non-compliance. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five complaints were investigated during the survey with findings as follows: VA00057247=Substantiated with Deficiency. VA00055907=Substantiated with Deficiency. VA00055623=Substantiated with Deficiency. VA00054529=Unsubstantiated. VA00054309=Substantiated with Deficiency. The census in this 80 certified bed facility was 77 at the time of the survey. The survey sample consisted of 44 resident reviews.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15)	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/18/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 1	F 580		

§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 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).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 2 §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 staff interview, record review, and policy review, the facility failed to ensure the physician was notified for a change of condition for one of 44 residents (Resident (R) 129). This failure to notify the physician when R129 was found to have low blood pressure, shallow breathing, and lethargy, resulted in Immediate Jeopardy at level 4 isolated on 06/26/2022. A Plan of Correction was reviewed for Past non-compliance and the Immediate Jeopardy was removed on 07/11/2022. Findings include: Review of R129's printed "Face Sheet" from the electronic medical record (EMR) "Reports" tab showed a facility admission date of 06/24/22 with medical diagnoses that included acute and chronic respiratory failure, chronic obstructive pulmonary disease, type II diabetes, hypertension, pneumonia, abnormal electrocardiogram (EKG), heart failure, long term steroid use, interstitial pulmonary disease, heart disease, atrioventricular block, deep vein embolism and thrombosis, major depressive disorder, and urine retention.	F 580	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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		F 580		

Continued From page 3

Review of R129's EMR "Notes" tab showed that Licensed Practical Nurse (LPN) E documented at 9:33 PM on 06/24/22 the resident arrived at the facility for admission at 5:01 PM with a blood pressure (BP) of 114/84.

Review of R129's EMR "Vital Signs" tab showed the following BP were documented on 06/25/22. At 11:48 AM the BP was recorded at 152/88 and 154/77 at 4:24 PM.

On 06/26/22 at 1:09 AM, LPN G documented "Went to check on [R129] at 12:00 AM, checked his vitals BP was 82/30 breathing was shallow [R129] was lethargic but talking. At 12:45 AM, I checked on [R129] and he had no pulse no respirations. Wife was notified and on call and DON [Director of Nursing] called."

During an interview on 06/15/23 at 2:43 PM regarding the BP of 82/30, the DON expressed an expectation would be "that the nurse would have notified the practitioner. It was her first time working with us so I don't know what her thoughts about the BP was, she might have thought it was fine."

In a telephone interview on 06/15/23 at 3:07 PM, LPN G identified a normal adult blood pressure from "120/70 to about 134/74" and stated 82/30 would not be considered a normal adult blood pressure. When asked what she would do if she had a patient with a BP like that, LPN G responded "If the patient is conscious, have them sit up and elevate their legs, give water, anything like that to elevate the blood pressure, and I'd contact the doctor. If the patient is unconscious, if I was in the nursing home, I would call 911 then call the doctor." After reviewing LPN G's charting,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 4	F 580		

she confirmed she did not contact the doctor.

Review of the facility's policy titled, "Notification of Changes," revised 01/25/17, showed, "Policy: The facility must immediately inform the resident; consult with the resident's physician or other professional (ex. Physician assistant, nurse practitioner, clinical nurse specialist, etc); and if known, notify the residents representative when there is: . . .A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). . . ."

The facility was notified of Immediate Jeopardy on 06/28/2023 @5:07pm. The facility presented the following plan.

1. The nurse involved in Resident #129 care, on 6/26/2022, is no longer employed. Resident #129 expired in the facility on 6/26/2022.

2. The clinical notes for all residents were reviewed for the past 24 hours to ensure the nursing staff had notified the provider of a change in condition. Any variances were immediately corrected.

3. Registered and Licensed Nurses will be re-educated on "Notification of Change", including but not limited to, the importance of notifying the physician of any change in condition to include abnormal blood pressures, breathing or lethargy.

4. The DON/designee review the morning meeting report including clinical notes at least weekly for 8 weeks to ensure any change in condition had appropriate notification of changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 5 Any variances will be corrected immediately, and audit findings will be reported to the Quality Assurance Performance Improvement Committee. 5. Our allegation of compliance is 7/11/22 The survey team reviewed the documentation provided and verified the agency nurse involved with care was no longer working at the facility. The survey team interviewed staff from all three shifts regarding physician notification of change in condition. The survey team reviewed the education provided to the staff, to ensure in included reasons for notification of change in condition such as Respiratory status change in vital signs, blood glucose (hyper or hypoglycemic) altered mental status, and pain. The survey team verified that the monitoring of clinical notes was completed. Immediate Jeopardy was removed on 07/11/2022, past non-compliance.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ____ B. WING ____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 600	Continued From page 6 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to protect the resident's right to be free from physical abuse by staff CNA C and CNA D for one (Resident (R) 42) of two residents reviewed for abuse. CNA C and CNA D caused bruising on R42's lower arms. This is harm. Findings include: Review of R42's "Face Sheet" printed from the electronic medical record (EMR) "Resident Info" tab showed medical diagnoses that included generalized muscle weakness, abnormalities of gait and mobility, and dementia. Review of a facility investigation showed that on 12/04/22 CNA C and CNA D were going to change R42 using a blue brief (incontinent product). R42 requested a pull up style product and relayed she was told "No" and that "she would be changed whether she liked it or not." R42 stated that she tried to fight them by hitting and clawing but the aides held her arms. The bruising to the lower arms was photographed and included in the facility investigation. The facility investigation showed the two certified nurse aides had been suspended during the investigation; terminated at the end of the investigation and	F 600	This plan of correction is respectfully submitted as evidence of alleged compliance. The submission is not an admission that the deficiencies existed or that we agree with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with the participation requirements. 1. A Facility Reported Incident (FRI) was initiated immediately upon reports of a potential violation of resident rights and abuse for Resident 42. Resident 42 was assessed by nursing to ensure no additional injuries, provider notified and saw resident on 12/07/2022 and her plan of care was updated to reflect her preferences related to continence. After investigation, the facility determined the allegation was substantiated and the employees involved were immediately terminated and reported to the Board of Health Professions. 2. The DON/designee will conduct a review of all resident's clinical notes and all resident's incident reports written for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 600	Continued From page 7 reported to the regulatory board. In a interview on 06/14/23 at 2:00 PM, R42's Resident Representative (RR42) stated she had met with the Administrator and the "CNAs involved were terminated and no longer work here. Everything is good." During an interview on 06/14/23 at 9:09 PM regarding the incident described by R42, the Administrator stated, "Yes, it's substantiated the aides held the resident down causing bruises [to the lower arms]." Review of the facility's policy titled, "Resident Abuse Policy and Procedure," revised 10/31/22, showed, "Policy: It is the policy of this facility to ensure the resident will be free from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. The facility will: -Not tolerate the use of verbal, sexual, physical or mental abuse, corporal punishment or involuntary seclusion, neglect, misappropriation of resident property, and exploitation towards the facilities residents by any individual...." Although the facility presented a plan with evidence for Past non-compliance, Past non-compliance could not be considered because the facility failed to fully implement their plan. Cross reference to F943.	F 600	the past seven days. This review will focus on the identification of any potential areas of bruising or discoloration that could be evidence of abuse. Any issues noted will be immediately investigated to ensure the proper procedure for reporting and investigating was initiated. 3. All staff will be educated on Resident Abuse Prevention. The inservice will include a review of the policies, procedures, definitions and strategies for preventing resident abuse. 4. The Administrator / designee will perform three resident interviews weekly for eight weeks to ensure residents are free from abuse. The Administrator /designee will review for patterns or trends and report to the Quality Assessment and Assurance Committee. 5. The allegation of compliance is August 13, 2023	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 658	Continued From page 8 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 observation, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed to provide care and services in accordance with professional standards for 2 residents, Residents #229 and #6, in a survey sample of 44 residents. The findings included: 1. For Resident #229, facility staff failed to administer medications as ordered by the physician on 4/1/22 and 4/5/22. On 6/14/23, Resident #229's clinical record was reviewed and revealed physician orders, schedule times, and actual administration times as follows: *Carbidopa 25mg-levodopa 100mg tablet (1/2 tab) TABLET Oral, Two times daily for Five Days--scheduled for 4/1/22 at 6:00 PM--documented as given at 8:07 PM *Carbidopa 25mg-levodopa 100mg tablet (1/2 tab) TABLET Oral, Three times daily for Five Days--scheduled for 4/5/22 at 6:00 PM--documented as given at 8:47 PM On 6/15/23, an interview was conducted with the Director of Nursing (DON) who confirmed the findings and stated that medications are expected to be given as ordered by the physician. She	F 658	1. Resident #229 has been discharged from the facility, therefore no corrective action can be taken. PICC line dressing for resident #6 was changed on 6/13/23. 2. The Director of Nursing/designee with review all resident's MARs for the past 7 days to ensure the medications are being administered as ordered within scheduled times. The Director of Nursing/designee will inspect all residents with PICC lines to ensure the dressing changes have been completed as ordered. If variances are identified, they will be corrected to ensure medications are being administered on time and PICC dressing changes are being done as ordered. 3. All RN's and LPN's were re-educated on Medication Administration Guidelines and PICC Line Care by the Director of Nursing/designee. The education included a review of ensuring medications are being administered on time and that during PICC care that the PICC site should be inspected to ensure dressing has been changed per policy. 4. The Director of Nursing/designee will review the MAR of 10 residents weekly for eight weeks to ensure medications are being administered on time. The Director of Nursing/designee will inspect 100% of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 658 Continued From page 9

stated that medications can be given within an hour before or an hour after of the scheduled time and verified the previously referenced administration times did not meet her expectation. The DON stated that the facility's professional nursing standards reference was "Lippincott". A facility policy on medication administration was requested and received.

Review of the facility policy entitled, "Medication Administration Guidelines", revised 9/8/2017, heading "Medication Administration" read, "Medications are administered in accordance with written orders of attending physicians, manufacturer's specifications, and professional standards of practice" and "Medications are administered within one hour before or within one hour after the schedules time...".

According to Lippincott "Nursing Procedures", Seventh Edition, 2016, section entitled, "Oral Drug Administration", steps in the implementation of medication administration included but were not limited to: "Verify the medication is being administered at the proper time ...to reduce the risk of medication errors".

On 6/15/23, the Facility Administrator was updated on the findings. No further information was provided.

2. For Resident #6, the facility staff failed to perform a dressing change to a peripherally inserted central catheter (PICC) intravenous access site as ordered by the physician.

On 6/13/23 at approximately 1:30 PM, Resident

F 658

resident□s with PICC lines weekly for eight weeks to ensure the dressing has been changed as ordered. Any patterns or trends and report results to the Quality Assessment and Assurance Committee at least quarterly.

5. Date of compliance is August 13, 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 658	Continued From page 10	F 658		

#6 was interviewed and a double lumen PICC line (peripherally inserted central catheter/line with two access ports) covered with a semipermeable dressing at the insertion site dated "6/5" was observed to her right upper arm. Resident #6 stated "I'm not sure what this thing is for" in reference to the PICC line.

On 6/14/23 at approximately 3:30 PM, a second observation, with the Director of Nursing (DON) present, revealed that the PICC dressing had not been changed and was still dated "6/5". The DON stated, "These dressings are expected to be changed at least once every seven days or as needed if the dressing becomes soiled, this dressing should have been changed on the 12th at minimum".

On 6/14/23, review of Resident #6's clinical record revealed a physician's order dated 5/31/23 which read, "Change Catheter Site Dressing on admission, then q [every] week and PRN [as needed]". The physician's order also read, "PICC Catheters: Measure arm circumference on admission, with each dressing change, & PRN" and "PICC Catheters: Measure external catheter length on admission, with each dressing change & PRN". There was no evidence in the clinical record for any PICC dressing changes and no measurements for arm circumference and external catheter length. These findings were confirmed by the DON. A facility policy was requested and received.

On 6/14/23, review of the facility policy entitled, "6.4 Peripherally Inserted Central Catheter (PICC) Dressing Change", last revised on 8/15/08, subtitle, "Considerations", item 1, read, "The catheter insertion site is a potential entry site

(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 658	Continued From page 11 for bacteria that may cause a catheter-related infection". Subtitle "Guidance", item 1, read, "Dressing changes using transparent dressings are performed: 24 hours post-insertion or upon admission, at least weekly, and if the integrity of the dressing has been compromised". Item 7 read, "Length of external catheter and upper arm circumference (3 inches or 10 centimeters above insertion site) is obtained: Upon admission, during dressing changes, and if signs or symptoms of complications are present". On 6/14/23, the DON stated that "Lippincott's" was the basis for nursing standards utilized within the facility. According to The Lippincott Manual of Nursing Practice, 11th edition, Nursing Role in Intravenous Therapy, Catheter-Associated Bloodstream Infections, Preventative Measures, item 9b read, "Transparent semipermeable dressing should be changed every 7 days". According to the Centers for Disease Control and Prevention (CDC) publication entitled "Checklist for Prevention of Central Line Associated Blood Stream Infections", based on 2011 CDC guidelines for prevention of intravascular catheter-associated bloodstream infections: https://www.cdc.gov/infectioncontrol/guidelines/bsi/index.html, "For Clinicians: Handle and maintain central lines appropriately....Immediately replace dressings that are wet, soiled, or dislodged, perform routine dressing changes using aseptic technique with clean or sterile gloves, change gauze dressings at least every two days or semipermeable dressings at least every seven days". On 6/14/23, the Facility Administrator was updated on the findings. No further information was provided.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the care and assistance for personal grooming for one of 44 residents (Resident (R) 35). Findings include: Observation of R35 on 06/14/23 at 9:06 AM showed the female resident had minimum half inch long facial hair on the lower right cheek and chin. In an interview on 06/14/23 at 12:54 PM, R35's family member stated, "As of March 1 she was put on hospice and a CNA [certified nurse aide] was assigned she did things like that [shaving]. The CNA had shoulder surgery and the facility has not done it [shaved R35]." In an interview and observation on 06/14/23 at 4:45 PM, CNA B confirmed R35 had facial hair and stated "She can switch on you and may or may not let you shave her. She's hospice also and they also help out." At 4:50 PM on 06/14/23, the Director of Nursing [DON] entered R35's room, observed R35 and asked her if she wanted the facial hair shaved off. R35 responded "Yes." The DON exited the room and confirmed that R35 needed to be shaved.	F 677	1. Resident #35 was provided personal grooming to include removal of facial hair on 6/14/2023. 2. The DON/designee observed all current residents who were extensive or total assist with personal hygiene to ensure the residents had appropriate personnel grooming. Any variances were immediately corrected. 3. All direct care staff were educated on Providing ADL Care for Dependent Residents which included ensuing necessary services are provided to maintain appropriate personnel grooming. 4. The DON/Designee will observe 5 residents who were extensive or total assist with personal hygiene to ensure they have appropriate grooming weekly for eight weeks. Patterns or trends will be reported to the Quality Assessment and Assurance Committee. 5. Date of compliance is August 13, 2023.	8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 677	Continued From page 13 Review of the facility policies titled, "Bath (Bed)," "Bath (Partial)," and "Activities of Daily Living (ADL) (Daily Life Functions)" did not address the dignity of shaving unwanted facial hair for residents.	F 677		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure a resident's end of life wishes were clarified and consistent in the medical record for one of 44 residents (Resident (R) 129). The facility staff did not initiate CPR or call Emergency Medical Services (EMS) when R129 was found without a pulse or respirations. This resulted in Immediate Jeopardy at level 4 isolated on 06/26/2022. A Plan of Correction was reviewed for Past non-compliance and the Immediate Jeopardy was removed on 09/30/2022. Findings include: Review of R129's printed "Face Sheet" from the electronic medical record (EMR) "Reports" tab showed a facility admission date of 06/24/22 with medical diagnoses that included acute and chronic respiratory failure, chronic obstructive pulmonary disease, type II diabetes, hypertension, pneumonia, abnormal	F 678	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 678	Continued From page 14	F 678		

electrocardiogram (EKG), heart failure, long term steroid use, interstitial pulmonary disease, heart disease, atrioventricular block, deep vein embolism and thrombosis.

A review of R129's hospital discharge information (paper file) printed on 06/24/22 on page 26 of 87 stated "Code Status: Full Code."

A review of R129's "Resident Info" tab showed a "POST [Physician Orders for Scope of Treatment]" form the resident signed for a full code status to sustain life signed by R129, a Nurse Practitioner, and a facility witness in March of 2021.

Review of R129's "Notes" tab showed on 06/24/22 at 9:25 PM the admitting nurse charted, "arrived to facility around 501pm. pt A&Ox3 [alert and oriented to person, place, and time].

Review of R129's EMR "Orders" tab showed Nurse Practitioner (NP), Employee G, gave an order for a DNR status on 06/24/22.

In response to a request for where the documentation was located that R129 changed his code status, on 06/15/23 at 10:05 AM, the Director of Nursing (DON) stated, "I can't find anything else." When clarified if she meant regarding the NP (Employee G) writing the DNR order, the DON responded "Yes."

During a telephone interview on 06/15/23 at 11:11 AM, NP Employee G stated she was reviewing her note in "GeriMed" (the EMR used) and noted she did not have access to the hospital or facility EMR. Employee G continued that "When the nurse calls after hours to verify orders, when they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 678	Continued From page 15 are reading a code status, if they give me a DNR status I expect that they have the documentation in front of them that states that." When asked what she reviewed, Employee G stated, "The orders via telephone. The nurse would read me the medication orders, wound care orders, and diet. My triage note showed the nurse called at 1701 [she clarified 5:01 PM]." Employee G clarified she was not at the facility and did not see or talk to the resident or family. In a telephone interview on 06/15/23 at 12:03 PM, the admitting Licensed Practical Nurse (LPN) E was asked the process for admission orders and verifying code status, LPN E responded, "We now go off the paperwork and ask the resident and put in our notes that the patient confirmed the code status. If [the resident is] not cognitive we talk to the resident representative and chart that." LPN E was queried if he remembered speaking with R129 about his code status, he stated, "No, not really. It [discussion] should be in my note if I did." LPN E's documented notes for 06/24/22 and 06/25/22 were read from the EMR, and LPN E responded "No, it's not in there. I probably asked and didn't put it in my notes. I probably asked him and confirmed it with family, that's the way I usually work it." On 06/26/22 at 1:09 AM, LPN G documented "Went to check on [R129] at 12:00 AM, checked his vitals BP was 82/30 breathing was shallow [R129] was lethargic but talking. At 12:45AM, I checked on [R129] and he had no pulse no respirations. Wife was notified and on call and DON [Director of Nursing] called." The note did not say if CPR was initiated or EMS was called. Review of the facility's policy titled, "Advance	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 678	Continued From page 16 Directive" revised 04/28/21, indicated, "Advance Directive will be discussed with the resident and/or family member upon admission as soon as clinically appropriate so the resident wishes, with respect to life prolonging treatments can be documented in the medical record.... The facility staff should attempt to obtain Advance Directives information from the resident, family, and/or hospital staff during the admission process. If advance directive information is provided, then this information will be placed in the resident medical record ..." The facility was notified of Immediate Jeopardy on 06/28/2023 @5:07pm. The facility presented the following plan. 1. Resident expired on 6/26/22 therefore no corrective action can be taken with resident at this time. The provider and resident representative were made aware of resident's condition at the time of discharge. 2. The Director of Nursing / designee will review the medical records of all current residents to ensure accuracy of transcription of advance directive orders. Any variances noted will be addressed and provider / resident representative will be notified. 3. The Director of Nursing / designee will educate RN's and LPN's on comparing the code status from the "Discharge Summary" that is sent prior to admission with the discharge paperwork that accompanies the resident upon admission. Education will include but is not limited to the importance of proper transcription of code status orders and the nursing admission process which includes accurate code status.	F 678		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 678	Continued From page 17 4. The Director of Nursing / designee will review 100 % of newly admitted residents' medical records weekly for the next three months to ensure code status orders have been accurately transcribed and verified with resident / resident representative. The Director of Nursing / designee will identify any patterns or trends and report to the Quality Assurance and Performance Improvement committee at least quarterly. 5. The date of our allegation of compliance for this plan of correction is 9/30/22. The survey team reviewed all the medical records of the residents to ensure accuracy of transcription of Advanced Directives. The survey team reviewed the documentation that the facility provided on any discrepancies they found and corrected. The survey team reviewed the education provided and interviewed staff about the education provided. The survey team reviewed the weekly monitoring for accuracy and completion. Immediate Jeopardy was removed on 09/30/2022, past non-compliance.	F 678		
F 700 SS=E	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	F 700		8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 700

Continued From page 18

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 observation, interview, and record review, the facility failed to ensure that four of four residents (Resident (R) 19, R35, R54, and R65) reviewed for bed rail use, had documented alternatives to the use of bed rails before the rails were used.

Findings include:

1. Review of R19's quarterly "Minimum Data Set (MDS)" assessment reference date (ARD) of 05/18/23 showed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, or indicative of being cognitively intact.

During an interview on 06/13/23 at 1:51 PM, it was noted that R19 had bilateral upper side rails on her bed.

F 700

1. Residents #19, #35, #54 and #65 have been assessed for appropriate alternatives prior to bedrail usage. Documentation of alternatives attempted are located in resident records.

2. All current residents were reviewed to ensure appropriate alternatives were attempted prior to bedrail usage. The DON/designee will ensure the medical record reflects alternatives that were attempted prior to bedrail usage.

3. The Bedrail and Entrapment Risk form was updated to include alternatives attempted prior to bedrail usage and resident's response to alternatives. All

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 700

Continued From page 19

Review of "Bed Rail Entrapment Risk Evaluation" forms, dated 02/15/23 and 05/23/23, found no documentation regarding what alternatives were attempted prior to the use of bed rails.

A review of the facility admission packet showed the "Bed Rail Consent" was included as a blank form to be completed with the other admission forms.

In an interview on 06/15/23 at 12:50 PM the Admission/Resident Navigator, Employee J, stated, "The form is in the admission packet and is signed and then nursing staff is to go in to evaluate for function and mobility." When asked to clarify if everybody signs the "Bed Rail Consent" form, Employee J stated, "Yes."

2. Review of R35's quarterly "MDS" with an ARD of 06/02/23 showed a " BIMS" score of 06 out of a possible 15, indicative of severe cognitive impairment.

During an interview on 06/14/23 at 12:59 PM bilateral upper rails were noted on R35's bed.

Review of "Bed Rail Entrapment Risk Evaluation" forms, dated 06/06/23, found no documentation regarding what alternatives were attempted prior to the use of bed rails.

3. Review of R54's five-day readmission "MDS" with an ARD of 06/05/23 showed a "BIMS" score of 14 out of 15, or indicative of being cognitively intact.

F 700

RN's, LPN's and CNA's were educated on bedrail usage and the importance of attempting alternatives prior to bed rail usage. The inservice will include a review of the Bedrail Policy and the revised Bedrail and Entrapment Risk form as well as education on alternatives to bedrails.

4. The DON/designee will review ten resident records weekly for eight weeks to include newly admitted residents ensure alternatives to bedrails are attempted and documented prior to bed rail use. Patterns and/or trends will be reported to the Quality Assessment and Assurance Committee.

5. The date of compliance is August 13, 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 700	Continued From page 20	F 700		

During an interview on 06/13/23 at 1:58 PM it was noted that R54 had bilateral upper bed rails.

A review of the "Bed Rail / Entrapment Risk Evaluation," dated 02/08/23, showed no bed rails were recommended and no alternatives attempted.

4. Review of R65's "Face Sheet" from the EMR "Resident Info" tab showed medical diagnoses that included hemiplegia affecting the dominant side and altered mental status.

Review of R65's quarterly "MDS" with an ARD of 04/06/23 showed a "BIMS" score of 04 out of 15, or indicative of severe cognitive impairment.

A review of the "Bed Rail / Entrapment Risk Evaluation," dated 04/04/23, showed no documented attempted alternatives.

During an interview on 06/05/23 at 1:05 PM regarding bed rail assessments, Registered Nurse (RN) B stated, "We usually see how they move in the bed and use the rails for mobility." When asked if mobility is attempted without the rails, RN B responded "For some, but residents prefer the rails." Responding to the query if alternates to bed rails were attempted were documented, RN B stated, "No, not that I am aware of."

Review of the facility's policy titled, "Bed Rail Policy," revised 02/18/18, indicated, "Policy: Residents are assessed for appropriate alternatives prior to installing a bed rail. If a bedrail is indicated, the facility will take measures to develop and implement a strategy to minimize

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 700	Continued From page 21 the possibility of resident entrapment while using side rails-.This will include assessment of residents who have a need for or desire to use side rails and that may have characteristics that place them at special risk for entrapment. The assessment will also include inspection of the bed, mattress and side rail for risk of entrapment. . . ."	F 700		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 761

Continued From page 22

Based on observation, staff interview, and facility documentation review, the facility staff failed to store controlled medications appropriately in 1 of 3 medication carts within the facility.

The findings included:

The facility staff failed to secure controlled medications in a separately locked, permanently affixed compartment.

On 6/13/23 at 2PM, the pharmacy delivery arrived. LPN C was observed to receive and sign for controlled medications from the delivery person. While Surveyor C was conducting medication administration observations with LPN B, LPN C approached with several packets of controlled medications and said she would secure them in her (LPN C's medication cart) until LPN B was able to receive them and log them.

On 6/13/23 at 2:40 PM, LPN C was asked about the controlled medications. LPN C said she still had them secured in her medication cart. Surveyor C asked to see them. LPN C opened one of her drawers on the medication cart and received 4 cards of controlled medications. When asked why they were not secured under double lock, she said she was just holding them until LPN B could obtain them. The medications included:
a. Oxycodone 5 mg, 30 tablets for Resident #181.
b. Hydrocodone/apap tab 5/325 mg, 30 tablets for Resident #10.
c. Clonazepam tablet 0.5 mg, 30 tablets for Resident #10.
d. Tramadol HCL 50 mg tablets, 30 tablets for Resident #23.

F 761

1. LPN C was provided education on how to properly store schedule II-V controlled medications in the medication cart. LPN C is no longer employed.

2. The DON/designee surveyed each medication cart to ensure the Schedule II-V Controlled substances were stored in separately locked, permanently affixed compartment. Any variances identified were immediately corrected and education provided.

3. All RN's and LPN's were educated on the General Storage Procedures for Controlled Substances. This included the securing of Schedule II-V Controlled substances in separately locked, permanently affixed compartments.

4. The DON/Designee will observe 4 medication carts weekly to ensure all the Schedule II-IV Controlled Substances are secured in separately locked, permanently affixed compartments in the medication cart. Patterns or trends will be reported to the Quality Assessment and Assurance Committee.

5. Date of compliance is August 13, 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 761	Continued From page 23 On 06/15/23 at 08:44 AM, an interview was conducted with LPN B. LPN B was asked about the storage of controlled medications, and she stated that they should be stored separate from other medications. LPN B went on to say that controlled medications are kept under "two locks" because "people could misuse them". On 06/15/23 at 08:48 AM, an interview was conducted with RN B. RN B was asked about the storage of controlled medications. She said, "They are double locked for extra protection because they are scheduled medications". The facility policy titled; "Medication Administration Guidelines" was reviewed. This policy read, "... Controlled Substances: Controlled substances are secured under double locks and counted at the end of each shift with the incoming and outgoing nurse...". The facility staff provided the facility policy titled, "Storage and Expiration Dating of Medications, Biologicals, Syringes, and Needles". This policy was reviewed and an excerpt from it read, "...General Storage Procedures: Facility should store Schedule II-V Controlled Substances and other medications deemed by facility to be at risk for abuse or diversion in a separate compartment within the locked medication carts and should have a different key or access device...". During the end of day meeting held on 6/13/23, the facility Administrator and Director of Nursing were made aware of the above findings. No further information was received.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 812

Continued From page 24

CFR(s): 483.60(i)(1)(2)

§483.60(i) Food safety requirements.
The facility must -

§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility documentation review, the facility staff failed to store, prepare, and distribute food in accordance with professional standards for food service safety in the main kitchen, which had the potential to affect Residents on 2 of 2 nursing units.

The findings included:

1. The facility staff failed to wear proper hair restraints when in food preparation areas.

On 6/13/23 at 11:30 AM, during an inspection of the kitchen, Surveyor C observed the Assistant Administrator/Employee F enter the kitchen and walk halfway into the kitchen which was around

F 812

1. All dining staff were educated regarding wet nesting and the procedure for air-drying dishware. Any dishware found to be affected was washed and sanitized. All dining staff were provided the appropriate hair and beard cover and received education regarding the policy requiring wearing hair and beard covers at all times in the kitchen.

2. All residents have the potential to be affected by this deficient practice.

3. A drying rack was purchased for the dining department to ensure all dishware will have adequate space to air dry before

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 812	Continued From page 25	F 812		

the steam table area. The Dietary Manager/Employee D noticed that the Assistant Administrator did not have any type of hair restraint (hair net or hat) on and immediately asked him to exit the kitchen. Employee F did leave the kitchen and did not re-enter.

On 6/13/23 at approximately 11:45 AM, while conducting an inspection of the kitchen Employee E, who was a dietary aide, was observed working the tray line, assisting with meal trays for the lunch meal. Employee E did not have a beard guard on and did have facial hair. The Dietary Manager, who was accompanying Surveyor C was asked what is required for hair restraints and she said, "He had one on earlier" and proceeded to obtain a beard guard and assisted Employee E with putting it on.

2. Facility staff failed to air dry dishes in a manner to prevent wet nesting and the growth of bacteria.

On 6/14/23 at 10:00 AM, Employee E, a dietary aide was observed in the dish room/dishwasher area. Employee E removed plates from the dishwasher, stacked them and took them to a cart where they were stacked while wet.

On 6/14/23 at approximately 10:10 AM, Surveyor C interviewed the dietary manager. She was asked how dishes are dried? The dietary manager said, everything is to be "air dried, we don't want wet nesting, it can harbor bacteria".

The dietary manager and Surveyor C then went to stack of plates and plate covers and confirmed they had water on the surface and were stacked wet, which is wet nesting and not permissible.

storage. All dining staff in-serviced regarding the procedure for air- drying all dishware to prevent wet nesting. All dining staff in-serviced regarding the policy for wearing hair and beard covers in the kitchen. Hair nets and beard covers are available to all staff on the outside of each door to the kitchen in the service hall.

4. Dining manager/designee will audit 10 random dish storage areas weekly for eight weeks to ensure all staff are following procedure regarding proper air-drying dishware. Dining manager/designee will audit 10 employees weekly for eight weeks to ensure all staff are following policy for hair and beard coverings. Patterns or trends will be reported to the Quality Assessment and Assurance Committee.

5. Date of compliance will be August 13, 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 812	Continued From page 26 Review of the facility policy titled, "Dining Service, Food Service and Meal Distribution" was reviewed. The policy didn't address how dishes are to be dried to prevent wet nesting. The U.S. Public Health Service, 2017 Food Code, published by the U.S. Department of Health and Human Services, Public Health Service, Food and Drug Administration" was reviewed. An excerpt from this document on page 151 read, "... After cleaning and sanitizing, equipment, and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940...". On 6/15/23, around 11:30 AM, the facility Administrator was made aware of the above findings. No additional information was provided.	F 812		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative	F 883		8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 883	Continued From page 27 has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F 883		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 883	Continued From page 28	F 883		

This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide an influenza vaccine for 1 resident, Resident #69, out of 5 residents reviewed for influenza immunization.

The findings included:

The facility staff failed to provide influenza immunization for Resident #69.

On 6/14/23 at approximately 10:30 AM, a clinical record review was performed and revealed Resident #69, who was admitted to the facility on 1/27/23, had no documentation with regard to influenza immunization, to include the resident's current influenza vaccination status, offer to provide immunization against influenza infection, or documentation of resident refusal or medical contraindication.

On 6/14/23 at approximately 2:30 PM, an interview was conducted with the Director of Nursing (DON) who accessed the clinical record for Resident #69 and verified the findings. The DON confirmed there was no additional information. A facility policy was requested and received.

On 6/15/23 at approximately 3:00 PM, a review of the facility policy entitled, "Infection Control, Influenza Vaccine" was conducted. It stated under the subtitle, "Policy", "...All residents should receive the influenza immunization unless medically contraindicated or refused".

On 6/15/23 at approximately 4:00 PM, the Facility

Provider's plan of correction:

1. Seasonal influenza vaccination is not recommended outside of flu season, ending on March 31, 2023, therefore no corrective action can be taken.

2. All current resident□s influenza records were reviewed to ensure the immunization record available in the medical record was accurate.

3. The Director of Clinical Support/Designee will educate all RN's and LPN's on the Infection Control, Influenza Vaccine policy and the importance of offering and documenting the acceptance and/or declination of the influenza vaccine.

4. Director of Clinical Support/designee will review the records all new admission weekly for 8 weeks for evidence of medical contraindication, refusal or administration of the influenza vaccine. Patterns and trends will be reported to the Quality Assurance and Assessment committee.

5. Date of compliance will be August 13, 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 883	Continued From page 29 Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum,	F 887		8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 887	Continued From page 30 the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff record review, staff interview and facility documentation review, the facility staff failed to offer and/or provide up to date COVID-19 immunization for 1 resident, Resident #69, in a survey sample of 5 residents reviewed for COVID-19 vaccination. The findings include: The facility staff failed to offer and/or provide a COVID-19 bivalent booster vaccine for Residents #69. On 6/14/23 at approximately 10:30 AM, a clinical record review was performed and revealed	F 887	1. Resident #69/Resident Representative was educated on the risks and benefits of the COVID-19 vaccine. Resident/Resident Representative was offered the COVID-19 bivalent booster which was declined. 2. All Current residents COVID-19 vaccine status will be reviewed and any eligible residents will be educated and offered to become "Up to Date". 3. The Director of Clinical Support/Designee will educate all RN's and LPN's on the importance of offering	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD** **YORKTOWN, VA 23692**

(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 887

Continued From page 31

Resident #69 completed a primary COVID-19 vaccine series on 9/27/21, however there was no evidence that Resident #69 had been offered or received a COVID-19 bivalent booster dose.

On 6/14/23 at approximately 4:15 PM, an interview was conducted with the Director of Nursing (DON) who confirmed the facility policies and procedures follow CDC (Centers for Disease Control and Prevention) guidance and recommendations for resident COVID-19 immunization.

The DON stated there were no concerns with the facility's ability to provide COVID-19 immunizations to residents. The DON stated that it is expected for all residents to be provided the opportunity to be up to date with COVID-19 immunizations, including the bivalent COVID-19 booster.

The DON accessed the clinical records for Resident #69 and verified the findings. The facility's COVID-19 vaccination policy for residents was requested and received.

On 6/15/23 at approximately 11:00 AM, a review of the facility's policy titled, "COVID-19 Vaccine" was conducted. It stated under the subheading "Purpose", "Maximizing COVID-19 vaccination rates in the facility will help reduce the risk residents and staff have of contracting and spreading COVID-19" and subheading "Offering the COVID-19 Vaccine" read, "COVID-19 vaccinations will be offered to all staff and residents...per CDC [Centers for Disease Control and Prevention] and/or FDA [Food and Drug Administration] guidelines...".

F 887

the COVID-19 vaccine in a timely manner-including but not limited to the current meaning of being "Up to Date", providing risk/benefit education, and how to obtain the vaccine.

4. Director of Nursing/Designee will review all admissions weekly for 8 weeks for evidence of being offered the recommended doses of the COVID-19 vaccine per CDC guidelines. Patterns or trends will be reported to the Quality Assessment and Assurance Committee.

5. Date of compliance will be August 13, 2023.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 887	Continued From page 32	F 887		

The CDC (Centers for Disease Control and Prevention) document titled, "Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Approved or Authorized in the United States", updated March 16, 2023, page 3, "Recommendations for COVID-19 vaccine use", subtitle, "Booster vaccination", read, "People ages 6 months and older are recommended to receive 1 bivalent mRNA booster dose after completion of any FDA-approved or FDA-authorized primary series or previously received monovalent booster dose(s)".

The CDC (Centers for Disease Control and Prevention) document titled, "Stay Up to Date with COVID-19 Vaccines Including Boosters", updated March 2, 2023, page 2, "COVID-19 Boosters", subtitle, "Updated Boosters", read, "The updated boosters are called 'updated' because they protect against both the original virus that causes COVID-19 and the Omicron variant BA.4 and BA.5...Updated COVID-19 boosters became available on: September 2, 2022, for people aged 12 years and older...You are up to date with your COVID-19 vaccines when you have completed a COVID-19 vaccine primary series and got the most recent booster dose".

The CDC (Centers for Disease Control and Prevention) document titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated September 23, 2022, page 2, item 1, read, "1. Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic...Encourage everyone to remain up to date with all recommended COVID-19 vaccine

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 887	Continued From page 33 doses...HCP [Healthcare Personnel], patients, and visitors should be offered resources and counseled about the importance of receiving the COVID-19 vaccine". On 6/15/23 at approximately 3:00 PM, the Facility Administrator and Director of Nursing were made aware of the findings. No further information was provided.	F 887		
F 942 SS=D	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure employees received Resident Rights training and education for 1 employee, (Employee #28), in a sample of 5 employees reviewed for training. The findings included: For Employee #28, the facility staff failed to provide any evidence of Resident Rights training. On 6/14/23, the facility Administrator was asked to provide in-service training for 5 employees. On the afternoon of 6/14/23, the facility administrator submitted training records for 4 of the 5 employees being sampled. The	F 942	1. Employee #28 completed training on Resident Rights on 07/11/2023. 2. The education records of all current employees were reviewed to ensure each team member had received Resident Rights education in the last 12 months. Any variances identified were immediately corrected and the education provided. 3. The facility's policy related to training and education was revised to include Resident Rights. The Director of Education in-serviced the facility management team on the changes to the Administration Policy and the importance of ensuring that staff members are educated on the rights of the residents	8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 942	Continued From page 34 Administrator stated they were still looking for Employee #28's records. On the morning of 6/15/23, the facility Administrator acknowledged they were still trying to pull together Employee #28's training records. On 6/15/23 at 12:15 PM, the facility administrator was asked to provide the facility policy with regards to annual training needs of staff. The Administrator let the survey team know they do not have a policy with regards to annual in-service/training of facility staff. The facility administration submitted no further documentation prior to the conclusion of the survey.	F 942	annually. 4. Director of Nursing/designee will review the Education and Training Records for 10 employees weekly for eight weeks to ensure they received training on Resident Rights. Patterns or trends will be reported to the Quality Assessment and Assurance Committee. 5. Date of compliance will be August 13, 2023.	
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by:	F 943		8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 943	Continued From page 35 Based on staff interview and facility documentation review, the facility staff failed to ensure employees received training on abuse, neglect and exploitation for 1 employee, (Employee #28), in a sample of 5 employees reviewed for training. The findings included: For Employee #28 who had been an employee for greater than 2 years, the facility staff failed to provide any evidence of training on abuse, neglect and exploitation. On 6/14/23, the facility Administrator was asked to provide in-service training for 5 employees. On the afternoon of 6/14/23, the facility administrator submitted training records for 4 of the 5 employees being sampled. The Administrator stated they were still looking for Employee #28's records. On the morning of 6/15/23, the facility Administrator acknowledged they were still trying to pull together Employee #28's training records. On 6/15/23 at 12:15 PM, the facility administrator was asked to provide the facility policy with regards to annual training needs of staff. The Administrator let the survey team know they do not have a policy with regards to annual in-service/training of facility staff. The facility administration submitted no further documentation prior to the conclusion of the survey.	F 943	1. Employee #28 completed training on Resident Abuse, Neglect and Exploitation on 07/11/2023. 2. The education records of all current employees were reviewed to ensure each team member had received Resident Abuse, Neglect and Exploitation education in the last 12 months. Any variances identified were immediately corrected and the education provided. 3. The Director of Education in-serviced the facility management team on the Administration Policy and the importance of ensuring that staff members are educated on Resident Abuse, Neglect and Exploitation annually. 4. Director of Nursing/designee will review the Education and Training Records for 10 employees weekly for eight weeks to ensure they received training on Resident Abuse, Neglect and Exploitation. Patterns or trends will be reported to the Quality Assessment and Assurance Committee. 5. Date of compliance will be August 13, 2023.	
F 945 SS=D	Infection Control Training	F 945		8/13/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	113 BATTLE ROAD YORKTOWN, VA 23692

(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 945	Continued From page 36 CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure employees received training on infection prevention and control for 1 employee, (Employee #28), in a sample of 5 employees reviewed for training. The findings included: For Employee #28, the facility staff failed to provide any evidence of infection prevention and control training. On 6/14/23, the facility Administrator was asked to provide in-service training for 5 employees. On the afternoon of 6/14/23, the facility administrator submitted training records for 4 of the 5 employees being sampled. The Administrator stated they were still looking for Employee #28's records. On the morning of 6/15/23, the facility Administrator acknowledged they were still trying to pull together Employee #28's training records. On 6/15/23 at 12:15 PM, the facility administrator was asked to provide the facility policy with regards to annual training needs of staff. The	F 945	1. Employee #28 completed training on Infection Prevention and Control on 07/11/2023. 2. The education records of all current employees were reviewed to ensure each team member had received Infection Prevention and Control education in the last 12 months. Any variances identified were immediately corrected and the education provided. 3. The Director of Education in-serviced the facility management team on the Administration Policy and the importance of ensuring that staff members are educated on Infection Prevention and Control annually. 4. Director of Nursing/designee will review the Education and Training Records for 10 employees weekly for eight weeks to ensure they received training on Infection Prevention and Control. Patterns or trends will be reported to the Quality Assessment and Assurance Committee. 5. Date of compliance will be August 13,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495342	A. BUILDING ______ B. WING ______	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
YORK NURSING & REHABILITATION CENTER	**113 BATTLE ROAD YORKTOWN, VA 23692**

(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 945	Continued From page 37 Administrator let the survey team know they do not have a policy with regards to annual in-service/training of facility staff. The facility administration submitted no further documentation prior to the conclusion of the survey.	F 945	2023.	