STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495358	A. BUILDING _____ B. WING _____	C 07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMELIA REHABILITATION AND HEALTHCARE CENTER	8830 VIRGINIA STREET AMELIA, VA 23002

(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 7/11/23 through 7/12/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during the survey (VA00059138 - substantiated, no deficiencies; VA00059182 - unsubstantiated; VA00059103 - substantiated, no deficiencies). The census in this 100 certified bed facility was 92 at the time of the survey. The survey sample consisted of two current resident reviews and three closed record reviews.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include	F 607		8/1/23

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

Electronically Signed | 07/26/2023

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

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F 607	Continued From page 1 but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to implement policies for the reporting of abuse for one of five residents in the survey sample; Resident #3. The findings include: Resident #3 made an allegation of abuse on 6/12/23. The nurse documented it in a nurse's note but did not follow facility policies to report the allegation of abuse to administrative staff. Therefore, the facility also did not report the allegation to the required State Agency as of the survey on 7/12/23. The facility policy, "Abuse Prevention Program" documented, "3. Develop and Implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents....7. Investigate and report any allegations of abuse within timeframes as required by federal requirements." The facility policy, "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" documented, "All reports of resident abuse (including injuries of unknown origin), neglect,	F 607	F-607 It is the intended practice of the facility to develop/implement Abuse/Neglect Policies. 1. Upon notification from surveyor on 7/12/2023 regarding documentation of an allegation in Resident #3 medical record, the IDT discussed and implemented a process change to review risk management collectively to ensure no further misses and to ensure allegations are reported timely. The allegation in Resident #3 chart is a prior occurrence and state is aware of it as of 7/12/2023. 2. Residents who reside in the facility have the potential to be affected. 3. DON and/or designee will educate facility staff on implementing policy & procedures related to incident reports, allegations, abuse, etc. 4. DON and/or designee will audit clinical morning meeting to ensure documentation that may be an allegation is handled appropriately 3 days a week x4 weeks and then monthly x2 months. The results of the random audits will be	

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F 607	Continued From page 2 exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported....1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown sources is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law...." A review of the admission MDS (Minimum Data Set) dated 4/16/23 coded Resident #3 as being severely cognitively impaired, scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. A review of the clinical record revealed a nurse's note dated 6/12/23 that documented, "...At 1800 (6:00 PM), while resident was in the dayroom, staff observed bruising and mild swelling of left eye. Resident stated that she was "hit earlier." Denies pain/discomfort. Call placed to DON (Director of Nursing) and notified. Call placed to (name of), NP (nurse practitioner) and updated. New order to activate standing Tylenol (1) order and Ice PRN (as needed) for discomfort and swelling..." The State Agency had not received a report of this allegation as of the survey date of 7/12/23. On 7/11/23 at 3:21 PM, an interview was conducted with ASM #2 (Administrative Staff Member) the DON. She stated that she never got this allegation of abuse and that this conversation was the first time she heard of this. She stated that she was called about the eye appearing	F 607	reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be August 1st, 2023.	

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F 607	Continued From page 3 bruised and swollen by the nurse that wrote the above note (LPN #1 - Licensed Practical Nurse), and she called another nurse (LPN #2) and requested that LPN #2 go and assess the resident to see what was going on with the eye. She stated that LPN #2 reported to her that LPN #2 did not see anything going on with the eye and that the resident was asked if anyone had hit her in the eye and the resident stated that no one had hit her. ASM #2 then stated that upon her arrival to the facility she also assessed the resident's eye and did not see anything going on with it and she also asked the resident if anyone had hit her and the resident did not respond to her. When asked if she had previously read the above nurse's note in the clinical record, she stated that she had not. No further information was provided by the end of the survey. References: (1) Tylenol is used for mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		8/1/23

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F 609	Continued From page 4 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to report an allegation of abuse to the facility management, and to the required State Agency, for one of five residents in the survey sample; Resident #3. The findings include: Resident #3 made an allegation of abuse on 6/12/23. The nurse documented it in a nurse's note but did not report the allegation of abuse to administrative staff, therefore, the facility also did not report the allegation to the required State Agency. A review of the admission MDS (Minimum Data Set) dated 4/16/23 coded Resident #3 as being	F 609	F-609 It is the intended practice of the facility to report allegations of abuse to facility management and to the required State Agency. 1. Upon notification from surveyor on 7/12/2023 regarding documentation of an allegation in Resident #3 medical record, the IDT discussed and implemented a process change to review clinical morning meeting collectively to ensure no further misses and to ensure allegations are reported timely. The allegation in Resident #3 chart is a prior occurrence and state is aware of it as of 7/12/23. 2. Residents who reside in the facility	

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F 609	Continued From page 5 severely cognitively impaired, scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. A review of the clinical record revealed a nurse's note dated 6/12/23 that documented, "...At 1800 (6:00 PM), while resident was in the dayroom, staff observed bruising and mild swelling of left eye. Resident stated that she was "hit earlier." Denies pain/discomfort. Call placed to DON (Director of Nursing) and notified. Call placed to (name of), NP (nurse practitioner) and updated. New order to activate standing Tylenol order and Ice PRN (as needed) for discomfort and swelling..." The State Agency had not received a report of this allegation as of the survey date of 7/12/23. On 7/11/23 at 3:21 PM, an interview was conducted with ASM #2 (Administrative Staff Member) the DON. She stated that she never got this allegation of abuse and that this conversation was the first time she heard of this. She stated that she was called about the eye appearing bruised and swollen by the nurse that wrote the above note (LPN #1 - Licensed Practical Nurse), and she called another nurse (LPN #2) and requested that LPN #2 go and assess the resident to see what was going on with the eye. She stated that LPN #2 reported to her that LPN #2 did not see anything going on with the eye and that the resident was asked if anyone had hit her in the eye and the resident stated that no one had hit her. ASM #2 then stated that upon her arrival to the facility she also assessed the resident's eye and did not see anything going on with it and she also asked the resident if anyone had hit her and the resident did not respond to her. When	F 609	have the potential to be affected. 3. DON and/or designee will educate facility staff on reporting allegations of abuse to facility management and to the required State Agency. 4. DON and/or designee will audit the clinical morning meeting to ensure documentation that may be an allegation is handled appropriately 3 days a week x4 weeks and then monthly x2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be August 1st, 2023.	

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F 609	Continued From page 6 asked if she ever read the above nurse's note in the clinical record, she stated that she had not. The facility policy, "Abuse Prevention Program" documented, "3. Develop and Implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents....7. Investigate and report any allegations of abuse within timeframes as required by federal requirements." The facility policy, "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" documented, "All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported....1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown sources is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law...." No further information was provided by the end of the survey.	F 609		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		8/1/23

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F 842	Continued From page 7	F 842		

agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained

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F 842	Continued From page 8 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for one of five residents in the survey sample; Resident #3. The findings include: For Resident #3, facility staff failed to document a resident assessment on 6/12/23. A review of the admission MDS (Minimum Data Set) dated 4/16/23 coded Resident #3 as being severely cognitively impaired, scoring a 4 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. A review of the clinical record revealed a nurse's	F 842	F-842 It is the intended practice of the facility to maintain a complete and accurate medical record. 1. Upon notification from surveyor on 7/11/2023 regarding LPN #2 not documenting the assessment and resident statement in resident #3 chart, LPN #2 was educated on complete and accurate documentation and LPN #2 wrote a statement that reflects the assessment of resident #3 from 6/12/2023. 2. Residents who reside in the facility have the potential to be affected. 3. DON and/or designee will educate	

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F 842	Continued From page 9 note dated 6/12/23 that documented, "...At 1800 (6:00 PM), while resident was in the dayroom, staff observed bruising and mild swelling of left eye. Resident stated that she was "hit earlier." Denies pain/discomfort. Call placed to DON (Director of Nursing) and notified. Call placed to (name of), NP (nurse practitioner) and updated. New order to activate standing Tylenol (1) order and Ice PRN (as needed) for discomfort and swelling..." On 7/11/23 at 3:21 PM, an interview was conducted with ASM #2 (Administrative Staff Member) the DON. She stated that she never got this allegation of abuse and that this conversation was the first time she heard of this. She stated that she was called about the eye appearing bruised and swollen by the nurse that wrote the above note (LPN #1 - Licensed Practical Nurse), and she called another nurse (LPN #2) and requested that LPN #2 go and assess the resident to see what was going on with the eye. She stated that LPN #2 reported to her that LPN #2 did not see anything going on with the eye and that the resident was asked if anyone had hit her in the eye and the resident stated that no one had hit her. ASM #2 then stated that upon her arrival to the facility she also assessed the resident's eye and did not see anything going on with it and she also asked the resident if anyone had hit her and the resident did not respond to her. When asked if she ever read the above nurse's note in the clinical record, she stated that she had not. On 7/12/23 at 10:43 AM, an interview was conducted with LPN #2. She stated that she received a call from the DON to assess Resident #3's eye and did not see anything going on with the eye. She stated that she asked Resident #3 if	F 842	licensed nursing staff on documenting accurately and completely in the resident's charts. 4. DON and/or designee will audit 2 resident charts for accurate and complete documentation 3 days a week x4 weeks and then monthly x2 months. The results of the random audits will be reported to the QAA Committee for review and follow up recommendations as indicated. 5. The facility's alleged date of compliance will be August 1st, 2023.	

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F 842	Continued From page 10	F 842		

she had been hit in her eye or anything, and the resident denied being hit.

Further review of the clinical record failed to reveal any documentation by LPN #2 related to the above interview regarding her assessment of the resident and the resident statement that she was not hit.

In a follow up interview with LPN #2 on 7/12/23 at at 1:53 PM, when asked if she documented her assessment of the resident's eye and the resident statement that she had not been hit, she stated she did not. When asked if she should have documented her assessment of the resident, she stated that she should have. LPN #2 stated that she was a new nurse and thought the DON was documenting it upon her report to the DON of her assessment.

The facility policy, "Charting and Documentation" documented, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care....2. The following information is to be documented in the resident medical record: a. Objective observations...9. Documentation of procedures and treatments will include care-specific details, including:...c. the assessment data...."

No further information was provided by the end of the survey.

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F 842	Continued From page 11 References: (1) Tylenol is used for mild to moderate pain. Information obtained from https://medlineplus.gov/druginfo/meds/a681004.html	F 842		