STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 7/25/2023 through 7/26/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. Two complaints were investigated during the survey (VA00056739-substantiated with deficiency and VA00056459-substantiated with deficiency). The census in this 177 certified bed facility was 133 at the time of the survey. The survey sample consisted of nine current resident reviews and two closed record reviews.	F 000	F656 1) Resident #5 care plan is being implemented for providing hydration support between meals and Resident #1 is no longer in the facility. 2) Current residents have the potential to be affected if their care plan is not being implemented. Current residents care plan will be audited by IDT team and/ or Designee to ensure care plan is implemented for providing hydration support. 3) The DON/designee provided re-education to licensed staff on implementing care plans. 4) Random audits of 10 residents conducted weekly for 8 weeks to ensure comprehensive care plans are being implemented. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 8/24/2023	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: KA Scott
TITLE: LNHA
(X6) DATE: 8-15-2023

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

F 656 Continued From page 1 F 656

rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to implement the comprehensive care plan for two of 11 residents in the survey sample, Resident #5 and Resident #1.

The findings include:

1. For Resident #5 (R5), the facility staff failed to implement the care plan to provide hydration support by not having water available between meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 656	Continued From page 2	F 656		

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/31/2023, the resident scored 3 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions.

On 7/25/2023 at 10:55 a.m. R5 was observed sitting in a wheelchair in their room awake and pleasant. An empty plastic 8 ounce cup was observed on the overbed table in front of R5. No water pitcher or cups with water were observed available to the resident in their room.

On 7/25/2023 at 12:20 p.m., an interview was conducted with R5 who stated that they received drinks with their meals and had to ask for water when they wanted it from the nurses.

Additional observations of R5 in their room were made on 7/25/2023 at 2:14 p.m. with no access to water and the empty cup sitting on the overbed table. R5 was observed asking a staff member for water, which was provided. On 7/26/2023 at 8:22 a.m. no water was available in the room for R5.

The comprehensive care plan for R5 documented in part, "I am at risk for altered Skin Integrity as evidenced by bowel and bladder incontinence, assistance required with bed mobility, DM (diabetes mellitus). I have history of recurrent periorbital cellulitis. I will bump into things which may cause skin impairment. I have history of picking my face and arms. I will pick at scratch at my face. I have self inflicted scratch to my left upper eyelid. Date Initiated: 02/27/2020." Under "Interventions" it documented in part,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 656	Continued From page 3	F 656		

"...Nutritional and Hydration support. Date Initiated: 05/15/2023..."

The clinical record for R5 failed to evidence any fluid restrictions.

On 7/26/23 at 1:40 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated that the staff tried to maintain residents' hydration by passing ice water. CNA #4 stated that ice water should be given to residents on all shifts, and that she provided ice water to residents three times during her shift.

On 7/26/23 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the staff tried to maintain residents' hydration by providing water throughout all shifts and as requested, as long as the residents could have water. LPN #3 stated residents were also provided beverages during meals. LPN #3 stated that the care plan was used to identify what the resident's needs were and any special requests. She stated that the care plan should be followed to make sure that the staff were following what the resident wanted and follow what the resident needed.

On 7/26/2023 at 2:00 p.m., LPN #3 observed R5's room without any water pitcher or water cup available to the resident and stated that the dishwasher had been down and the CNA's had been using Styrofoam cups for the residents instead of the water pitchers. LPN #3 stated that R5 should have had access to water between meals.

On 7/26/2023 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 656	Continued From page 4	F 656		

director of nursing, ASM #3, the regional director of clinical services, ASM #4, the vice president of operations and LPN #3 were made aware of the concern.

No further information was provided prior to exit.

The facility policy "Care plan preparation" undated, documented in part, "A care plan directs the patient's nursing care from admission to discharge. This written action plan is based on nursing diagnoses that have been formulated after reviewing assessment findings, and it embodies the components of the nursing process: assessment, diagnosis, planning, implementation and evaluation..."
2. For Resident #1 (R1), the facility staff failed to implement the resident's comprehensive care plan for obtaining food preferences.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/18/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

R1's comprehensive care plan dated 7/12/22 documented, "Obtain and updated food/beverage preferences."

A review of R1's clinical record failed to reveal the facility staff attempted to obtain the resident's food/beverage preferences.

On 7/26/23 at 1:53 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated the purpose of the care plan is to, "Identify what the resident needs are and also any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 656	Continued From page 5 special requests." LPN #3 stated it is important to implement the care plan to make sure staff follows what the resident wants, and resident needs as well. On 7/26/23 at 3:11 p.m., an interview was conducted with OSM (other staff member) #2 (the dietary manager who was not employed during R1's stay at the facility). OSM #2 stated he asks each resident about his or her food preferences, fills out a food preference interview sheet and enters the preferences into the meal tracker computer system. On 7/26/23 at 3:55 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 656	F677 1) Resident #6 was provided with fingernail care. Resident #2 is no longer in the facility. 2) Current residents have the potential to be affected. Current residents will be assessed by nursing, IDT team and/ or Designee for finger nail care needs. 3) The DON/designee will re-educate certified nursing assistances regarding providing ADL care to dependent residents. 4) Nursing Administration will randomly audit fingernail care weekly for 8 weeks. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 8/24/2023	
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, staff interview and clinical record review, the facility staff failed to provide ADL (activities of daily living) care to dependent residents for two of 11 residents in the survey sample, Residents #6 and #2. The findings include: 1. For Resident #6 (R6), the facility staff failed to provide fingernail care.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 6 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/8/23, the resident scored 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. Section G coded R6 as requiring extensive assistance of one staff with personal hygiene. On 7/25/23 at 10:55 a.m. and 7/25/23 at 2:57 p.m., observation of R6's fingernails was conducted. A black substance was observed under the resident's fingernails and the resident's thumb nails were approximately one fourth inch long. On 7/26/23 at 1:40 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated she looks at residents' fingernails each day and if needed, she soaks them, cleans them, and clips them. CNA #4 stated she does this often because a lot of residents' fingernails are long. On 7/26/23 at 3:55 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility did not provide a policy regarding fingernail care. 2. For Resident #2 (R2), the facility staff failed to provide baths/showers between 9/15/2022-9/21/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/16/2022, the resident was	F 677		

F 677 Continued From page 7 F 677

assessed as requiring extensive assistance from one person for bathing.

The comprehensive care plan for R2 documented in part, "I have a physical functioning deficit related to: physical decondition, AMS (altered mental status). Date Initiated: 09/13/2022."

Review of the ADL (activities of daily living) documentation for R2 dated 9/1/2022-9/30/2022 under "ADL-Bathing Tuesday/Friday 3-11 & PRN (as needed)" failed to evidence a bath or shower provided on 9/16/2022 or 9/20/2022. It documented "NA" on those dates with the documentation key documenting in part, "...NA-Not Applicable." The document failed to evidence a bath or shower provided between 9/15/2022-9/21/2022.

On 7/26/2023 at 3:00 p.m., an interview was conducted with CNA (certified nursing assistant) #5. CNA #5 stated that showers were given twice a week and as needed. She stated that the showers were documented in the computer in the ADL's under showers and bathing and they documented what type of bath was provided and the amount of assistance the resident required. When asked what "NA" meant under the documentation, CNA #5 stated that it meant that it was not the residents shower day and they did not get one.

On 7/26/2023 at 3:55 p.m., ASM (administrative staff member) #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, vice president of operations and LPN #3 were made aware of the concern.

On 7/26/2023 at 5:14 p.m., ASM #2 provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 8 evidence of R2 receiving a shower on 9/14/2022. The documentation failed to evidence showers provided between 9/15/2022 to 9/21/2022. No further information was provided prior to exit.	F 677		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, clinical record review and facility document review, it was determined that the facility staff failed to provide podiatry services for one of 11 residents in the survey sample, Resident #4. The findings include: For Resident #4 (R4), the facility staff failed to ensure toenail care was provided. R4 was admitted to the facility with diagnoses that included but were not limited to Type 2 Diabetes Mellitus.	F 687	F687 1) Resident #4 received toenail care. 2) Current residents have the potential to be affected. Current residents will be assessed by nursing, IDT team and/ or Designee for toe nail care needs. 3) The DON/designee provided re-education to Licensed staff on providing toenail care. 4) Nursing Administration will randomly audit toenail care weekly for 8 weeks. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 8/24/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 687	Continued From page 9	F 687		

On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/3/2023, the resident scored 13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section G documented R4 requiring limited assistance of one person for dressing, supervision with setup help only for personal hygiene and extensive assistance of one person for bathing.

On 7/25/2023 at 10:55 a.m. and 12:20 p.m., observations of R4 in their room revealed the resident asleep in their bed. R4's feet were observed to be visible on top of the bed covers. The toenails on both feet were observed to be long, jagged, yellowed and thick with the great toenails on both feet long and growing curved over towards the second toes.

On 7/25/2023 at 2:14 p.m., an interview was conducted with Resident #4 (R4) in their room. R4 was observed sitting on the side of the bed after finishing lunch. When asked about foot care related to their toenails, R4 stated that they needed to have their toenails trimmed because the last time they were done was about two years ago by the beautician. R4 stated that the staff had not offered to file or trim their nails and they had not seen a podiatrist since they had been at the facility.

The clinical record for R4 failed to evidence any podiatry services provided.

The physician orders documented in part, "May see podiatrist, dentist, audiologist, ophthalmologist. Order Date: 9/15/2021."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 687	Continued From page 10	F 687		

The comprehensive care plan for R4 documented in part, I have a Self Care/ADL (activities of daily living) deficit related to: impaired mobility, intermittent confusion, CVA (cerebrovascular accident), NSTEMI (non-ST elevation myocardial infarction). My most recent triggered mobility CAA (care area assessment) reflects a significant improvement in my overall status because I now require limited assist when attempting to transfer, walk and complete my ADLs. Date Initiated: 09/09/2021."

On 7/26/23 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that resident's nails were assessed when the nurses did skin checks and when the CNA's (certified nursing assistants) performed care. She stated that non-diabetic residents nails were trimmed by the nursing staff and diabetic residents were seen by the podiatrist because they required special clippers. She stated that they alerted social services which residents needed the podiatrist who set up referrals and they came out once a month and the visits were documented in the medical record.

On 7/26/2023 at 2:00 p.m., LPN #3 observed R4's toenails and stated that they needed podiatry services and she would get her on the podiatry list to be seen. LPN #3 offered to attempt to file R4's nails at that time, however R4 declined and wanted to wait for the podiatrist to be set up.

On 7/26/2023 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the vice president of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 687	Continued From page 11 operations and LPN #3 were made aware of the concern. No further information was provided prior to exit. The facility provided policy, "Foot Care" undated, documented in part, "Daily bathing of feet and regular trimming of toenails promotes cleanliness, prevents infection, stimulates peripheral circulation, and controls odors by removing debris from between the toes and under toenails. It's particularly important for bedridden patients and those especially vulnerable to foot infection. Increased susceptibility may be caused by peripheral vascular disease, diabetes mellitus... Patients with diabetes should have yearly foot examination to identify factors that increase the risk of ulcers or amputation...Toenail trimming is contraindicated in patients with toe infections; diabetes mellitus, neurologic disorders, renal failure, or peripheral vascular disease, unless performed by a practitioner. Some facilities prohibit nurses from trimming toenails. Check to see whether you're permitted by your facility before trimming the patient's toenails..."	F 687		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

Based on observation, staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to provide the required assistance while providing ADL (activities of daily living) care which resulted in an injury for one of 11 residents in the survey sample, Resident #11. The resident sustained a laceration to the forehead requiring transport to the emergency room and sutures which constituted harm cited at past non-compliance.

Past noncompliance: no plan of correction required.

The findings include:

For Resident #11 (R11), the facility staff failed to implement the plan of care while providing ADL care which resulted in the resident sustaining a laceration to the forehead requiring sutures at the emergency room.

On the resident's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/7/2023, the resident was assessed as being severely impaired for making daily decisions. Section G documented R11 requiring extensive assistance from two or more persons for bed mobility, transfers and toilet use. R11 was assessed as always being incontinent of bowel and bladder.

The MDS assessment, a quarterly assessment with an ARD of 11/6/2022 documented R11 being severely impaired for making daily decisions. Section G documented R11 requiring extensive assistance from two or more persons for bed mobility, transfers and toilet use. R11 was assessed as always being incontinent of bowel and bladder.

The progress notes for R11 documented in part:

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ____ B. WING ____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13 - "12/15/2022 11:23 (11:23 a.m.) Situation: Staff reported resident rolled on her side during AM care and pulled the clothes bin and it tipped over and hit her on the left side of her head. Background: Unspecified Dementia, Unspecified Severity, without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Assessment: Staff reported resident rolled on her side during AM care and pulled the clothes bin and it tipped over and hit her on the left side of her head. Upon assessment open area noted on left side of forehead measuring 1.5cm (centimeter) by 1.0cm...NP (nurse practitioner) on unit and assessed resident. Response: New order obtained to send resident to (Name of hospital) for evaluation. RP (responsible party) updated and made aware." - "12/15/2022 19:33 (7:33 p.m.) Note Text: Resident admitted under observation (Name of hospital). Has history of hydrocephalus (1) and upon completing CT (computed tomography) scan per hospital hydrocephalus is progression. Per hospital resident will stay for observation." - "12/22/2022 19:13 (7:13 p.m.) Note Text: Resident readmitted from (Name of hospital). 3 (three) stitches intact over left eye. Bruising and swelling noted at site. No facial grimacing or s/s (signs/symptoms) of pain when site was touched..." The comprehensive care plan for R11 documented in part, "I have a Self Care/ADL deficit related to: Self care impairment, Dementia, OA (osteoarthritis), muscle weakness. Date Initiated: 03/08/2022." The facility synopsis of events dated 12/16/2022 documented in part, "...Thursday, December 15th, 2022 at approximately 10am, staff was	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14 proving [sic] ADL care which involved turning and reposition. (Name of R11) was in bed while CNA (certified nursing assistant) was attempting to provide peri-care, and the CNA rolled the resident on her side and the resident pulled on the lining [sic] trash bin and it tipped over and hit her on the head, and (Name of R11) sustained a laceration over her forehead. The resident was transferred to the hospital for evaluation, and remained in observation. Investigation initiated." The document contained a written statement from the assigned CNA on 12/15/2022 who no longer worked at the facility which documented in part, "... After washing (Name of R11) and putting her blouse on, I was standing on the left side of (Name of R11) to roll her to the right and put her brief on. Then I pulled the brief threw [sic] her legs and walked to the right side to roll her to the left to connect the brief while rolling (Name of R11) pulled on the dirty lining [sic] trash bin in her room and it tipped over and hit her in the head. I ran to the other side to pick it up. I sat (Name of R11) up on the side of the bed and noticed she had a knot on her head. I went and notified my nurse (Name of LPN (licensed practical nurse) #1). I then went to get the instrument to get her vitals." The investigation summary documented in part, "...the CNA (Name of CNA), did not follow the resident's Kardex (2) for bed mobility when providing peri-care. The Kardex shows that the resident requires two persons assisting her with bed mobility, and at the time of peri-care, the staff did not ask for assistance; however, the facility was not able to prove that the staff member actions was neglectful or abusive. The CNA (Name of CNA) was terminated from the facility for failure to comply with the resident plan of care..."	F 689		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 On 7/26/2023 at 11:10 a.m., an interview was conducted with CNA #1. CNA #1 stated that when they were providing care for residents who required two persons, they got help from another staff member. CNA #1 stated that they knew which residents required two persons for care by their report from the previous shift and looking at the Kardex in the computer. On 7/26/2023 at 11:15 a.m., an interview was conducted with CNA #2. CNA #2 stated that they checked the Kardex to know which residents required one- or two-person assistance. She stated that they also communicated between the shifts to the next nurse, so they knew. On 7/26/2023 at 11:30 a.m., an interview was conducted with CNA #3. CNA #3 stated that they used the Kardex to tell them the needs of the resident and it advised them if the resident required one- or two-person assistance with ADL's. On 7/26/2023 at 12:53 p.m., an interview was conducted with ASM (administrative staff member) #1, the administrator. ASM #1 stated that they had identified that R11 had been injured so they started an investigation and took a statement from the employee. He stated that they had the employee re-enact the situation and they had identified that R11 was a two-person assistance at that time and the CNA had not used two persons to perform the care. He stated that they had found that CNA did not act with the policy, so they had suspended them until they dug deeper into the investigation and found that the Kardex matched the chart and plan of care, so they had terminated the CNA based on the investigation. ASM #1 stated that the laundry bin	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

in the room was metal and had a sharper edge than a normal bin and had some weight to it and the CNA had stated that the resident had grabbed for the bin, and it tipped over and hit her on the head. He stated that once they identified the laundry bin issue, they removed all metal bins from the facility. He stated that if the CNA had utilized the second person in the room that R11 could have potentially grabbed that second person rather than the laundry bin. He stated that R11 was sent to the emergency room and received sutures. ASM #1 stated that when they self- identify any issue, they bring the interdisciplinary team together to meet, bullet point their actions and make a plan to prevent recurrence. He stated that they had immediately removed one of the issues which was the bins, started education, performed audits, and did follow ups in QAPI (quality improvement performance improvement) meetings.

On 7/26/2023 at 2:15 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that they were not assigned to R11 on 12/15/2022 but had come over to assist the nurse at that time. LPN #4 stated that they were told the resident had hit their head and they went in the room to find R11 sitting up in their wheelchair with a laceration on their forehead. She stated that the CNA told her that R11 had hit their head on the laundry basket which was beside the bed when she was getting her up during morning care. She stated that the CNA told her that she was rolling R11 over when the resident had grabbed the bin and it had fallen over and hit her on the head.

On 7/26/2023 at approximately 2:20 p.m., an interview was conducted with LPN #1. LPN #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ____ B. WING ____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17	F 689		

stated that they were working with R11 on 12/15/2022 and had held pressure to the laceration after the injury. She stated that she had another resident having an emergency, so LPN #4 had taken over and sent R11 to the hospital.

Review of the plan of correction provided by ASM #1 for R11's injury on 12/15/2022 documented a date of compliance of 12/19/2022. The plan of correction folder contained an ad hoc QAPI meeting dated 12/16/2022 for the incident and a performance improvement plan dated 12/16/2022. The plan included a 100% audit of current resident Kardex's completed 12/19/2022, 12/6/2022 [sic], 1/2/2023, 1/9/2023, 1/16/2023, 1/30/2023, 2/6/2023 and 3/6/2023, documentation of an audit of all resident rooms with removal of clothes bins dated 12/15/2022, the written CNA statement, evidence of education completed to all staff including the terminated CNA dated 12/16/2022, and a copy of R11's Kardex which documented in part, "...Bed mobility: Extensive assistance, Two+ persons physical assist..." The plan further documented QAPI improvement worksheets reviewing the incident on 1/27/2023, 2/28/2023, and 3/31/2023. Verification of the facility plan of correction was completed by observations, staff interviews and review of the facility audits, staff education and resident audits. No concerns were identified.

Observations conducted of current residents receiving ADL care including turning and repositioning during the survey dates revealed no concerns with staff following the Kardex for one- or two-person assistance with ADL's.

On 7/26/2023 at 12:20 p.m., the director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 18	F 689		

nursing provided evidence of education completed on 3/30/2022 for providing ADL care to residents including positioning, for the CNA terminated for the 12/15/2022 incident involving R11.

On 7/26/2023 at 1:20 p.m., ASM #1, the administrator was made aware of the concern for harm. No further information was provided prior to exit.

Based on the acceptable plan of correction, all components of the plan verified, and no concerns identified during the survey, this deficient practice is cited at past non-compliance.

Reference:
(1) Hydrocephalus is the buildup of too much cerebrospinal fluid in the brain. Normally, this fluid cushions your brain. When you have too much, though, it puts harmful pressure on your brain. This information was obtained from the website: https://medlineplus.gov/hydrocephalus.html

(2) Kardex
Originally, the proprietary name for a filing system for nursing records and orders that was held centrally on the ward and contained all the nursing details and observations of patients that had been acquired during their stay in hospital. Although this system is no longer used for nursing records, since care plans are now held at the patient's bedside rather than centrally, the term 'kardex' continues to be used generically, for certain centrally held patient record systems. This information was obtained from the website: https://www.oxfordreference.com/display/10.1093/oi/authority.20110803100030337

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 803	Continued From page 19	F 803		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to follow dietary menus for four of 11 residents in the survey sample, Residents #3, #9, #10 and #4. The findings include:	F 803	F803 1) Resident #3 no longer resides in the facility. Resident #9 #10 and #4 dietary menus are being followed. 2) Current residents have the potential to be affected. The dietary manager and/ or Designee will ensure current residents' dietary menus are being followed. 3) The Administrator will re-educate the dietary manager on ensuring accurate dietary menus are being followed. 4) Administrator will randomly audit dining rooms during meal times to ensure dietary menus are being followed weekly for 8 weeks. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 8/24/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 803	Continued From page 20 For Residents #3, #9, #10 and #4, the facility staff failed to follow dietary menus during lunch and dinner on 7/25/23. 1. For Resident #3 (R3), on the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/2/23, R3 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 7/25/23 at 10:28 a.m., an interview was conducted with R3. The resident voiced concern that the facility was not providing food according to the menus. 2. For Resident #9 (R9), on the most recent MDS, a quarterly assessment with an ARD of 6/24/23, R9 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions. On 7/25/23 at 1:40 p.m., an interview was conducted with R9. R9 stated that during the previous evening, the menu documented the residents were going to have liver and onions, rice and gravy. R9 stated he anticipated having this meal, but the kitchen ran out, didn't serve what was on the menu, he received a turkey patty, and that was not real meat. R9 stated this happens all the time. 3. For Resident #10 (R10), on the most recent MDS, a quarterly assessment with an ARD of 6/27/2023, R10 scored 15 out of 15 on the BIMS assessment, indicating that the resident was cognitively intact for making daily decisions.	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 803	Continued From page 21	F 803		

On 7/26/2023 at 8:20 a.m., an interview was conducted with R10. When asked about the food at the facility, R10 stated that the food served was not the food that was posted on the walls. R10 stated that she would check the menu on the wall each day and notify the kitchen directly if she wanted the alternate meal however, she often still received the wrong item. R10 stated that the facility frequently substituted foods on the menu without letting residents know so they did not know if they wanted to eat until the food arrived. She stated that this happened.

4. For Resident #4 (R4) on the most recent MDS, an annual assessment with an ARD of 6/3/2023, R4 scored 13 out of 15 on the BIMS assessment, indicating that the resident was cognitively intact for making daily decisions.

On 7/25/2023 at 2:14 p.m., an interview was conducted with R4. The resident stated that they were often served meals that did not match what was posted on the menus and they were told that they had run out of food or did not have what was supposed to be served that day. R4 stated that it was annoying to never know what they were going to get and whether they would like it or not.

The scheduled lunch menu approved by the RD (registered dietician) for 7/25/23 documented:
-hamburger on a bun
-lettuce and tomato plate
-ketchup
-pickle spear
-tuna salad sandwich
-confetti coleslaw
-broccoli salad
-garden pasta salad

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 803		F 803		

Continued From page 22
-chocolate chip cookie

The lunch menu posted for the residents to see on 7/25/23 documented:
-hamburger on a bun
-toss salad
-bake beans
-brownie
-tuna salad sandwich
-pasta salad

On 7/25/23 at 12:25 p.m., observation of the lunch meal for residents was conducted with OSM (other staff member) #8 (the cook). The following food was prepared and available for lunch:
-hamburger on bun
-coleslaw
-baked beans
-tuna salad sandwiches
-chocolate cake and vanilla cake

The following items from the RD approved menu were not prepared for lunch:
-lettuce and tomato plate
-broccoli salad
-garden pasta salad
-chocolate chip cookie

The following items from the menu posted for residents to see were not prepared for lunch:
-toss salad
-brownie

The scheduled dinner menu approved by the RD for 7/25/23 documented:
-chicken parmesan
-spaghetti noodles
-parsley pork chop

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 803	Continued From page 23 -herbed green beans -sugar snap peas -mashed potatoes -garlic bread -fruit cocktail The dinner menu posted for the residents to see on 7/25/23 at 12:20 p.m. documented: -egg salad sandwich -pasta salad -creamy dill macaroni salad -dinner rolls -hamburger steak -green beans -season rice The dinner menu posted for the residents to see on 7/25/23 at 4:15 p.m. documented: -chicken parmesan -spaghetti noodles -snap peas -garlic bread -chocolate cake -beef patty -sweet potatoes On 7/25/23 at 4:27 p.m., observation of the dinner meal for residents was conducted with OSM #2 (the dietary manager). The following food was prepared and available for dinner: -chicken patties -beef patties -peas -spaghetti noodles -spaghetti sauce -sweet potatoes -garlic bread -chocolate cake and vanilla cake	F 803		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 803 Continued From page 24 F 803

The following items from the RD approved menu were not prepared for dinner:
-parsley pork chop
-herbed green beans
-mashed potatoes
-fruit cocktail

None of the items from the menu initially posted for residents to see were available for dinner. All items from the second menu posted for residents to see were available for dinner.

On 7/25/23 at 4:30 p.m., an interview was conducted with OSM #2, the dietary manager. OSM #2 stated he served pork chops earlier in the week and ran out, so he was substituting beef patties. OSM #2 stated he didn't have mashed potatoes, so he was substituting sweet potatoes. OSM #2 stated someone accidentally pulled peas out of the freezer, so he was serving them, but green beans were available. OSM #2 stated fruit cocktail was used for another meal, so he was serving cake.

On 7/26/23 at 3:11 p.m., another interview was conducted with OSM #2. OSM #2 stated menus should be followed and there should be consistency between the scheduled RD approved menus, menus posted for residents and meals served, to meet residents' nutritional needs and so residents know what food they will be getting. OSM #2 stated broccoli salad was not served during lunch on 7/25/23 because there was a shortage, french fries were not served during lunch on 7/25/23 so baked beans were substituted, and pasta salad was not served during lunch on 7/25/23 because it was served on the previous Sunday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 803	Continued From page 25 On 7/26/23 at 3:55 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "Menus" documented, "Menus are prepared in advance and followed."	F 803	F806 1) Resident #3, #1, and # 2 no longer reside in the facility.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to review and/or honor food preferences for three of 11 residents in the survey sample, Residents #3, #1, and #2. The findings include: 1. For Resident #3 (R3), the facility staff failed to honor the resident's food preference for no beef. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 7/2/23, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.	F 806	2) Current residents have the potential to be affected. The Dietary Managers and/or designee will ensure current residents food preferences have been obtained and are being honored. 3) Administrator will re-educate the dietary manager on obtaining and honoring resident food preferences. 4) Administrator will audit new admissions to ensure food preferences obtained and random dining room audits will be conducted to ensure preferences are being honored. 5) Compliance Date: 8/24/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 806	Continued From page 26	F 806		

On 7/25/23 at 10:28 a.m., an interview was conducted with R3. The resident voiced concern because she had requested no beef and continued to receive beef during some meals. R3 discharged from the facility approximately 30 minutes after the interview so the resident's meals could not be observed during the survey.

A facility concern form dated 7/19/23 documented, "Does not want beef." The facility follow-up documented by OSM (other staff member) #2 (the dietary manager) documented, "The resident's preferences have been updated to reflect the resident's wishes."

A review of R3's meal tickets from 7/20/23 through 7/24/23 revealed the resident was served a meatball sub sandwich for dinner on 7/22/23 and beef stir fry for dinner on 7/23/23.

On 7/26/23 at 3:11 p.m., an interview was conducted with OSM #2. OSM #2 stated residents' meals are plated and served based on the meal tickets, so the meal tickets are a reflection of the meals previously served. OSM #2 stated he incorrectly placed R3's request for no beef in a diet note. OSM #2 stated he should have put no beef in the preference section of the meal tracker system, and if he had done this, a substitute for beef would have automatically printed out on the meal ticket and have been served.

On 7/26/23 at 3:55 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.

2. For Resident #1 (R1), the facility staff failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 806		F 806		

Continued From page 27
attempt to obtain the resident's food preferences.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 10/18/22, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident was cognitively intact for making daily decisions.

A review of R1's clinical record failed to reveal the facility staff attempted to obtain the resident's food preferences.

On 7/26/23 at 3:11 p.m., an interview was conducted with OSM (other staff member) #2 (the dietary manager who was not employed during R1's stay at the facility). OSM #2 stated he asks each resident about his or her food preferences, fills out a food preference interview sheet, and enters the preferences into the meal tracker computer system.

On 7/26/23 at 3:55 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern.

The facility policy titled, "Menus" documented, "5. Alternate food items must be provided to residents with food allergies, intolerances and dislikes."

3. For Resident #2 (R2), the facility staff failed to evidence a review of food preferences.

On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 9/16/2022, the resident scored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 806	Continued From page 28 12 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was moderately impaired for making daily decisions. The resident was assessed as not having any swallowing problems, no weight loss, and not receiving a tube feeding or mechanically altered diet. The physician orders for R2 documented in part, "Regular diet Regular texture, No added salt. Order Date: 9/13/2022." The clinical record for R2 failed to evidence a review of food preferences. On 7/25/2023 at 7:20 p.m., a request was made to ASM (administrative staff member) #3, the regional director of clinical services, for evidence of a review of food preferences for R2. On 7/26/2023 at approximately 8:30 a.m., ASM #1, the administrator provided food preference sheets for additional requested residents and stated that they were still looking for R2's. On 7/26/2023 at 3:11 p.m., an interview was conducted with OSM (other staff member) #2, dietary manager. OSM #2 stated that they had been at the facility since June of 2023 and checked with each new admission to review their preferences. He stated that he attempted to speak with each new admission and ask them what their likes and dislikes were and put them on the preference sheet. He stated that he entered the information into the computer meal tracker if they had preferences so that the system would automatically substitute anything that the resident did not like when it was being served.	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 806	Continued From page 29 On 7/26/2023 at 3:55 p.m., ASM #1, administrator, ASM #2, director of nursing, ASM #3, regional director of clinical services, ASM #4, vice president of operations and LPN #3 were made aware of the concern. On 7/26/2023 at 5:10 p.m., ASM #3 stated that they did not have any further information to provide. No further information was provided prior to exit.	F 806		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and clinical record review, it was determined that the facility staff failed to offer water to maintain hydration to three of 11 residents in the survey sample, Resident #4, #5 and #6. The findings include: 1. For Resident #4 (R4), the facility staff failed to offer water to maintain hydration between meals. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 6/3/2023, the resident scored	F 807	F807 1) Resident #4, #5, #6 are being offered water to maintain hydration. 2) Current residents have the potential to be affected. The DON, IDT and/or designee will ensure current residents are offered water to maintain hydration. 3) The DON/designee provided re-education to staff on offering water to maintain hydration. 4) Administration will audit water availability to maintain hydration weekly for 8 weeks. Results will be presented to QAPI monthly. Any noted trends will be corrected immediately. 5) Compliance Date: 7/27/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ____ B. WING ____	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 807	Continued From page 30	F 807		

13 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions.

On 7/25/2023 at 10:55 a.m. and 12:20 p.m., observations of R4 in their room revealed the resident asleep in their bed. No water pitcher or cups of water were observed available to the resident in their room.

On 7/25/2023 at 2:14 p.m., an interview was conducted with Resident #4 (R4) in their room. R4 was observed with a Styrofoam tray containing a hamburger on a bun, baked beans, coleslaw and an approximately 8 ounce plastic cup of tea. When asked about drinks provided by the facility including water, R4 stated that they got tea on their meal trays. R4 stated that they did not receive any drinks between meals unless they asked for them and the staff had not offered any water to them. During the interview a staff member entered the room where R4's roommate asked for water which was provided to the roommate by the staff member, no water was provided or offered to R4.

Additional observations of R4 in their room were made on 7/25/2023 at 4:30 p.m. and 7/26/2023 at 8:22 a.m. No water was available in the room for R4.

The clinical record for R4 failed to evidence any fluid restrictions.

The comprehensive care plan for R4 documented in part, "(Name of R4) is at Nutritional risk related to cerebral infarction, CHF (congestive heart failure), dementia, T2DM (type 2 diabetes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 807	Continued From page 31	F 807		

mellitus), PCM (protein calorie malnutrition), A (atrial) fib (fibrillation), dysphagia, PCM, heart dz (disease), GERD (gastroesophageal reflux disease), HLD (hyperlipidemia), depression, vitamin deficiencies, and HTN (hypertension). Date Initiated: 08/30/2021."

On 7/26/23 at 1:40 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated that the staff tried to maintain residents' hydration by passing ice water. CNA #4 stated that ice water should be given to residents on all shifts, and that she provided ice water to residents three times during her shift.

On 7/26/23 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the staff tried to maintain residents' hydration by providing water throughout all shifts and as requested, as long as the residents could have water. LPN #3 stated residents were also provided beverages during meals.

On 7/26/2023 at 2:00 p.m., LPN #3 observed R4's room without any water pitcher or water cup available to the resident and stated that the dishwasher had been down and the CNA's had been using Styrofoam cups for the residents instead of the water pitchers. LPN #3 stated that R4 should have had access to water between meals.

On 7/26/2023 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the vice president of operations and LPN #3 were made aware of the concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 807	Continued From page 32	F 807		

No further information was provided prior to exit.

On 7/26/2023 at 5:05 p.m., ASM (administrative staff member) #4, the vice president of operations stated via email that they did not have a policy regarding hydration and providing water.

2. For Resident #5 (R5), the facility staff failed to offer water to maintain hydration between meals.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/31/2023, the resident scored 3 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was severely impaired for making daily decisions.

On 7/25/2023 at 10:55 a.m. an observation was made of R5 sitting in a wheelchair in their room awake and pleasant. An empty plastic 8 ounce cup was observed on the overbed table in front of R5. No water pitcher or cups of water were observed available to the resident in their room.

On 7/25/2023 at 12:20 p.m., an interview was conducted with R5 who stated that they received drinks with their meals and had to ask for water when they wanted it from the nurses.

Additional observations of R5 in their room were made on 7/25/2023 at 2:14 p.m. with no access to water and the empty cup on the overbed table. R5 was observed asking a staff member for water, which was provided. On 7/26/2023 at 8:22 a.m. no water was available in the room for R5.

The clinical record for R5 failed to evidence any fluid restrictions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 807

Continued From page 33

F 807

The comprehensive care plan for R5 documented in part, "I am at risk for alteration in Hydration related to: Diuretic Use. Date Initiated: 09/16/2020." The care plan further documented in part, "I am at risk for altered Skin Integrity as evidenced by bowel and bladder incontinence, assistance required with bed mobility, DM (diabetes mellitus). I have history of recurrent periorbital cellulitis. I will bump into things which may cause skin impairment. I have history of picking my face and arms. I will pick at scratch at my face. I have self inflicted scratch to my left upper eyelid.
Date Initiated: 02/27/2020." Under "Interventions" it documented in part, "...Nutritional and Hydration support
Date Initiated: 05/15/2023..."

On 7/26/23 at 1:40 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated that the staff tried to maintain residents' hydration by passing ice water. CNA #4 stated that ice water should be given to residents on all shifts, and that she provided ice water to residents three times during her shift.

On 7/26/23 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that the staff tried to maintain residents' hydration by providing water throughout all shifts and as requested, as long as the residents could have water. LPN #3 stated residents were also provided beverages during meals.

On 7/26/2023 at 2:00 p.m., LPN #3 observed R5's room without any water pitcher or water cup available to the resident and stated that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 807	Continued From page 34	F 807		

Continued From page 34

dishwasher had been down and the CNA's had been using styrofoam cups for the residents instead of the water pitchers. LPN #3 stated that R5 should have had access to water between meals.

On 7/26/2023 at 3:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional director of clinical services, ASM #4, the vice president of operations and LPN #3 were made aware of the concern.

No further information was provided prior to exit.

3. For Resident #6 (R6), the facility staff to ensure water was provided during multiple observations on 7/25/23 and 7/26/23.

A review of R6's clinical record (including a physician order summary for July 2023) failed to reveal any dietary or fluid restrictions or need to not offer water to the resident.

On 7/25/23 at 10:55 a.m., 7/25/23 at 2:57 p.m., 7/25/23 at 4:50 p.m. and 7/26/23 at 8:26 a.m., R6 was observed lying in bed. No water was observed on the resident's side of the room.

On 7/26/23 at 1:40 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated staff tries to maintain residents' hydration by passing ice water. CNA #4 stated ice water should be given to residents on all shifts, and she gives ice water to residents three times during her shift.

On 7/26/23 at 1:55 p.m., an interview was conducted with LPN (licensed practical nurse) #3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	**3900 PLANK ROAD FREDERICKSBURG, VA 22407**

(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 807	Continued From page 35 LPN #3 stated staff tries to maintain residents' hydration by providing water throughout all shifts and as requested, as long as the residents can have water. LPN #3 stated residents are also provided beverages during meals. On 7/26/23 at 3:55 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 807	F812 1) Staff are serving food in a safe and sanitary manner. 2) Current residents have the potential to be affected. The Administrator, Dietary Manager and/or designee will ensure staff are serving current residents' food in a safe and sanitary manner. 3) The dietary manager and/or designee provided dietary staff re-education on ensuring food is served in a safe and sanitary manner. 4) Random audits will be conducted during dining times to ensure food is being served in a safe and sanitary manner weekly for 8 weeks. Results of audits will be reviewed at the monthly QAPI meeting. Any discrepancies will be addressed immediately. 5) Compliance Date: 8/24/2023	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary 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 document review, the facility staff failed to serve food in a safe and sanitary manner on one of four units, the west two unit.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(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 36 The findings include: On 7/25/23, during the dinner meal service on the west two unit, uncovered cookies were served on meal trays that were brought to the resident rooms from the meal carts located in the hallway. On 7/25/23 at 6:37 p.m., observation of staff serving meal trays from a meal cart to resident rooms was conducted. Uncovered individual cookies were observed in individual Styrofoam cups on the meal trays. The staff were walking with the meal trays from the hallway to the residents rooms. On 7/26/23 at 3:11 p.m., an interview was conducted with OSM (other staff member) #2 (the dietary manager). OSM #2 stated each food item on a meal tray should be covered to keep germs and diseases away from the food. On 7/26/23 at 3:55 p.m., ASM (administrative staff member) #1 (the administrator) was made aware of the above concern. The facility policy titled, "Serving Food" documented, "Serve food at the proper temperatures, attractively and under sanitary conditions."	F 812	F925 1) The center is currently maintaining an effective pest control program in the kitchen. 2) Current residents have the potential to be affected. The Administrator, Maintenance Director and/or designee will ensure effective pest control is maintained. 3) The Administrator provided re-education to staff on the center's pest control program. 4) Dietary staff will audit for an effective pest control program weekly for 8 weeks to ensure the center is maintaining an effective pest control program.	
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 925	5) Compliance Date: 8/24/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

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

F 925 Continued From page 37 F 925

Based on observation, staff interview and facility document review, the facility staff failed to maintain an effective pest control program for one of one kitchen.

The findings include:

The facility staff failed to ensure the kitchen was free from fruit flies and cockroaches.

A review of the facility pest control logs revealed cockroach sightings in the kitchen on the following dates:
1/1/23- the log documented the area was treated on 1/9/23.
4/13/23- the log documented the area was sprayed.
5/7/23 (blank)
5/12/23- the log documented the area was sprayed on 5/12/23.
5/19/23- the log documented the area was sprayed.

A facility synopsis of events dated 6/30/23 documented the local health department was on-site for a visit and noticed sanitation concerns regarding storage, maintenance and pest control. The synopsis further documented the dish machine and ice machine were taken offline for deep cleaning, paper products were in use, the exterminator was in on that date to complete a treatment, and immediate education regarding proper cleaning, storage and sanitation was done.

A food establishment inspection report from the local health department dated 6/30/23 documented the following observations:
- dead and crawling insects inside the ice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 38 machine, in direct contact with the ice. -dead pests around the area where sugar was stored in the dry storage room. -a large presence of dead and live roach like crawling insects around and in the dish machine, behind equipment in the kitchen area, underneath shelves in the dry storage area, inside the ice machine, underneath the three-compartment sink, on a shelf where clean dishes were stored, on the surface of a clean dish and inside a stainless-steel hot holding container lid. A five-day summary facility synopsis of events dated 7/5/23 documented, "Situation: During the visit from the Virginia Department of Health (VDH), sanitation concerns regarding storage, maintenance, and pest control were identified. To address these concerns, the dish machine and ice machine were immediately taken offline for a thorough deep cleaning. Additionally, paper products are being used and temperatures will be closely monitored to ensure proper maintenance. An exterminator has been scheduled for treatment, with a follow-up appointment already planned. Immediate education has also been provided to ensure proper cleaning, storage, and sanitation practices as followed. Summary: Following the initial recommendations from the VDH's visit on June 30th, the facility has taken prompt action. The dish room and dish machine have been thoroughly cleaned, and the areas prone to insects have been treated by pest control. In addition, loose weather stripping on the back door has been sealed, and a missing ceiling tile in the chemical storage room has been replaced. Other openings along ceiling tiles and dry storage conduit lines have also been addressed..."	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 39	F 925		

Residents were observed eating meals in the dining room on 7/25/23 and 7/26/23.

On 7/26/23 at 9:10 a.m., an observation of the facility kitchen and dining room was conducted. The ice machine and dishwasher remained out of service. Fruit flies were observed around the garbage disposal pipes in the dishwashing area. Dead cockroaches were observed in glue traps in the dishwashing area, behind the ice machine and outside the dry storage area, one dead cockroach was observed in the dining room, multiple dead cockroaches and one live, crawling cockroach was observed in the steam table nook area in the dining room (the steam table was not in operation).

On 7/26/23 at 12:50 p.m., an interview was conducted with ASM (administrative staff member) #1 (the administrator) and OSM (other staff member) #3 (the facilities manager). OSM #3 stated that prior to January 2023, an exterminator came to the facility twice a month and treated the outside of the facility once a month and the inside of the facility once a month. OSM #3 stated cockroaches were first seen in the kitchen in January 2023. OSM #3 stated that once he was made aware, extra cleaning was conducted, and the exterminator was contacted. OSM #3 stated the exterminator conducted an inspection, applied baits, and laid down glue traps. OSM #3 stated the exterminator returned in two weeks, applied more baits, laid down more glue traps and determined that treatment was sufficient. OSM #3 stated the exterminator continued to come to the facility and inspect and treat the interior twice a month, then in late May, the exterminator said there was an increase in activity. OSM #3 stated more aggressive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495240	A. BUILDING ______ B. WING ______	C 07/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREDERICKSBURG HEALTH AND REHAB	3900 PLANK ROAD FREDERICKSBURG, VA 22407

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 925	Continued From page 40 treatment including pheromone wafers and the spraying of cracks, crevices, baseboards and ceilings began in June 2023 and continued into July 2023. ASM #1 stated the local health department completed an on-site visit on 6/30/23 due to a complaint. ASM #1 stated the facility has followed all recommendations by the local health department and continues to update the local health department. ASM #1 stated the ice machine and dishwasher remains out of service until there is no further evidence of cockroaches. On 7/26/23 at 3:11 p.m., an interview was conducted with OSM #2 (the dietary manager). OSM #2 stated the kitchen staff has increased the amount of cleaning in the kitchen. On 7/26/23 at 3:55 p.m., ASM #1 was made aware of the above concern. The facility policy titled, "Pest Control" documented, "The facility will maintain a pest control program, which includes inspection, reporting, and prevention."	F 925		