

REHABILITATION AND NURSING

RECEIVED

SEP 0 5 2023

VDH/OLC

August 29, 2023

Shyrn Nyarko, LTC Supervisor
Division of Long Term Care
Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485

RE: Mountain Laurel Nursing and Rehab Provider Number 495417

Dear Shyrn Nyarko:

Please find attached the Statement of Deficiencies and Plan of Correction, CMS 2567 with the facilities corrections and or plan of corrections for the items found deficient in practice for the survey ending August 14, 2023 standard and abbreviated stadard complaint survey. The facility kindly ask that the PoC serve as the facility's allegation of compliance.

There is no IDR consideration as the facility accepts the citations as identified by the Survey Team. I am thankful to the surveyors for the degree of professionalsm and kindness displayed during the days of survey. I have also to the right of the tag numbers made reference identification to the cross over tags.

Please consider accepting the PoC as allegation of compliance and notify myself as soon as you may be able to do so. Thank you Shyrn and Happy Labor Day weekend to you.

Respectfully,

Stephen Reynolds, MA, NHA

Administrator

PRINTED: 08/25/2023 **FORM APPROVED** OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		SURVEY PLETED
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				RURAL RETREAT, VA 24368		
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E 000	An unannounced Em	ergency Preparedness	E	000		
E 037	Corrections are required. CFR Part 483.73, Recars Facilities. No/# investigated during the EP Training Program	d 8/8/23 through 8/14/23. red for compliance with 42 quirement for Long-Term complaint(s) was/were e survey.	E	037 F037		
SS=D	§441.184(d)(1), §460. §483.73(d)(1), §483.4 §485.68(d)(1), §485. §485.727(d)(1), §485. §491.12(d)(1). *[For RNCHIs at §403 Hospitals at §482.15, at §484.102, REHs at under §485.727, OPC RHC/FQHCs at §491. (1) Training program. the following:	12:] The [facility] must do all of		 The facility recognizes maintain an emergency program that includes trawith documentation and staff knowledge. All residents have the impacted by the alleged practice. The Maintenance Director of the staff on the	preparedness aining annually demonstrated potential to be deficient	
AROPATORY	policies and procedur staff, individuals provi arrangement, and vole expected roles. (ii) Provide emergence least every 2 years. (iii) Maintain document preparedness training (iv) Demonstrate staff procedures. (v) If the emergency procedures are significant must conduct training	unteers, consistent with their y preparedness training at station of all emergency		preparedness policies and that new staff are also extheir on-boarding. The HR/BOM and Mainte will discuss new hire in the meeting to ensure educate been provided to them.	d will ensure ducated during enance Director he am IDT	

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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E 037	procedures. *[For Hospices at §41 hospice must do all of (i) Initial training in empolicies and procedur hospice employees, a services under arrangexpected roles. (ii) Demonstrate staff procedures. (iii) Provide emergence least every 2 years. (iv) Periodically review emergency preparedremployees (including special emphasis place procedures necessary others. (v) Maintain document preparedness training (vi) If the emergency procedures are signifficant training procedures. *[For PRTFs at §441. program. The PRTF in (i) Initial training in empolicies and procedure staff, individuals proviarrangement, and volvexpected roles. (ii) After initial training preparedness training (iii) Demonstrate staff procedures.	8.113(d):] (1) Training. The fithe following: nergency preparedness es to all new and existing and individuals providing rement, consistent with their knowledge of emergency by preparedness training at a vivid and rehearse its ressipant with hospice repeated policies and repeated policies and repeated policies and cantly updated, the hospice on the updated policies and regency preparedness es to all new and existing ding services under unteers, consistent with their reprovide emergency	E	037	4. The Administrator will audit up new hires weekly for 6 weeks to excompliance with emergency preparedness. The findings of the quality monitoring will be reported the Quality Assurance/Performand Improvement Committee monthly quality monitoring schedule may be modified based on findings with quarterly monitoring by the Administrator/designee. 5. PoC compliance date is 9-12-23	d to ce	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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E 037	preparedness training (v) If the emergency procedures are signiff must conduct training procedures. *[For PACE at §460.8 organization must do (i) Initial training in empolicies and procedur staff, individuals proviarrangement, contract volunteers, consistent (ii) Provide emergence least every 2 years. (iii) Demonstrate staff procedures, including what to do, where to gase of an emergency (iv) Maintain document (v) If the emergency procedures are signiff must conduct training procedures. *[For LTC Facilities at Program. The LTC facilities and procedure staff, individuals proviarrangement, and volexpected role. (ii) Provide emergence least annually. (iii) Maintain documer preparedness training	preparedness policies and cantly updated, the PRTF on the updated policies and 4(d):] (1) The PACE all of the following: hergency preparedness es to all new and existing ding on-site services under tors, participants, and the with their expected roles, by preparedness training at the knowledge of emergency informing participants of go, and whom to contact in go, and go,						

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E 037	CORF must do all of to (i) Provide initial training preparedness policies and existing staff, indiction under arrangement, a with their expected role (ii) Provide emergency least every 2 years. (iii) Maintain document (iv) Demonstrate staff procedures. All new pand assigned specific the CORF's emergency their first workday. The include instruction in the alarm systems and significant equipment. (v) If the emergency procedures are significant existence.	.68(d):](1) Training. The the following: ing in emergency is and procedures to all new ividuals providing services and volunteers, consistent ales. It is preparedness training at antation of the training. It is knowledge of emergency personnel must be oriented in responsibilities regarding cy plan within 2 weeks of the training program must the location and use of	E	037			
	The CAH must do all (i) Initial training in empolicies and procedure reporting and extinguiand where necessary personnel, and guests cooperation with firefigauthorities, to all new individuals providing and volunteers, consistroles.	nergency preparedness es, including prompt ishing of fires, protection, r, evacuation of patients, s, fire prevention, and ghting and disaster					

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E 037	least every 2 years. (iii) Maintain documer (iv) Demonstrate staff procedures. (v) If the emergency procedures are signifi must conduct training procedures. *[For CMHCs at §485 CMHC must provide i preparedness policies and existing staff, ind under arrangement, a with their expected ro documentation of the demonstrate staff kno procedures. Thereaft emergency preparedr years. This REQUIREMENT by: Based on staff intervi review, the facility fail emergency preparedr which provided emerg at least annually, mail emergency preparedr demonstrated staff kno procedures. Per regulations, facilit documentation of the annual training for all must include the spec well as the methods of knowledge of the train of the method, facilities	preparedness policies and cantly updated, the CAH on the updated policies and cantly updated, the CAH on the updated policies and cantly updated, the CAH on the updated policies and cantly in emergency and procedures to all new cividuals providing services and volunteers, consistent can describe the cantly updated policies, and maintain training. The CMHC must provide the cantly updated prov	E	037			

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E 037	that staff are knowled procedures. The surveyor reviewe maintenance director in new employee ories building tour to show emergency equipmen Records of drills with employees who partic staff performance were department. On 8/10/23, the corpor stated that there was or performance evaluations included emergency puring a summary meincluded the administration nursing, and the corpor surveyor informed administrations are concern with late INITIAL COMMENTS An unannounced Mecconducted 8/08/23 through a required for comperced for comp	d the EP plan with the on 8/10/23. The stated that EP was included ntation and included a employees where to find it and policy manuals. sign in sheets for cipated and comments on re stored in the maintenance or at clinical consultant no record of annual training ations for employees. This preparedness training. Seeting on 8/14/23 which rator, assistant director of crate clinical consultant, the ministrative staff that there ck of annual EP training. dicare/Medicaid survey was rough 08/14/23. Corrections liance with 42 CFR Part 483 are requirements. ere investigated during the impliant with regulations cient practice cited in-compliant with regulations		000			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C 495417 B. WING 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) (D (D (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) Continued From page 6 F 000 4. VA00059341 - Non-compliant with regulations with deficient practice cited VA00059492 - Compliant with regulations The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample F677-D 12VAC 5-371-220 D and F consisted of 22 current resident reviews and 7 closed record reviews. **ADL Care Provided for Dependent Residents** F 677 F 677 1. Grooming and nail care has been SS=D | CFR(s): 483.24(a)(2) provided resident's #44 and #71. §483.24(a)(2) A resident who is unable to carry 2. All residents have the potential to be out activities of daily living receives the necessary impacted by the alleged deficient services to maintain good nutrition, grooming, and personal and oral hygiene; practice. A quality monitoring audit will This REQUIREMENT is not met as evidenced be conducted by nursing/therapy, for bv: those resident dependent upon staff for Based on observation, staff interview, resident grooming and nail and issues interview, family interview, clinical record review, and facility document review, the facility staff addressed. failed to provide activity of daily living (ADL's) care for 2 of 29 dependent care residents. 3. The DON/designee will re-educate Resident #44 and #71. nurses and aides on ADL care for dependent residents focusing on The findings included: grooming and nail care. 1. For Resident #44, the facility staff failed to The Unit Managers will review provide ADL care. Resident #44 was observed to scheduled showers/baths weekly and have long fingernails and facial hair. will ensure grooming and nail care Resident #44's diagnoses included, but were not provided as indicated. Those residents limited to Parkinson's disease, unspecified that refuse routine care will be care dementia, major depressive disorder, difficulty in planned. Issues identified will be walking, and muscle weakness. addressed immediately and reviewed at the next IDT meeting. Section C (cognitive patterns) of Resident #44's

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495417 B. WING 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 677 Continued From page 7 F 677 4. The DON/designee will conduct a significant change minimum data set (MDS) random quality monitoring of grooming assessment with an assessment reference date and nail care for 10 residents weekly for (ARD) of 07/25/23 included a brief interview for 6 weeks to determine compliance with mental status (BIMS) summary score of 3 out of a ADL care. The findings of the quality possible 15 points. monitoring will be reported to the Resident #44's comprehensive care plan included Quality Assurance/Performance the focus areas resident and/or family have Improvement Committee monthly. The chosen comfort care, impaired visual function. quality monitoring schedule may be ADL self-care performance deficit. modified based on findings with communication problem, and impaired thought processes. quarterly monitoring by the Administrator/designee. 08/08/23 during initial tour Resident #44's family expressed a concern to the surveyor regarding 5. PoC compliance date is 9-12-23 Resident #44's facial hair. The surveyor observed the residents nails to be long on both hands. 08/08/23 4:10 p.m., during an observation of Resident #44 the Director of Nursing (DON) stated Resident #44 refused to be shaved at times. The DON acknowledged Resident #44's fingernails were long and needed trimming. The clinical record included a progress noted documented by the DON on 08/08/23 at 6:02 p.m., stating the residents fingernails were trimmed, face shaved with part of moustache left intact. 08/08/23 4:42 p.m., end of day meeting with the Administrator, DON, Assistant Director of Nursing, Regional Director of Clinical Services. and Regional Director of Operations. The issue regarding Resident #44's nails and facial hair was reviewed. No further information regarding this issue was provided to the survey team prior to the exit

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495417 B. WING 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 677 Continued From page 8 F 677 conference. 2. For Resident #71, the facility staff failed to provide ADL care to include bathing for a dependent care resident. Resident #71's diagnoses included, but were not limited to, type 2 diabetes, gastro-esophageal reflux disease, bipolar disorder, difficulty in walking, polyneuropathy, an anxiety disorder. Section C (cognitive patterns) of Resident #71's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/28/23 included a brief interview for mental status (BIMS) summary score of 15 out of a possible 15 points. Section G (functional status) was coded 3/3 (extensive assist) of 2 people for bed mobility, transfers, dressing, toilet use, and personal hygiene. Bathing was coded 3/2 for requiring physical help in part of bathing activity, one-person physical assist. Resident #71's comprehensive care plan included the focus areas requires assistance with ADLs and resident noted to refuse various aspects of nursing care. 08/09/23 9:15 a.m., Resident #71 was observed lying in bed, disheveled in appearance, stated they had been at the facility since 2022. When asked about showers/baths Resident #71 stated they had to ask, you can't get one unless it's your scheduled day, they were supposed to get two showers a week and their scheduled days were Wednesday and Saturday. Resident #71 stated

without getting one.

the staff don't give showers at the facility on Saturday and as for a bed bath you can go days

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F 677	there was documenta #71 received 5 shows 06/12, 06/16, and 06/ documentation to ind 5 showers/baths (07/ 07/24). The facility fa documentation regard 1-August 7 2023, the Resident #71 receive 2. There was no documentation to ind	ed the residents ocumentation from the month of June 2023 ation to indicate Resident ters/baths (06/05, 06/08, (21). For July 2023 there was icate Resident #71 received 01, 07/05, 07/16, 07/20, and tilled to provide any ding 07/12/23. For August facility documented d 1 bath/shower on August umentation to indicate the		377				
	(C.N.A.) #4 stated be day and the shower to #71 was observed conduring this interview. 08/09/23 11:16 a.m., part of the shower test baths two times a we room numbers, aides and Sunday was a model of the work of the showers two to improve and they report.	he Director of Nursing enerally try and do a week. They were looking now had a shower team on						
		e surveyor with a copy of a Resident." This policy						

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F 677	assist residents with the bathing/hygiene option hygiene and help prescare provided in Point The shower book at the documentation to indiffere resident resided in has on Wednesday and State residents electron #71 had been in this state of the interest of the listen of	e practice of this facility to their choice of one to maintain proper event skin issuesRecord to Click Care Point of Care" the nurses station included to the room that this ad shower/baths scheduled that the same room since 05/28/23. The practice of the day of the day of the residents and Assistant Director of arding the residents	F6		F684-D 12 VAC 5-371-220 A		
F 684 SS=D	S 483.25 Quality of ca Quality of care is a fur applies to all treatment facility residents. Base assessment of a resident residents receive accordance with profer practice, the compreher care plan, and the resident REQUIREMENT by: Based on clinical recoveriew, and staff inter	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of nensive person-centered	F	2.	Resident #359 no longer reside facility. The facility recognizes antibiotic ceftin for resident #4 not administered per MD order facility recognizes that the anticeftriaxone and Bactrim were administered per MD order. All residents have the potential impacted by the alleged deficity practice. A quality monitoring be conducted by nursing for worders and antibiotic since 8/1 ensure MD orders were complianticated.	that the 44 was er. The ibiotics, not al to be ent audit wiveight 1/23/23	ill

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F 684	29 residents records #71) The findings include: 1. For resident #359, obtained weights thre by the physician. Resident #359's dem diagnoses that includ acute on chronic syst hyponatremia, hypert malnutrition, obesity, The admission minim assessment reference assigned resident #359 were cognitively interesting and Nutri #359 was coded as hadmission. Under Seconded as receiving directions weekly. Resident #359's physoorder dated 6/1/2023 three times weekly. The hospital dischargifacility upon resident	the facility staff failed to be times weekly as ordered ographic sheet listed led but was not limited to, solic congestive heart failure, sension, mild protein calorie depression and anxiety. Sum data set (MDS) with an led date (ARD) of 6/3/2023 59 a brief interview for secore of 15 indicating they let. Under Section K, tion of the MDS, resident leaving a weight loss prior to ction N, resident #359 was furetics. Sician orders included an for weights to be obtained les summary sent to the #359's admission was	F	684	3. The DON/designee will nurses on nursing assess admission process/sche The DON/designee will nurses and aides on the care to all residents as documentation in the 8 both PCC and POC The UMs/designee will documentation in the comeeting to ensure come documentation. The UMs/designee will admission charts in the meeting to ensure come admission assessments 4. The DON/designee will random quality monitor residents per week to assessments and POC was captured according The findings of the quality will be reported to the Assurance/Performance Committee monthly. The process of the process of the quality monitor and pockets are processed to the Assurance/Performance Committee monthly. The process of the quality monitors are processed to the Assurance/Performance Committee monthly. The process of the quality monitors are processed to the Assurance/Performance Committee monthly. The process of the quality monitors are processed to the Assurance/Performance Committee monthly. The processed to the process of the quality monitors are processed to the Assurance/Performance Committee monthly. The process of the quality monitors are processed to the Assurance/Performance Committee monthly. The process of the quality monitors are processed to the Assurance Performance Committee monthly.	ssment: edule. edule. educat e provis needed EMR to review daily cli apliance review e daily cli apliance conduction pring au ensure docume gly. ality mo Quality ce Impr	s and the se both sion of and include the POC nical with new linical with ct a dit of 10 admission entation onitoring
	discharge summary r weight assessment: a	w up instructions, the ead in part,"3 time a week adjust diuretics accordingly." a copy of resident #359's			monitoring schedule n based on findings with monitoring by the	quarte	
	weight record. Accord document, the order There were two weigh	ding to the Weight Summary was not followed as written. hts recorded for week one, he same day 6/2/2023 at 34			Administrator/designe 5. The PoC compliance designer		-12-23

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/25/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ 495417 B. WING 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ľD (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 684 Continued From page 12 F 684 minutes apart. There were three weights on three different days for week two. There were two weights documented for week three, week four and week five and one weight documented for week six The care plan for resident #359 was reviewed. A problem statement that read in part, "the resident has nutritional problem or potential nutritional problem." Under interventions the care plan read in part, "Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (cachexia), muscle wasting, significant weight loss: 3 lbs in 1 week, >5% in 1 month, > 7.5% in 3 months, > 10% in 6 months." 8/11/2023 at 9:46 AM surveyor met with the Assistant Director of Nursing (ADON) to discuss this concern. They stated that the previous ADON and Director of Nursing (DON) were in charge of ensuring weights were done per order and being documented. They stated they looked in their weight book and found weights on resident #359 that were not in the record. The ADON gave surveyor a post-it note with dates and weights written on it. The note had no resident name and was not attached to any official facility document or clinical record. The survey team met with the Administrator, ADON and Regional Nurse Consultant on 8/14/2023 at 9:46 AM and this concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference. 2. For Resident #44, the facility nursing staff failed to administer the antibiotic medication Ceftin as ordered by the provider.

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F 684	limited to Parkinson's dementia, major deprivalking, and muscle with significant change mines assessment with an at (ARD) of 07/25/23 indices mental status (BIMS) possible 15 points. Resident #44's compite focus areas reside chosen comfort care, had ADL self-care percommunication proble processes. Resident #44's clinical order for Ceftin 500 m 8 days on 07/06/23 and 07/07/23 the order was tab twice a day for 3 done dose on 07/06/23. For dose on 07/07/23 the order was tab twice a day for 3 done dose on 07/07/23. 08/10/23 3:45 p.m., the (DON) reviewed the Cacknowledged reside doses of the antibiotic 08/11/23 4:38 p.m., the Regional Director of Caware that Resident #4.	oses included, but were not disease, unspecified ressive disorder, difficulty in weakness. Coatterns) of Resident #44's nimum data set (MDS) assessment reference date cluded a brief interview for summary score of 3 out of a rehensive care plan included rent and/or family have impaired visual function, and impaired thought all record included a providering 1 tab two times a day for Resident #44 received one on one dose on 07/07/23. On as changed to read Ceftin 1 days. Resident #44 received and two doses on the Director of Nursing Ceftin orders and on the Administrator and operations were made that antibiotic Ceftin was not	F	684	DEFICIENCY)			
	given per the provide	rs orders.		ĺ			And the second s	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		(X3) DATE COMP	
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F 684	provided to the survey conference. 3. For Resident #71, failed to administer the Ceftriaxone and Baction Resident #71's diagnolimited to, diabetes, godisease, bipolar disorpolyneuropathy, and section C (cognitive property minimum day with an assessment of 6/28/23 included a bitatus (BIMS) summa possible 15 points. 08/09/23 9:15 a.m., Received their medical and sometimes they be cidentified the following antibiotic medication oprovider ordered 1-group bedtime for urinary transmistrations on 07 #71's medication administrations on 07 #71's medication administration admin	the facility nursing staff e antibiotic medications rim per the providers orders. Deses included, but were not astro-esophageal reflux der, difficulty in walking, anxiety disorder. Determine the termine the set of the termine the te	F	684				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 690 SS=D	with nine alert and ori facility the consensus was no issue with reconstruction of the consensus was no issue with reconstruction of the construction of the construct	group meeting was held entated residents of the of the group was that there eiving their medications. The Director of Nursing sident #71 received one in in July. The Administrator and Diperations were made regarding Resident #71's The regarding this issue was to team prior to the exit thence, Catheter, UTI (3) The ce. Sility must ensure that thent of bladder and bowel on ervices and assistance to sinless his or her clinical the such that continence is ain.	F 69		ation and atheters pacted by ce will be nanagement		
	catheterization was notice (ii) A resident who end			3. The DON/designee will e clinical staff on the expecta anchoring foley catheters			

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OMB NO. 0938-0391

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F 690	is assessed for remoras possible unless the demonstrates that ca and (iii) A resident who is receives appropriate prevent urinary tract i continence to the extension of the ext	val of the catheter as soon a resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's asment, the facility must t who is incontinent of bowel treatment and services to hal bowel function as is not met as evidenced in, resident interview, staff record review, the facility an indwelling foley catheter Resident #85.	F	-	conduct a audit of 5 5 weeks to indicated. monitoring e Quality provement e quality e modified quarterly the

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indwelling foley cath Resident #85's comp the focus area obstor retention catheter, re (04/11/23). 08/09/23 8:25 a.m., resting on bed, foley When asked if the fo strapped/secured/an it had never been str it but it's never done down. Resident #85 the surveyor did not be anchored. 08/10/23 8:30 a.m., their foley catheter w if it got in their way the adjust it. 08/10/23 2:20 p.m., Assistant Director of that Resident #85's for anchored. 08/11/23 4:38 p.m., Regional Director of aware of the issue re catheter not being see No further information provide to the survey conference. Parenteral/IV Fluids	prehensive care plan included active uropathy and urinary readmitted with foley catheter. Resident #85 was observed catheter on side of bed. Iley catheter was chored Resident #85 stated apped, staff had talked about a sometimes it just hangs in pulled the covers back and observe the foley catheter to resident #85 again stated was not anchored and stated he staff would come and the Director of Nursing and Nursing were made aware foley catheter was not anchored and stated he staff would come and resident #85's foley ecured.		F694D			
CFR(s): 483.25(h)			1. Resident # 209's IV according to the second seco	cess has been		
	SUMMARY'S (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY OR RESIDENCE AND THE FORM	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 indwelling foley catheter. Resident #85's comprehensive care plan included the focus area obstructive uropathy and urinary retention catheter, readmitted with foley catheter (04/11/23). 08/09/23 8:25 a.m., Resident #85 was observed resting on bed, foley catheter on side of bed. When asked if the foley catheter was strapped/secured/anchored Resident #85 stated it had never been strapped, staff had talked about it but it's never done, sometimes it just hangs down. Resident #85 pulled the covers back and the surveyor did not observe the foley catheter to be anchored. 08/10/23 8:30 a.m., Resident #85 again stated their foley catheter was not anchored and stated if it got in their way the staff would come and adjust it. 08/10/23 2:20 p.m., the Director of Nursing and Assistant Director of Nursing were made aware that Resident #85's foley catheter was not anchored. 08/11/23 4:38 p.m., the Administrator and Regional Director of Operations were made aware of the issue regarding Resident #85's foley catheter not being secured. No further information regarding this issue was provide to the survey team prior to the exit conference. Parenteral/IV Fluids	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 17 indwelling foley catheter. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE \$14 NORTH MAIN STREET SUMMARY STATEMENT OF DEFICIENCIES (ECAT DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 17 Indiwelling foley catheter. Resident #85's comprehensive care plan included the focus area obstructive uropathy and urinary retention catheter, readmitted with foley catheter (04/11/23). 08/09/23 8:25 a.m., Resident #85 was observed restling on bed, foley catheter as strapped/secured/anchored Resident #85 stated it had never been strapped, staff had talked about it but it's never done, sometimes it just hangs down. 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F 694	§ 483.25(h) Parente Parenteral fluids mu with professional state accordance with phy comprehensive personal state accordance with phy comprehensive personal state accordance with phy comprehensive personal state resident's goals. This REQUIREMEN by: Based on staff interest the facility staff failed policy for 1 of 29 sar #209). Resident #209 was a multiple diagnoses in diabetes mellitus, modysphagia, atheroso obstructive pulmona infarction, and heart Data Set assessment date 5/4/2022, the resident had impaired. Clinical record review.	ral Fluids. st be administered consistent indards of practice and in visician orders, the on-centered care plan, and and preferences. T is not met as evidenced view, clinical record review d to remove an IV access per impled residents. (Resident admitted to the facility with including encephalopathy, porbid obesity, hypertension, lerotic heart disease, chronic ry disease, sepsis, cerebral failure. On the Minimum int with assessment reference in with a status, indicating the indica	F 694		ave the alleged will be with IV place to educate n order dicated. IV y to eir ct a s of or 6	
	dated 5/5/2022 for Sodium chloride 0.9% use 1 liter one time only for dehydration for 1 day 300 ml (milliliter) bolus then run at 125 ml per hour until complete. A nursing Health Status Note dated 5/5/2022 at 18:51: Note Text: IV placed by this nurse, to left AC X 1 attempt without difficulties. Flushes and is patent, IV fluids initiated. A nursing skilled note dated 5/5/2022 at 23:46 noted under Special Care: IV device: Peripheral cannula. Hep lock/buff cap: Yes.			indicated. The findings of the question monitoring will be reported to the Quality Assurance/Performance Improvement Committee month quality monitoring schedule may modified based on findings with quarterly monitoring by the Administrator/designee.	ality ne ly. The v be	
	ac Peripheral IV is p dated 5/6 through 5/	022 12:00 AM IV location: left atent. Skilled nursing notes 11/2022 were blank under mention was made of IV		5. The PoC compliance date is 9-	12-23	

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F 710	a facility. Each reside care of a physician. A assistant, nurse pract specialist must provid immediate care and respecialist must provid immediate care and respecialist must provid immediate care and respective for facility must ensure supervised by a physician is unavailable. This REQUIREMENT by: Based on clinical recreview, and staff interto ensure medical supersidents review. (Respectively, and staff interto ensure medical supersidents review. (Respectively) included. The findings included. For resident #96 the findings included. For resident #96 the findings included. Resident #96's demodiagnoses that include paroxysmal atrial fibriobesity due to excess apnea, type 2 diabeted dementia, adjustment mood and gastro-eso.	an individual be admitted to ent must remain under the A physician, physician itioner, or clinical nurse le orders for the resident's needs. Supervision. Ire that- edical care of each resident ysician; Ir physician supervises the ents when their attending ole. It is not met as evidenced ord review, facility document yiew the facility staff failed pervision of care for 1 of 29 is #96) Edicality staff failed to ensure diffied of and addressed a segraphic sheet listed end but was not limited to,	F 7	10	2. All current residents with weight orders have the potential to be impacted by the alleged deficient practice. A quality monitoring audit will be conducted and the MD will be not of significant weight changes. 3. The DON/designee will educate nursing management team on phrotification with significant weight changes. The UMs will review weights in the weekly RISK meeting and ensure the medical team has been notification with changes and proorders as indicated. 4. The DON/designee will conduct random quality audit of significant weight losses weekly for 6 weeks significant weight change for 5 reto ensure proper medical team notification and follow up. The first of the quality monitoring will be reported to the Quality Assurance/Performance Improve Committee monthly. The quality monitoring schedule may be most based on findings with quarterly monitoring by the	e the ysician t echat ed of ovided et a t of sidents eddings	48	
	that in April of 2023 th		4 6 7		monitoring by the			

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	indication the physicial loss or the RD recommasked the DON if they physician to be notified recommendations to stated, "absolutely, I will be surveyor request entitled, "Weight Monof 12/1/2022. The pol Documentation: the pof a significant change nutritional intervention." The survey team met Assistant Director of Clinical Seconcern was reviewed. No further information team prior to the exit Competent Nursing SCFR(s): 483.35(a)(3)(a)(b)(b)(a)(b)(c)(c)(c)(c)(c)(c)(c)(c)(c)(c)(c)(c)(c)	an was notified of the weight mendations." Surveyor would have expected the ad and the dietician's be instituted and they would." ed and received the policy itoring" with a revised date icy read in part, "7. hysician should be informed e in weight and may order hs." with the Administrator, Nursing, and the Regional exices on 8/14/2023. This diet with them at that time. It was provided to the survey conference. It was provided to the survey conference.	F 7	26 1.	F 726D 12 VAC 5-371-210 B Licensed nurse staff have not identified for completion of competencies. All residents have the potent impacted by this alleged defipractice. A quality monitorin be completed on the compelicensed nurses to ensure the has been completed.	their tial to be icient g audit w tencies o	vill of

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F 726	licensed nurses have and skill sets necessareds, as identified the assessments, and de §483.35(a)(4) Providi limited to assessing, implementing resident to resident's needs. §483.35(c) Proficience The facility must ensure to demonstrate competechniques necessary needs, as identified the assessments, and de This REQUIREMENT by: Based on staff intervively review the facility staff nurses have the species necessary to carridentified through residentified through residescribed in the plan. The findings were: During a review of refuncidents (FRIs) with director of clinical ser of operations (DOO) the RDCS reported a 06/30/23 and 07/01/2 their business office reported to be a regis presented the facility verification document	the specific competencies ary to care for residents' nrough resident scribed in the plan of care. In g care includes but is not evaluating, planning and t care plans and responding If y of nurse aides. If that nurse aides are able etency in skills and y to care for residents' arough resident scribed in the plan of care. If is not met as evidenced it was and facility document if failed to ensure licensed iffic competencies and skill e for residents' needs, as ident assessments, and of care. Cent Facility Reported the administrator, regional vices (RDCS), and director on 08/09/2023 at 1:32 p.m., in incident which occurred on 3. The facility discovered manager (BOM) who stered nurse (RN) and	F	726	 The DON/designee will proviservice education to the nurmanagement and HR/BOM monitoring of licensed nurse competencies are complete indicated. A tracking log will developed to track the composition competencies for current number hires will be added and competencies completed doorientation period. The DON/designee will congrandom quality monitoring competency tracking weekly weeks to ensure that require competency education is confused additional training and/or confused action. The findings of the monitoring will be reported Quality Assurance/Perform Improvement Committee in quality monitoring schedule modified based on findings quarterly monitoring by the Administrator/designee. The PoC compliance date is 	sing on the es to ensu d as l be pleted urses and their uring thei duct a audit of y for 6 ed empleted. ited with orrective quality to the ance nonthly. The with e may be with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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F 726	facility staff realized a nurse on orientati passing medication on 06/30/23 did not license. That BOM medications, on 07 hours; those were the employee staffed the 07/05/23, facility staworked as a nurse license verification. The employee had having the same redays. On 08/11/23 at 9:28	or of clinical services reported of the BOM who had worked as ion (with another nurse) is for approximately four hours a actually possess a nursing worked as a nurse, passing //01/23 for approximately 12 the only two days this are facility as a nurse. On aff verified the BOM who had on two dates, had provided a with someone else's name. provided care to 24 residents, is ident assignment on both	F7	26			
	found for the BOM The RDCS reported any nurse working competency check The concern regard training/competency discussed with the director of nursing, services at a summa 11:56 a.m. The RE had provided the sithey had to provided Nurse Aide Peform CFR(s): 483.35(d)(7) Regular RDCS reported to the sith the sit	ency check off documentation who had worked as a nurse. In the expectation would be for on the floor to have a off document. It ding lack of the expectation was administrator, assistant and regional director of clinical many meeting on 08/14/23 at DCS stated she believed they curvey team with everything the expectation. Review-12 hr/yr In-Service	F 7	F730E 12 VAC 5-371-260 30 1. CNA#3, CNA#14, CNA performance evaluation them and follow up educ completed as indicated.	#7 have had a reviewed with		

OLITICI	COT OIL MEDIONILE C	MEDIONID OFICEO				CIVID INC	/. U930-U391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 730	Continued From page	Continued From page 25			F 730 2. All residents have the potential to be			
	of every nurse aide a		1		impacted by the alleged deficient	1		
		ovide regular in-service				1	:	
	education based on the	•			practice. A quality monitoring au	JIT WIII		
		aining must comply with the			be completed by the HR/BOM to			
	requirements of §483				determine current CNA evaluation	1		
	This REQUIREMENT	is not met as evidenced			status.			
	by:							
	Based on staff interview and facility document review, the facility staff failed to complete a review of every nurse aide at least every 12 months and failed to provide regular in-service		3.5		3. The Administrator will educate	the		
					DON and HR/BOM regarding annu			
						- 1		
					evaluations. A tracking log will be			
	education based on the reviews.	ne outcome of these			developed to track evaluations for			
	reviews.		current aids and new hires will be					
	The findings included	•			added to track when their evaluat	ions		
	THO IIIIdiii.go iiioidood	•			become due.	-		
	The facility administra	itive staff failed to complete			5			
		se aide at least every 12			4. The Administrator will conduct			
		provide regular in-service	-					
	education based on the	ne outcomes of	İ		random quality monitoring audit			
	reviews/evaluations.				evaluations of 5 CNAs weekly for			
					weeks to ensure they are being tr	acked		
		ne Assistant Director of			and their evaluations/follow up			
		given 5 names of Certified			education is completed as indicat	ed.		
	Nursing Assistants(C				The findings of the quality monitor			
	reviewed for performa	ance reviews/evaluations.			will be reported to the Quality	" III B		
	08/10/23 9:25 a.m., th	an ourrest Director of						
		led the survey team with a			Assurance/Performance Improve	nent		
	document titled, Job (•			Committee monthly. The quality			
		ds dated 11/2018. This			monitoring schedule may be mod	ified		
		signed by C.N.A. #3. The			based on findings with quarterly			
		d not find anything further,			monitoring by the			
		rformance evaluations to be			Administrator/designee.			
		and they had been the DON			Administrator/designee.			
	approximately 3 or 4 weeks.							
					5. The PoC compliance date is 9-1	.2-23		
	08/10/23 2:20 p.m., d	uring a meeting with the						
	DON and ADON thee	e staff stated Nurse Aide						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			514 N	EET ADDRESS, CITY, STATE, ZIP CODE NORTH MAIN STREET VAL RETREAT, VA 24368		<u> </u>	14/2023
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F 730	12 months and the for person who would had completing performant spoken with different staff stated it had been also been given performance evaluated think they had one. On the performance evaluated a written evaluation of their policy titled, "on their policy titled, "o	were not completed every rmer DON was the staff we been responsible for noe reviews. They had staff members, and these en quite a while since they rmance evaluations. C.N.A. #14 was asked about ation and stated they did not e.N.A. #7 stated they had not ion. the ADON stated they had 3 administrators in the last 6 the survey team with a copy Competency Evaluation" this is the policy of this facility to yee to assure appropriate ills for performing his or her eeds of facility competency forms are	F	730				
	08/11/23 4:38 p.m., the Regional Director of Caware of the issue reperformance reviews.	Operations were made garding the missing						
		the Regional Nurse stated s they may be able to find ough to satisfy the						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ C 495417 B. WING 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 10 (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 730 | Continued From page 27 F 730 No further information regarding this issue was provided to the survey team prior to the exit conference. F 812 | Food Procurement, Store/Prepare/Serve-Sanitary F 812 F812D 12 VAC 5-371-340 A SS=D | CFR(s): 483.60(i)(1)(2) 1. The salsa and French dressing have §483.60(i) Food safety requirements. been disposed up. The facility must -§483.60(i)(1) - Procure food from sources 2. All residents have the potential to be approved or considered satisfactory by federal, impacted by the alleged deficient state or local authorities. practices. A quality monitoring audit will (i) This may include food items obtained directly be completed by the dietary supervisor from local producers, subject to applicable State and local laws or regulations. of the refrigerators in the nutrition (ii) This provision does not prohibit or prevent pantries for proper storage and dating of facilities from using produce grown in facility foods. 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. 3. The Administrator will re-educate the dietary and nursing staff on the §483.60(i)(2) - Store, prepare, distribute and expectations of food procurement. serve food in accordance with professional standards for food service safety. storage and preparation of foods to This REQUIREMENT is not met as evidenced include use by date. The dietary bv: supervisor will conduct weekly Based on observation, staff interview, and facility walkthroughs of the nutrition pantries document review, the facility staff failed to store, prepare, distribute and serve food in accordance area focusing on proper storage, dating with professional standards for food service of food expirations and/or use by dates. safety. 4. The Administrator/designee will conduct The findings include: a quality monitoring audit of the kitchen On 8/9/2023 at 2:20 PM Surveyor entered the pantries weekly for 6 weeks focusing on East wing nutrition room to check the residents the storage and dating of foods. refrigerator. In the door of the refrigerator, a jar of The findings of the quality monitoring

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F 812	Great Value Thick and expiration date of Apr The salsa had initials marker and had been to indicate when the jim On 8/9/2023 at 2:36 F. West wing nutrition roobserved a bottle of K an expiration of 8/9/20 opened. There were robottle and there was robottle had been opened. On 8/9/2023 at 2:24 F. LPN #3 who discarded dietary is responsible refrigerator and ensuredate or expired. On 8/9/2023 at 2:38 F. LPN #1 who discarded that dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietary generally the refrigerator are dastated that with no resident dietar	d Chunky Salsa with an il 1, 2023, was observed. written in permanent opened. There was no date ar had been opened. PM Surveyor checked the om refrigerator and fraft French Dressing with 2. This bottle had been no initials written on the no date to indicate when the ed. PM surveyor interviewed d the salsa and stated that for maintaining the ring things are not out of the dressing and stated makes sure that the items in sted and not expired. They sident name or initials the belonged to a staff member. Surveyor requested and a policy entitled "Date ety" with a revised date of read in part, "2. The food and to indicate the date or day all be consumed or rking system shall consist of of opening, and day/date the ed or discarded. 5. The lay not exceed the	F.	812		provemo e qua e modif quarte	ent lity ied

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preparation counts as or designee, shall be refrigerator daily for for and shall discard accordance. On 8/14/2023 at 11:5 with the Administrator Nursing and Regional Services and this contime. No further information team prior to the exit Resident Records - Ic CFR(s): 483.20(f)(5), §483.20(f)(5) Resident (ii) The facility may not resident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance with a re- (ii) Complete; (iii) Accurately docum (iii) Readily accessibl (iv) Systematically or §483.70(i)(2) The factors and standard for the standard for	s day one. 6. The head cook, responsible for checking the cod items that are expiring, ordingly." 6 AM the survey team met r. Assistant Director of I Director of Clinical Incern was discussed at that the was provided to the survey conference. Identifiable Information 483.70(i)(1)-(5) Int-identifiable information. Intelease information that is to the public. Intelease information that is the public of the public. Intelease information that is the public of the public. Intelease information that is the public of t		F842E 12 VAC 5-371-360 A 1. Resident #45 has had a medicate regime review by both the medicate team and the pharmacy. The facili recognizes that the result of Residerinto the clinical record as observed during the survey. LPNs#1 and #6 been educated to the proper documentation of accuchecks. 2. All residents with orders for accuchecks and those that receives medication regime reviews have to potential to be impacted by the adeficient practice. A quality monital audit will be completed by the DC medication regime reviews for the	ity ity dent ed d have he lleged toring DN of	
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	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page preparation counts as or designee, shall be refrigerator daily for for and shall discard accomposed on the exit of the exit	CORRECTION A95417 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 preparation counts as day one. 6. The head cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly." On 8/14/2023 at 11:56 AM the survey team met with the Administrator, Assistant Director of Nursing and Regional Director of Clinical Services and this concern was discussed at that time. No further information was provided to the survey team prior to the exit conference. Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) \$483.20(f)(5) Resident-identifiable 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 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) Medical records. \$483.70(i) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	CORRECTION A BUILDING 495417 B. WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 preparation counts as day one. 6. The head cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly." On 8/14/2023 at 11:56 AM the survey team met with the Administrator, Assistant Director of Nursing and Regional Director of Clinical Services and this concern was discussed at that time. No further information was provided to the survey team prior to the exit conference. Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) \$483.20(f)(5) Resident-Identifiable 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 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) Medical records. \$483.70(i) 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,	TREAT CARE CENTER SUMMANY STATEMENT OF DEPICIENCIES EACH DEPCIENCY WILLST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 preparation counts as day one. 6. The head cook, or designee, shall be responsible for checking the refrigerator daily for food items that are expiring, and shall discard accordingly.* On 8/14/2023 at 11:56 AM the survey team met with the Administrator, Assistant Director of Nursing and Regional Director of Clinical Services and this concern was discussed at that time. No further information was provided to the survey team prior to the exit conference. Resident Records - Identifiable Information. (i) A facility may not release information that is resident-identifiable to an agent only in accordance with a contract under which the agent 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) Medical records on each resident that are- (iii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized DETRICATE ARCH CENTER STRIBLA TRIBLAT, VA 24388 DEPRIFY, VA 24388 TRUBAL RETREAT, VA 24388 DEPRIFY, VA 24388 DEPRIFY, VA 24388 TRUBAL RETREAT, VA 24388 DEPRIFY, VA 24388 DEPRIFY, VA 24388 TRUBAL RETREAT, VA 24388 DEPRIFY, VA 24388 DEPRIFY, VA 24388 TRUBAL RETREAT, VA 24388 DEPRIFY AND OR CORDS-REPREVENCED TO THE APPROPRIFY AND OR CROSS-REPREVENCED TO THE APPROPRIFY	

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F 842	(vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on staff intervireview the facility staff complete medical recresidents with a media recommendations and residents in the surversidents Note that the surversidents in the surversidents were commendations. Note that the surversidents in the surversident recommendations were commendations were commendations were commendations were commendations. The placed in the clinical recommendations. The placed in the clinical recommendations. The clinical record if there clinical record if there clinical record if there clinical record if the recommendation regimen recommendations. The placed in the clinical record if there clinical record if the clin	ogy and other diagnostic equired under §483.50. I is not met as evidenced siews and clinical record failed to maintain a ord on each resident for all cal regimen review without d also for two of 29 y sample. Inedication regimen reviews, e to locate routine monthly eviews after Decembers had documented o regimen reviews without re recorded in the clinical sked nursing staff where eviews without	F 84	based on findings with quarterly monitoring by the Administrator/designee. 5. The PoC compliance date is 9-	

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F 842	interview for mental s without signs of delirit affecting care. During clinical record find monthly medicatistaff provided a list of recommendations made July 2023. Recommented to change levothyroxileast 4 hours apart from 30-60 minutes prior to Recommendations or levothyroxine administapart from iron administrator to food or enterations of the stimulation of the levothyroxine and the levothyroxine and the levothyroxine and please consider of This recommendation when Medication Regionducted 7/1-7/28/2	review, the surveyor did not on regimen reviews. Facility residents reviewed and ide from January through endations included 5/16/23 in administration to be at om iron administration and o food or enteral feedings. In 6/24/23 included to change stration to be at least 4 hours instration and 30-60 minutes of feedings and added that ing hormone) was high in roxine dose was increased changing times on the MAR. It was listed as still pending itimen Reviews were 1023.	F	842			
		the facility nursing staff sults of blood sugars (BS) in					

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F 842	Resident #71's diagnostic properties of the prop	pases included diabetes. Patterns) of Resident #71's at set (MDS) assessment reference date (ARD) of the interview for mental and score of 15 out of a dicating Resident #71 was rehensive care plan included a mellitus. Interventions at timited to, diabetes diby doctor, monitor needed any signs symptoms or	F	842			
	BS on the MAR for th	e dates in question. le to identify 2 other nurses					for all the second seco

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE	SURVEY PLETED	
		495417	B. WING		- 1	C	
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 08	/14/2023	
RURAL RI	ETREAT CARE CENTER			514 NORTH MAIN STREET RURAL RETREAT, VA 24368			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 842	required. Both nurses the MARs. 08/11/23 9:15 a.m., Li (LPN) #1 (unit manag system does not alert The surveyor identified document the BS as I stated this nurse was leave. 08/10/23 2:20 p.m., d Director of Nursing ar Nursing the missing d Resident #71's BS was 08/11/23 4:38 p.m., th Regional Director of O	included the BS results on censed Practical Nurse er) stated the software the nurse to put in a BS. d the nurse who did not LPN #6. The unit manager currently out on extended uring a meeting with the ad Assistant Director of ocumentation regarding as reviewed.	F8	42			
F 851 SS=D	provided to the survey conference. Payroll Based Journa CFR(s): 483.70(q)(1)- §483.70(q) Mandatory information based on format. Long-term care facilities submit to CMS comples staffing information, in agency and contract so other verifiable and according to the conference.		F 8	F851D 1. The facility recognizes that electronic staff information w submitted to CMS for the 2 quereviewed during the survey. 2. All residents have the pote impacted by the alleged deficing practice. A quality monitorin will be completed by the HR/the Payroll Based Journal reprocess. CMS since August 14th to ensuron compliance.	ntial to be ient g audit BOM of orting to		

PRINTED: 08/25/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ B. WING 495417 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 35 3. The Administrator will educate the §483.70(q)(1) Direct Care Staff. HR/BOM on Payroll Based Journal Direct Care Staff are those individuals who. submission expectations. The HR/BOM through interpersonal contact with residents or will provide the Administrator with resident care management, provide care and proof on a quarterly basis that the services to allow residents to attain or maintain the highest practicable physical, mental, and required documentation has been psychosocial well-being. Direct care staff does reported to CMS as indicated. not include individuals whose primary duty is maintaining the physical environment of the long 4. The Administrator will verify that the term care facility (for example, housekeeping). PBJ hours have been submitted §483.70(q)(2) Submission requirements. quarterly through transmission reports. The facility must electronically submit to CMS The findings will be reported to the complete and accurate direct care staffing Quality Assurance/Performance information, including the following: Improvement Committee monthly. The (i) The category of work for each person on direct care staff (including, but not limited to, whether quality monitoring schedule may be the individual is a registered nurse, licensed modified based on findings with practical nurse, licensed vocational nurse, quarterly monitoring by the QAPI certified nursing assistant, therapist, or other type Committee and or designee. of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and 5. The PoC compliance date is 9-12-23 tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 14 NORTH MAIN STREET URAL RETREAT, VA 24368	1 00/	14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED 8Y FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 851	The facility must subrinformation in the unit CMS. §483.70(q)(5) Submis The facility must subrinformation on the scibut no less frequently This REQUIREMENT by: Based on staff interview, the facility stasubmit staffing inform Medicare & Medicaid quarters. The findings included The facility staff failed staffing information to 31 and April 1-June 3 08/08/23 3:32 p.m., the confirmed to the survice payroll based journal submitted to CMS for 08/11/23 4:38 p.m., dimeeting with the Admit Director of Operations	nit direct care staffing form format specified by some format specified by some science of the care staffing nedule specified by CMS, than quarterly. I is not met as evidenced sew and Casper Report ff failed to electronically ation to The Centers for Services (CMS) for 2 I to electronically submit of CMS for January 1-March 0 2022. The current Administrator ey team that there was no (PBJ) documentation these 2 quarters. For evidence of the day inistrator and Regional some former company did not	F	851			
	provided to the surve conference.	n regarding this issue was y team prior to the exit Fraining for Nurse Aides -(4)	F	947	F947-E 12VAC5-371-260 B,	F	

PRINTED: 08/25/2023 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES. (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495417 B. WING 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (XS) COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 947 1. CNA staff have now been identified for F 947 | Continued From page 37 completion of their required training. §483.95(g) Required in-service training for nurse 2. All residents have the potential to be impacted by this alleged deficient In-service training mustpractice. An audit will been completed §483.95(g)(1) Be sufficient to ensure the on the required training for CNAs to continuing competence of nurse aides, but must ensure the required training has been be no less than 12 hours per year. completed. §483.95(g)(2) Include dementia management training and resident abuse prevention training. 3. The DON/designee will provide in-§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews service education to the ADON and and facility assessment at § 483.70(e) and may HR/BOM on the monitoring of staff address the special needs of residents as training to ensure requirements are met determined by the facility staff. and the facility will incorporate the new §483.95(g)(4) For nurse aides providing services electronic education program to aid to individuals with cognitive impairments, also with tracking. address the care of the cognitively impaired. 4. An audit will be completed by the This REQUIREMENT is not met as evidenced ADON/designee weekly for 6 weeks to bv: Based on staff interview and facility document ensure that required in-service review, the facility staff failed to provide 12 hours education is completed. Any variances of in-service training for nurse aides. will be corrected with additional training and/or corrective action. The The findings included: findings of the quality monitoring will The facility staff failed to provide nurse aides with be reported to the Quality 12 hours of in-service training. Assurance/Performance Improvement Committee monthly. The quality During the task sufficient and competent nurse monitoring schedule may be modified staffing the surveyor requested information regarding in-service training. based on findings with quarterly monitoring by the 08/09/23 4:15 p.m., the Director of Nursing Administrator/designee. (DON) stated they were unable to find training for 5. The PoC compliance date is 9-12-23

employees that was requested. The DON stated

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		NSTRUCTION		(X3) DATE COMP	SURVEY LETED
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F 947	left without notice, the records, and they were SDC. 08/11/23 12:28 p.m., Nursing (ADON) state DON's and Administration of the their policy titled, "Trapolicy read in part, "It develop, implement, atraining program for a individuals providing arrangement, and volexpected rolesDoct training will be forwar be placed into the ind accordance with facilit training records" 08/11/23 4:38 p.m., the Regional Director of the missing aide training. 08/14/23 11:05 a.m., they did not have the	elopment Coordinator (SDC) bey were unable to find their re in the process of hiring an other the Assistant Director of eld they had 3 different ators in the last 6 months. The Assistant Director of survey team with a copy of survey tea	F	947				

FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C VA0414 B. WING 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION. (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 000 Initial Comments F 000 An unannounced biennial State Licensure Inspection was conducted 8/08/23 through 8/14/23. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. Corrections are required. The census in this 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 22 current resident reviews and 7 closed record reviews. 12 VAC 5-371-75 A.3. There were five (5) complaints investigated. F 001 Non Compliance F 001 1. The facility recognizes that LPN #4's background check was not completed The facility was out of compliance with the until 3/15/2023 as observed during the following state licensure requirements: survey. This RULE: is not met as evidenced by: 2. All residents have the potential to be The facility was not in compliance with the impacted by the alleged deficient following Virginia Rules and Regulations for practice. A quality monitoring audit will Licensure of Nursing Facilities. be completed to ensure that all staff had a background check in their Management & Administration personnel file. 12 VAC 5-371-110 (B)(2) and (3) - cross reference to F-602 3. The Administrator will educate the **Nurse Staffing** HR/BOM and ABOM to the onboarding 12 VAC 5-371-210 (B) - cross reference to F-726 process related to obtaining background 12 VAC 5-371-210 (E) - cross reference to F-839 checks. The HR/BOM will provide the Administrator with verification of ran **Nursing Services** background checks weekly to cross 12 VAC 5-371-220 (A) - cross reference to F684 12 VAC 5-371-220 (D) and (F) - cross reference check with new hires.

LABORATORY DIRECTOR'S OFFROVIDER/SUPPLIED: REPRESENTATIVE'S SIGNATURE

10 ()-(m)(d)

12 VAC 5-371-220 (C) - cross reference to F-690

tam wistrator

30/23

to F-677

State of Virginia

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLI	CONSTRUCTION	(X3) DATE SURVEY	
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		VA0414	B. WING		08/14/2023	
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F 001	Continued From page		F 001	4. The Administrator will review	n	П
		•			±	
				weekly meetings prior to orienta		
	Physician Services			any new hires and if their backgr	1	
	12 VAC 5-371-240 (F)) - cross reference to F-710		checks were initiated as indicate	d	
	Ota# danalamana	article and a second	-	weekly for 6 weeks to ensure		
	Staff development and	<u> </u>		compliance with background che	cks.	
	to F-730) and (F) - cross reference				
	101-730			The findings of the quality monit	oring	
	Dietary and Food Ser	vice Program		The findings of the quality monit	OTHE	
) - cross reference to F-812		will be reported to the Quality		
	•	,		Assurance/Performance Improve	i	
	Clinical Records			Committee monthly. The quality	'	
	12 VAC 5-371-360 (A) - cross reference to F-842		monitoring schedule may be mo	dified	
				based on findings with quarterly		
	5		1	monitoring by the	29	
				Administrator/designee.		
	40)/405 074 75 /4 0)	Octobra da con contra altra altra		Administrator/designee.		
	12VAC5-371-75 (A.3)	. Criminal records check.			40.00	
	Based on staff intensis	ew, employee record review,		5. The PoC compliance date is 9-	12-23	
	facility document review			1		
		aff failed to obtain a criminal				
		thin 30 days of employment				
		state Police for 1 of 25 new			2.0	
	hires, new hire #20.					
	The findings included	:				
			ì		Į Į	
	The facility staff failed				ļ	
		ough the Virginia State				
	Police within 30 days					
	Practical Nurse (LPN	"").				
	Per the Code of Virgin	nia 12VΔC5-371-75				
		ecord report on applicants				
	l .	ployment from the Virginia			1	
		Police no more than 30			T.	
	calendar days after e					
	New hire #20 (LPN #	4) was hired at the facility				

State of Virginia

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
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NAME OF F	NOVIDER OR SUPPLIER		RESS, CITY, STA		
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F 001	Continued From page	2	F 001		-
	01/13/23. A criminal bethe Virginia State Poli 03/15/23. No identifia when the search was 08/10/23 2:20 p.m., the Assistant Director of a the issue regarding Libackground check. The facility staff provictopy of their policy titl Exploitation." This polemployees will be scrabuse, neglectBack	packground check through ice was not completed until ble records were returned completed. The Director of Nursing and nursing were made aware of PN #4's Virginia State Police ded the survey team with a led, "Abuse, Neglect and licy read in part, "Potential			
	No further information	n potential employees" In regarding this issue was by team prior to the exit			
	clinical record review, the facility staff failed bath 2 times a week of The findings included For Resident #71, the	erview, staff interview, , and the Code of Virginia, to provide a tub or shower or a bed bath daily.		 VAC 5-371-220 f. Resident #71 was provided a s during the survey All residents have the potential impacted by the alleged deficient practice. Clinical staff will be re-educated the DON/designee regarding process. 	il to be t ed by oviding
	receive tub or shower	nia "Each resident shall r baths as often as needed, e weekly. Residents whose		showers/baths weekly for reside the documentation that is to accompany it.	nts and

PRINTED: 08/25/2023 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING: B. WING VA0414 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 1D (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 001 F 001 Continued From page 3 The UMs will review bathing documentation prior to the clinical medical conditions prohibit tub or shower baths morning meeting to determine shall have a sponge bath daily." compliance with offering Resident #71's diagnoses included, but were not baths/showers. Issues will be limited to, type 2 diabetes, gastro-esophageal addressed immediately. They will reflux disease, bipolar disorder, difficulty in report their findings in the daily clinical walking, polyneuropathy, an anxiety disorder. meeting. Section C (cognitive patterns) of Resident #71's quarterly minimum data set (MDS) assessment 4. The DON/designee will conduct a with an assessment reference date (ARD) of random quality monitoring audit of 5 06/28/23 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 residents weekly for 6 weeks to ensure points. Section G (functional status) was coded compliance with baths/showers. The 3/3 (extensive assist) of 2 people for bed mobility, findings of the quality monitoring will transfers, dressing, toilet use, and personal be reported to the Quality hygiene. Bathing was coded 3/2 for requiring physical help in part of bathing activity, Assurance/Performance Improvement one-person physical assist. The MDS was coded Committee monthly. The quality to indicate this resident used a walker and/or monitoring schedule may be modified wheelchair for mobility. based on findings with quarterly monitoring by the Resident #71's comprehensive care plan included the focus areas requires assistance with activities Administrator/designee. of daily living (ADLs) and resident noted to refuse various aspects of nursing care. 5. The PoC compliance date is 9-12-23 08/09/23 9:15 a.m., Resident #71 was observed lying in bed, disheveled in appearance, stated they had been at the facility since 2022. When asked about showers/baths Resident #71 stated they had to ask, you can't get one unless it's your

scheduled day, they were supposed to get two showers a week and their scheduled days were Wednesday and Saturday. Resident #71 stated the staff don't give showers at the facility on Saturday and as for a bed bath you can go days

The surveyor reviewed the residents

without getting one.

State of Virginia

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
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INTING OF IT	NOVIDER OR SUFFLIER		DRESS, CITY, STA			
RURAL RETREAT CARE CENTER 514 NORT RURAL R			ETREAT, VA 24			
1940.15	CUMMARY CT.	——————————————————————————————————————	al es			
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F 001	Continued From page	2 4	F 001			
	13.7				†	
	bathing/showering do					
		he month of June 2023				
		ition to indicate Resident				
	1	ers/baths (06/05, 06/08,				
	1	21). For July 2023 there was cate Resident #71 received				
		01, 07/05, 07/16, 07/20, and	ł			
	07/24). The facility fai					
		ding 07/12/23. For August				
		documented Resident #71	ļ			
		er on August 2. There was				
	no documentation to					
		hs and no documentation to				
		received a bath/shower on a				
	Saturday.					
	08/09/23 11:14 a.m.	Certified Nursing Assistant				
		d baths were done every				
		eam did showers. Resident	-			
		come out of shower room	,			
	during this interview.					
	08/00/23 11:16	C.N.A. #5 stated they were				İ
		C.N.A. #5 stated they were am, the residents receive				
		ek, showers are done by				
	room numbers, the ai	_				
	showers, and Sunday					
		are and are and are are a second				
	08/09/23 1:00 p.m., th	ne Director of Nursing				
	(DON) stated they ge		-			
		a week. They were looking				
	to improve and they r	now had a shower team on			į.	
	board.					
	The DON provided th	a augment with a same of				
		e surveyor with a copy of a Resident." This policy				
		e practice of this facility to				
	assist residents with t		1			
		ns to maintain proper				
		vent skin issuesRecord				
	1 1.7 States mile track bio		_1	<u> </u>		

State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ С B. WING _ VA0414 08/14/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **514 NORTH MAIN STREET RURAL RETREAT CARE CENTER RURAL RETREAT, VA 24368** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 001 Continued From page 5 F 001 care provided in Point Click Care Point of Care..." The shower book at the nurses station included documentation to indicate the room that this resident resided in had shower/baths scheduled on Wednesday and Saturdays. Per the census in the residents electronic health record Resident #71 had been in this same room since 05/28/23. 08/10/23 2:20 p.m., during an end of the day meeting with the DON and Assistant Director of Nursing the issue regarding the residents bathing/showers was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.