PRINTED: 11/28/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE COMF	SURVEY	
		495362	B. WING _	B. WING		C 11/20/2023	
NAME OF P	ROVIDER OR SUPPLIER	<u>, , , , , , , , , , , , , , , , , , , </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 117	LUILULU	
				906 THOMPSON STREET			
ASHLAND	NURSING AND REHAB	ILITATION		ASHLAND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000			
F 580 SS=D	standard survey was Corrections are requi CFR Part 483 Federa requirements. One of during the survey (V/with deficiency).  The census in this 19, 167 at the time of the consisted of four currone closed record re Notify of Changes (Ir CFR(s): 483.10(g)(14) S483.10(g)(14) Notifici) A facility must imm	omplaint was investigated a00059807- substantiated a00certified bed facility was a survey. The survey sample rent resident reviews and view.  augicary/Decline/Room, etc.)	F (	F580 Notify of Changes (Injury/Decline/I 1.Resident #2, Facility notified Physiciar 11/20/2023 of the positive urinalysis rep 11/18/2023. Resident's antibiotic that w to known organism was changed to app antibiotic.	on orted on as resistant opriate	12/19/2023	
LABORATORY	consistent with his or representative(s) who (A) An accident involves and in physician intervention (B) A significant charmental, or psychosor deterioration in healt status in either life-the clinical complications (C) A need to alter the aneed to discontinuous treatment due to advocmmence a new for (D) A decision to transident from the fact \$483.15(c)(1)(ii).  (ii) When making not (14)(i) of this section	ther authority, the resident en there is- ving the resident which has the potential for requiring en; ange in the resident's physical, cial status (that is, a h, mental, or psychosocial reatening conditions or es); eatment significantly (that is, a en existing form of treatment); or enserved on the consequences, or to enserve of the consequences or to enserve or discharge the		Resident #4, Facility notified Physician of about the positive urinalysis reported on this was not timely notification.  2.Quality review conducted by the Direct of Clinical Services/ Designee of current ordered to have a urinalysis in the last 3 determine if Physician or Nurse Practition notified in a timely manner.  3.Nurses RN/LPNs re-educated by the Clinical Services/ Designee related to Mof changes. A facility must immediately resident; consult with the resident's physician interpresentative(s) when there is—An actinvolving the resident which results in in the potential for requiring physician intersignificant change in the resident's physic or psychosocial status (that is, a deterior health, mental, or psychosocial status in	or residents D days to ner was Director of D notification inform the cician; and we the resident control of the resident control, A cical, mental, ration in		

Any deficiency statement endrou with an asterick (\*) 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.

Facility ID: VA0008

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495362	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER  NURSING AND REHA	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005		20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	is available and prophysician.  (iii) The facility must resident and the rewhen there is- (A) A change in rocas specified in §48 (B) A change in resident and the rewhen there is- (A) A change in rocas specified in §48 (B) A change in resident in gaste in	ation specified in §483.15(c)(2) evided upon request to the stalso promptly notify the sident representative, if any, or or roommate assignment (3.10(e)(6); or sident rights under Federal or tions as specified in paragraph on. (at record and periodically (amailing and email) and the resident (as defined in posite distinct part (as defined in pose in its admission agreement tration, including the various prise the composite distinct cify the policies that apply to even its different locations (a). (b) NT is not met as evidenced (c) interview, staff interview, eview and clinical record (staff failed to notify the page in status for two of fivence) as ample, Residents #2 and (d).	F 58	O life-threatening conditions or cli A need to alter treatment signif to discontinue an existing form adverse consequences, or to c of treatment. Laboratory and R be reported to MD in a timely m 4. The Director of Clinical Servic conduct quality monitoring rela ordered to have a urinalysis to notified in a timely manner, 3 x The findings of these quality m reported to the Quality Assurar Improvement Committee montl schedule modified based on fi monitoring by the Regional Dire Services/designee.	icantly (that is, a need of treatment due to ommence a new form adiology reports will nanner. ces/ Designee to ted to residents ensure MD/NP were weekly x 6 weeks. onitoring's to be nce/Performance hly. Quality Monitoring ndings with quarterly		
	notify the physiciar	(R2), the facility staff failed to n of a positive urinalysis 23. The urinalysis was positive					

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495362	B. WING _			C 11/20/2023	
	ROVIDER OR SUPPLIER  NURSING AND REF	IABILITATION		STREET ADDRESS, CITY, STATE, ZIP ( 906 THOMPSON STREET ASHLAND, VA 23005	<del> </del>		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF  ( (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	was receiving an resistant to.  On the most rece significant change ARD (assessmen resident scored 1 interview for men resident was cog decisions.  A review of R2's ophysician's order with culture and swas transferred to the resident's require that day. A physician documented to accept the decision of the physician of the resident's require that day. A physician of the physician of the physician of the physician of the resident's require that day. A physician of the physician o	tract infection) and the resident antibiotic that the organism was at MDS (minimum data set), a in status assessment with an at reference date) of 8/25/23, the 4 out of 15 on the BIMS (brief tal status), indicating the nitively intact for making daily clinical record revealed a dated 11/13/23 for a urinalysis ensitivity for a possible UTI. R2 of the hospital on 11/15/23, per usest due to pain, and returned cian's order dated 11/15/23 diminister the antibiotic, 00 mg (milligrams) one time a refer a UTI. A urinalysis report ate of 11/18/23 documented R2's a for ESBL (Extended spectrum E. coli (2), and the organism was exacin. A nurse's note dated	F	580			
	11/19/23 (7:17 a.i (Urinalysis) reflex from labs was cal abnormal, positiv R2's clinical recorphysician or nurs of the urinalysis r  On 11/20/23 at 10 conducted with R went to the hospi	m.) documented, "UA to culture/ urine culture results led in critical from lab. Results e for E. coli." Further review of rd failed to reveal the resident's e practitioner was made aware					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED						
		495362	B. WING_			C 1/20/2023					
	ROVIDER OR SUPPLIER  D NURSING AND REHAE			STREET ADDRESS, CITY, STATE, ZIP C 906 THOMPSON STREET ASHLAND, VA 23005		1/20/2023					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 580	conducted with LPN LPN #1 stated that if the staff at the lab w facility staff. LPN #1 happens, she prints lab, calls the physicia and places the result communication book.  On 11/20/23 at 2:15 conducted with ASM member) #3, the nur stated that if a reside tract infection, then the physician as soot ASM #3 stated she in through Thursday are abnormal lab result then, the nurses known supposed to place the communication book recall being made as reported date of 11/2 on 11/20/23 at 3:20 director) and ASM # nursing) were made.  The facility policy titl and X-Ray" docume critical values to be Center to notify the covering physician is outside the reference order." The facility policy if the facility physician is outside the reference order." The facility policy.	p.m., an interview was (licensed practical nurse) #1. is a lab result is abnormal then ill call or fax the results to the stated that after that the results of the abnormal an to make him or her aware, its in the physician c.  p.m., an interview was a call (administrative staff is e practitioner. ASM #3 is ent is positive for a urinary the nurses should call her or on as they receive the results is at the facility Monday found 9:00 a.m., so if an is received shortly before ow not to call her and are the results in the c. ASM #3 stated she did not ware of R2's urinalysis with a	F	580							

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495362	B. WING _	B. WING		C 11/20/2023	
	ROVIDER OR SUPPLIER  NURSING AND REHA	BILITATION		STREET ADDRESS, CITY, STATE, ZII 906 THOMPSON STREET ASHLAND, VA 23005	<del></del>	1120/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	Continued From pag Representative whe status or condition."	ge 4 n there is a change in the	F 5	580			
	information was obtahttps://medlineplus.gtml (2) "Enterobacteraledifferent types of geboth in healthcare shealthcare, in commin the Enterobacteracoli (E. coli)" This from the website: https://www.cdc.govml#anchor_1613662  2. For Resident #4 (notify the physician timely manner of a partial physician to the results of	R4), the facility staff failed to or nurse practitioner in a positive urinalysis reported on practitioner was not made until 11/6/23.  Idical record revealed a ted 10/27/23 for a urinalysis isitivity for dysuria (painful e specimen was collected on is with a reported date of the resident was positive for ae ESBL (Extended spectrum a. Further review of R4's to reveal the physician or as made aware of the positive til a physician's order dated of an order for Zosyn (2) 3.375 of every six hours for seven					

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495362	B. WING			C 11/20/2023	
	ROVIDER OR SUPPLIER  NURSING AND REH	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE  906 THOMPSON STREET  ASHLAND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICI	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		I SHOULD BE	(X5) COMPLETION DATE		
F 580	Continued From p	-	F 58	0			
	conducted with LF LPN #1 stated that the staff at the lab facility staff. LPN happens, she prin lab, calls the phys	10 p.m., an interview was PN (licensed practical nurse) #1. It if a lab result is abnormal then will call or fax the results to the #1 stated that after that its the results of the abnormal ician to make him or her aware, sults in the physician bok.					
	conducted with AS member) #3, the restract infection, the the physician as s ASM #3 stated sh through Thursday abnormal lab resuthen, the nurses k supposed to place communication by think any facility s placed R4's urinal communication by	ook. ASM #3 stated she did not taff called the physician or lysis results in the pok so when she returned to 11/6/23, she gave an order for					
	director) and ASM	20 p.m., ASM #1 (the executive 1 #2 (the interim director of de aware of the above concern.					
	different types of both in healthcare healthcare, in cor in the Enterobact	ales are a large order of germs that can cause infections esettings and outside of nmunities. Examples of germs erales order include Escherichia (lebsiella pneumoniae." This					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		495362	B. WING	-	11/2	) 20/2023
	ROVIDER OR SUPPLIER  NURSING AND REHAB	ILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	https://www.cdc.gov/ ml#anchor_1613662 (2) Zosyn is used to t	ined from the website: HAI/organisms/organisms.ht 156049	F 580		-	
F 757 SS=D	https://medlineplus.getml	ov/druginfo/meds/a694003.h e from Unnecessary Drugs	F 757	7 F757 Drug Regimen is Free from Unnecessa 1.Resident #2, Facility notified Physician on		12/19/2023
		sary Drugs-General. regimen must be free from An unnecessary drug is any		<ul> <li>11/20/2023 of the positive urinalysis reported</li> <li>11/18/2023. Resident's antibiotic that was reknown organism was changed to appropriate antibiotic.</li> <li>2.Quality review conducted by the Director of Services/ Designee of current residents or designed to the last of the last</li></ul>	esistant to ee of Clinical ered to	
	§483.45(d)(1) In exce duplicate drug therap §483.45(d)(2) For ex			have a urinalysis in the last 30 days to deter Physician or Nurse Practitioner was notified manner and Culture and Sensitivity reviewed MD/NP to ensure appropriate medical treatm ordered.	in a timely d with	
		it adequate monitoring; or its		3.Nurses RN/LPNs re-educated by the Direct Clinical Services/ Designee related Residen regimen must be free from unnecessary druunnecessary drug is any drug when used in dose (including duplicate drug therapy); or the service of th	t's drug gs. An excessive	
	§483.45(d)(5) In the consequences which reduced or discontinu	indicate the dose should be		excessive duration; or without adequate more without adequate indications for its use. and Sensitivity are to be reviewed with MD/t ensure appropriate medical treatment is ord 4. The Director of Clinical Services/ Designe	Culture NP to ered.	
	stated in paragraphs section. This REQUIREMEN by: Based on resident ir facility document revreview, the facility sta	mbinations of the reasons (d)(1) through (5) of this  r is not met as evidenced  atterview, staff interview, iew and clinical record aff failed to ensure one of five ey sample, Resident #2, was		conduct quality monitoring related to resider ordered to have a urinalysis to ensure MD/N notified in a timely manner and Culture and are reviewed with MD/NP to ensure approprimedical treatment is ordered, 3 x weekly x to reported to the Quality Assurance/Performa Improvement Committee monthly. Quality N schedule modified based on findings with quantitatives/designee	nts IP were Sensitivity iate 6 weeks. be nce lonitoring uarterly	

CENTERS FOR MEDICARE & MEDICAID SERVICES

I, '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495362	B. WING		C 11/20/2023		
	ROVIDER OR SUPPLIER  NURSING AND REHAI			STREET ADDRESS, CITY, STATE, ZIP COD 906 THOMPSON STREET ASHLAND, VA 23005			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F 757	Continued From page free from unnecessar. The findings include 1. For Resident #2 (ensure a urinalysis addressed. The urin (urinary tract infection receiving an antibiod resistant to.  On the most recent significant change in ARD (assessment or resident scored 14 conterview for mental resident was cognitic decisions.  A review of R2's climphysician's order dawith culture and ser was transferred to the resident's requestion.	ge 7 ary medication.	F 757	DEFICIENCY)			
	documented to adm mg (milligrams) one a UTI. A urinalysis 11/18/23 documente ESBL (Extended sp coli (2), and the org levofloxacin. A nurs a.m.) documented, culture/ urine culture in critical from lab. E. coli." Further reviailed to reveal the in practitioner) was may	inister levofloxacin (1) 500 time a day for seven days for report with a reported date of ed R2's urine was positive for ectrum beta-lactamase) E. anism was resistant to se's note dated 11/19/23 (7:17 'UA (Urinalysis) reflex to e results from labs was called Results abnormal, positive for riew of R2's clinical record resident's physician (or nurse ade aware of the urinalysis in had reviewed the results,					

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495362	B. WING _		C 11/20/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
ASHLAND	NURSING AND REHAE	BILITATION		906 THOMPSON STREET ASHLAND, VA 23005	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 757	Continued From pag	e 8	F 7	57	
	and the physician ha resistance.	d addressed the levofloxacin			
	conducted with R2. went to the hospital a	a.m., an interview was R2 stated she had been sick, week ago, and was told she d concern that she still felt			
	conducted with LPN LPN #1 stated that if the staff at the lab wi facility staff. LPN #1 happens, she prints				
	conducted with ASM member) #3 (the nur stated that if a reside tract infection, then the physician as soo ASM #3 stated she is through Thursday ar abnormal lab result if then, the nurses kno supposed to place the communication book presented with sympordered a urinalysis requested to go to the she knew the hospital UTI, and an antibioticated she usually losure the organism is	se practitioner). ASM #3 ent is positive for a urinary he nurses should call her or n as they receive the results. s at the facility Monday ound 9:00 a.m., so if an s received shortly before w not to call her and are			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495362	B. WING_			11/3	20/2023
	ROVIDER OR SUPPLIER  NURSING AND REHAE	ILITATION		90	REET ADDRESS, CITY, STATE, ZIP CODE 16 THOMPSON STREET SHLAND, VA 23005	1 172	2072020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
F 757	wasn't aware the org levofloxacin. ASM # and stated she was gantibiotic for R2.  On 11/20/23 at 3:20 girector) and ASM #2 nursing) were made  The facility policy title and X-Ray" documer critical values to be covering physician if outside the reference order."  References: (1) Levofloxacin is us information was obtahttps://medlineplus.gtml (2) "Enterobacterales different types of ger both in healthcare se healthcare, in commin the Enterobacteral coli (E. coli)" This from the website: https://www.cdc.gov/ml#anchor_1613662 Infection Prevention	ported on 11/18/23, and she anism was resistant to 3 reviewed the lab results going to prescribe a different on		757	F880 Infection Prevention & Control		
SS=D	CFR(s): 483.80(a)(1) §483.80 Infection Co The facility must esta infection prevention a	ntrol ablish and maintain an			<ol> <li>Resident #2, Facility implemented infectio control precautions such as signage on the of available personal protective equipment outs the room appropriate to Resident's current in</li> </ol>	door and side of	12/19/2023

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION (X3) DATE SURVE  NG COMPLETED			
		495362	B. WING			C 11/20/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	20/2023	
				906 THOMPSON STREET			
ASHLAND	NURSING AND REHAB	LITATION		ASHLAND, VA 23005			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 880	development and trar diseases and infection §483.80(a) Infection program.  The facility must esta and control program (a minimum, the follow §483.80(a)(1) A systematic reporting, investigating and communicable distaff, volunteers, visit providing services un arrangement based us conducted according accepted national statistation [§483.80(a)(2)] Written procedures for the procedures.	safe, sanitary and sent and to help prevent the esmission of communicable ins.  Drevention and control solicition prevention (IPCP) that must include, at ving elements:  Improvements in the sent of	F 8	2. Quality review conducted by the Dire Services/ Designee to ensure current F infections have appropriate signage on available personal protective equipmer the room.  3. Nurses RN/LPNs re-educated by the Clinical Services/ Designee related to I Control. The facility must establish and infection prevention and control progra provide a safe, sanitary, and comforta environment and to help prevent the deand transmission of communicable disinfections. Standard and transmission-precautions to be followed to prevent sinfections; When and how isolation sho for a resident; including but not limited and duration of the isolation, depending infectious agent or organism involved, requirement that the isolation should be restrictive possible for the resident und circumstances. Implementing infection precautions when appropriate such as the door and available personal protections of the room.  4. The Director of Clinical Services/ Designation in the control of the room.	desidents with the door and toutside of Director of Infection Infe		
	possible communicable diseases or infections before they can spread to other persons in the facility;  (ii) When and to whom possible incidents of communicable disease or infections should be reported;  (iii) Standard and transmission-based precautions		conduct quality monitoring related to e Residents with infections have appropi on the door and available personal pro- equipment outside of the room, 3 x we The findings of these quality monitorin reported to the Quality Assurance/Perf Improvement Committee monthly. Qua- schedule modified based on findings w monitoring by the Regional Director of Services/designee.	iate signage tective ekly x 6 weeks. g's to be ormance lity Monitoring ith quarterly			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495362	495362 B. WNG			C 11/20/2023	
	ROVIDER OR SUPPLIER  NURSING AND REHA	BILITATION		906 THOM	DDRESS, CITY, STATE, ZIP CODE IPSON STREET ID, VA 23005		20/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 880	circumstances.  (v) The circumstance must prohibit employed disease or infected contact with resider contact will transmit (vi)The hand hygier by staff involved in \$483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must has transport linens so infection.  §483.80(f) Annual of the facility will confection.  §483.80(f) Annual of the facility will confection.  §483.80(f) Annual of the facility will confection.  For Pand update the the facility staff failed to standards of practic the survey sample, the findings included for Resident #2 (Rimplement infection urinalysis result with documented the reconfection (Extended spectrum).	ces under which the facility byees with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.  Stem for recording incidents afacility's IPCP and the taken by the facility.  Indle, store, process, and as to prevent the spread of the review.  Induct an annual review of its the program, as necessary.  In is not met as evidenced tion, staff interview, facility and clinical record review, the primplement infection control to the for one of five residents in Resident #2.	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495362	B. WING		_	С		
NAME OF PI	ROVIDER OR SUPPLIER	455502	B: VIII   _	STREET ADDRESS, CITY,	STATE ZIP CODE	11/20/2023		
ASHLAND NURSING AND REHABILITATION				906 THOMPSON STREET ASHLAND, VA 23005				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)			
F 880	with culture and sens (urinary tract infectio antibiotic for a UTI or report with a reported documented R2's uricoli. The report also was resistant to the afor R2. A nurse's no documented, "UA (Uurine culture results critical from lab. Rescoli." Further review to reveal any physici control precautions.	ed 11/13/23 for a urinalysis sitivity for a possible UTI n). R2 was prescribed an n 11/15/23. A urinalysis	F8	80				
	and the resident's ro were no infection cor implemented, to incli	om was conducted. There						
	conducted with LPN who was the nurse of that her unit manage this day that R2's uri ESBL. LPN #2 state the nurse practitione dose of her antibiotic not placed on infections staff were going to the for ESBL. LPN #2 states positive for ESI be placed on contact results are received, bathroom with anyor	p.m., an interview was (licensed practical nurse) #2 paring for R2. LPN #2 stated by was just made aware on nalysis results documented and that on this day, she made by made aware and R2 only had one by medication left, so R2 was con control precautions but the best the resident's roommate tated that when a resident BL in the urine, they should to precautions as soon as the and they should not share a the else. LPN #2 stated R2 to a bathroom with another						

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495362		B. WING		C 11/20/2023	
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/2	20/2023
ASHLAND	NURSING AND REHAB	ILITATION		ASHLAND, VA 23005			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		BE	(X5) COMPLETION DATE
F 880	different two rooms a room used the bathroom used the resident that she was rurinalysis results with documented the reside. Coli until this day. facility she had previous protocol that any resident's roommate ASM #3 stated that the about moving R2 to a only one day of antib ASM #3 was made a urinalysis results, the to the current antibiod R2. ASM #3 stated is re-testing R2 and recresident who shared On 11/20/23 at 3:16 conducted with ASM ASM #2 stated that re ESBL should be placed policy and that should enhanced barrier predirector) and ASM #2 nursing) were made. The facility policy title Precautions" docume	m was shared between and a resident in the other from).  D.m., an interview was (administrative staff se practitioner). ASM #3 not made aware that R2's a a reported date of 11/18/23 dent was positive for ESBL ASM #3 stated that at a pusity worked at, there was a dent with ESBL in the urine and on isolation unless the does not use the bathroom. The morning, LPN #2 asked another room but there was inotic medication use left. It ware that according to the accordin	F	880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495362	B. WING		С		
NAME OF PROVIDER OR SUPPLIER  ASHLAND NURSING AND REHABILITATION			.	STREET ADDRESS, CITY, STATE, ZIP CODE 906 THOMPSON STREET ASHLAND, VA 23005			20/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE
F 880	spread of multi-drug (MDROs) to residents gown and glove use care activities when cotherwise apply4. Econtact precautions or residents infected or g. ESBL-producing EReferences:  (1) "Enterobacterales different types of gerr both in healthcare se healthcare, in communin the Enterobacteral coli (E. coli)" This i from the website:	or intervention to reduce the resistant organisms s. 2. EBPs employ targeted during high contact resident contact precautions do not EBPs are indicated (when lo not otherwise apply) for colonized with the following: interobacterales"  are a large order of ms that can cause infections titings and outside of inities. Examples of germs es order include Escherichia information was obtained  HAI/organisms/organisms.ht	F	880			