STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E151	A. BUILDING _____ B. WING _____	02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SISTERS OF THE POOR IN RICHMOND	1503 MICHAEL ROAD RICHMOND, VA 23229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/9/21 through 2/17/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/09/21 through 02/17/21. An extended survey was conducted 02/10/21 through 02/17/21. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey Immediate Jeopardy was identified in the area of Freedom from Abuse, Neglect and Exploitation at a Scope and Severity Level 4, isolated which constituted Substandard Quality of Care. The census in this 32 bed certified bed facility was 24 at the time of the survey. The survey sample consisted of 17 resident reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		4/2/21

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

Electronically Signed | 03/09/2021

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F 600	Continued From page 1 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the faintly staff failed to ensure Residents were free from abuse for 1 Resident (# 15) in a survey sample of 17 Residents. The findings included: 1. For Resident #15 the facility allowed LPN A was accused and written up for "Intimidating a Resident." This is abuse. Resident #15 an 85 year old woman, was admitted to the facility on 10/18/19 with diagnoses of but not limited to dementia without behavioral disturbance, anemia, chronic kidney disease, anxiety, major depressive disorder, falls, and atherosclerotic heart disease. Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/21/20, an quarterly assessment, coded Resident #15 as having a BIMS (brief interview of mental status) score of 10 out of a possible 15. This score indicates moderate cognitive impairment. The MDS codes the resident as needing extensive assistance with physical assistance of 1 person for toileting, hygiene, dressing and bed mobility. She requires limited	F 600	1. LPN A disciplined, written up and terminated on 2/11/21. Resident#15 continues her psychotherapy and psychiatry visits. APS/OLC were notified of Resident#15 allegation of abuse/mistreatment on 2/9/21. 2. DON/Designee will interview each Nursing Home resident to ensure other Residents are free from abuse or neglect. 3. DON/Designee will in-service certified nursing assistants and licensed staff regarding abuse and neglect required compliance. 4. DON/Designee will interview on the subject of "Abuse and Neglect" a sample group of 12 residents weekly for a period of 4 weeks, thereafter monthly for a period of three (3) months. 5. Results of audit will be forwarded to QA Committee for 3 consecutive months, where a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	

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F 600	Continued From page 2	F 600		

assistance with physical assistance of 1 person for walking in room, and transfers. She requires supervision for eating meals. The Resident uses a walker to aid in mobility.

On 2/9/21 approximately 1:00 PM Resident #15 was asked about abuse and neglect in the facility, she stated "There was one aide that wasn't nice but I told her to leave. She hasn't been around lately."

On 2/10/20 during clinical record review it was discovered that the following entry was made in the progress notes:
"1/1/21 at 9:18 PM - At 430 PM [Resident #15 name redacted] came out from her room and was ambulating with her rollator. She passed by the nurse's station and stated 'Someone banged my face and head in the bars this morning.' Writer asked if she can recall the name of the person and she stated 'I don't know.'"

On 2/10/21 at 11:41 an interview was conducted with the DON and the Administrator who was asked about an incident involving Resident #15 and LPN A. The Administrator stated it happened when she was out sick with Covid. "The DON called me at home." She stated 2 CNA's that work night shift reported the incident. When asked who they reported it, to her she stated "They called me at home and I told the DON to do the investigation."

The Administrator submitted a "Corrective Action Plan" for LPN A, excerpts are as follows:
"Employee Name: [redacted] Department: Nursing Date: 1/28/21 Date of Occurrence: 1/1/21

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F 600	Continued From page 3	F 600		

Location: Nursing Time: 11 pm -7 am "Action Taken: Written Counseling"

"Description of Issue: [box checked] Policy Violation [box checked] other: Mental Intimidation."

"Explanation: It was reported to Acting DON by Administrator on 1/6/21 of an incident involving resident # [medical record number redacted] on the morning of 1/1/21. The report stated that Resident was refusing care which was reported to the Charge Nurse, [LPN A name redacted]. At that time, Charge Nurse and CNA both went in to care for Resident. Per report, Resident continued to be resistant to care and Charge Nurse began to pull down Residents clothes while Resident was in bed and was speaking to Resident in a loud and uncalm voice. When Charge Nurse was pulling Resident's clothes off, the bed was unlocked on one side and began to move with the headboard hitting the wall. Charge Nurse locked the bed and continued pulling clothes off, kicking the soiled depends and clothing on the floor at which time she was bumping or hitting the walker and rocking chair with her feet which in turn was hitting the wall and the furniture in the Resident's room. Resident yelled at Charge Nurse to stop and Charge Nurse responded that they were there to help her and she was fighting them and telling them that they were hitting her furniture. Charge Nurse then stated "This is how we hit furniture" and grabbed the walker or the rocking chair and was hitting it against the wall or the china dresser. CNA approached the Resident and took over washing her up and changing her clothes and Charge Nurse exited the room, however she was still talking to the Resident in a loud and Unocal manner. Per CNA, Resident at

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F 600	Continued From page 4	F 600		

this time was reported to be shaking and walked outside of her room and sat in recliner on the unit. Another staff member came to see what all the loud voices was about and to see if everything was okay. The Charge Nurse said everything was Okay."
"On the night of 1/2/21 staff reported that when they knocked on the Resident's door, Resident jumped, seemed scared and was shaking. She reported to the staff that 'the black woman with the round thing on her head' came into her room and kept hitting her head on the wall. At a later time that same night Resident reported the same thing and also said ' I think it was [name redacted], (which is what she calls the Charge Nurse), but why would she do that?' At a later time, a staff member stated that Resident approached her and stated the night nurse T, who wears that knot on her head, hit her in the arm and the head. The staff member asked when that happened and was told it happened a few nights ago and that the nurse was hitting and kicking her bed and throwing her chair around. Staff also reports that Resident has been telling other people who will listen to her, including her family, that she was hit and kicked by the night nurse, [name redacted], and that she did not want to stay at [facility name redacted] anymore because she might be killed."

It was noted that the "Corrective Action Plan" had not been signed by the DON or the LPN. The DON was asked about why the document had not been signed and she stated "The LPN has been out of the facility on Administrative Leave." When asked was that due to this incident she stated, "Yes I believe so."

On 2/10/21 a review of the time clock punches for

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LPN A revealed that LPN A continued to work on the very same unit with the Resident until 2/1/21 when she was written up for "Sleeping on the job."

On 2/10/21 at approximately 3:00 PM an interview was conducted with the Administrator and she was asked if the LPN A was still an employee there and she stated that she is supposed to come in on Thursday (2/11/21) to sign the corrective action plan.

Excerpts from CNA D's statement is as follows: "I was disappointed by the actions of my supervisor [LPN A name redacted]. Normally if a resident refuses care (especially at this time early in the morning or during the night) I would leave give them time and come back to them. This morning [LPN A name redacted] said she'll go in there with me and get [resident name redacted] up. [LPN A] began to pull [resident #15's name redacted] clothes down while she was still in bed. As [LPN A] was yanking on her pajama pants she was also speaking in a loud, uncalm voice. I could tell that [resident name redacted] was frightened as she tried to hold on to her pajama pants. I couldn't look [LPN A's name redacted] way and all I could think was to get between [LPN A] and [Resident #13]."

By then [Resident #13 name redacted] was on the side of the bed looking scared and confused as [LPN A name redacted] kept talking loudly and kicking the ripped pull-up that fell to the floor. I heard [Resident #13] telling [LPN A] stop hitting my furniture. When [LPN A] was kicking the stuff (pull up and pants) on the floor out of the way, she was bumping or hitting the walker and rocking chair with her feet which then were hitting

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the wall."
"At this time I was standing there looking for an opening to get between LPN A and what she was doing, and in front of [resident #13] So I got to [Resident #13] and washed and changed her right there at her bedside."
"LPN A still talking loudly and inappropriately to [Resident #13] at this time she was shaking."

"The next night I went to work and when I knocked on her door she jumped. I went to her to calm her down and she was shaking and seemed scared. She told me that she black woman with the round thing on her head wet into her room and kept hitting her head on the wall."

On 2/11/21 the Administrator showed surveyor second "Corrective Action Plan" for LPN A dated 2/2/21 excerpts are as follows:
"Employee name: [redacted] Department: Nursing Date 2/2/21 Date of Occurrence: 2/2/21 Action Taken: [box checked] Discharge from Employment"
"Description of Issue: [box checked] Unsatisfactory Work Quality [box checked] Policy Violation"
"Explanation: Employees are subject to appropriate diciplinary [sic] action up to and including dismissal for violations of the Home's policies including but not limited to the following : Negligent or poor performance of duties; Sleeping on Duty. pg. 74 employee handbook."

NOTE: The LPN A was subsequently terminated on Thurs 2/11/21 for "Sleeping on Duty."

A review of the Abuse and Neglect Policy read:

Page 7 of 13 Paragraph E Investigation

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"Abuse Policy Requirements:
It is the policy of this Home that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated."
Page 9 Paragraph F Protection"
Abuse Policy Requirements: It is the policy of this HOME that the resident(s) will be protected from the alleged offender(s).

"Procedure:
Immediately upon receiving a report of alleged "abuse", the Administrator, and / or designee will coordinate delivery of appropriate medical and or psychological care and attention. Ensuring safety and wellbeing for the vulnerable individual are of utmost priority. Safety, security and support of the Resident, their roommate, if applicable and other Residents with the potential to be affected will be provided. This should include as appropriate:"
1. Procedures must be in place to provide the Resident with a safe, protected environment during the investigation.
a. The alleged perpetrator will immediately be removed and the Resident protected. Employees accused of alleged abuse will be immediately removed from the Home and will remain removed pending the results of a thorough investigation. (Decision of the extent of immediate disciplinary action will be made by the Administrator and/or designee)."

On 2/11/21 during the end of day conference the Administrator was made aware of the concerns and no further information was provided.

The Administrator was made aware of the

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F 600	Continued From page 8 concerns during the end of day meeting on 2/10/21, and no further information was provided.	F 600		
F 607 SS=J	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to implement policies and procedures related to abuse and neglect for 3 Residents (#15, #13, and #5), in a survey sample of 17 Residents. Immediate Jeopardy was called on 2/10/21 at 3:26 P.M. related to Residents #15 and #13. It was abated on 2/12/21 at 5:30 P.M. After Immediate Jeopardy was removed, the deficiency was assigned a Scope and Severity of level 2, isolated. The findings included: 1. For Resident #15, the facility did not implement facility policies and procedures by allowing LPN A to continue to work with Resident #15 after being accused of abusing Resident #15	F 607	1. LPN A was disciplined , written up and terminated on 2-11-21. Resident #15 continues on her psychotherapy and psychiatry visits. APS/OLC were notified of Resident#15 allegations of abuse on 2/9/21. LPN B and LPN C were in-serviced on facility policies and procedures on reporting allegations of abuse. Resident#13 allegations of abuse /mistreatment were reported to APS/OLC on 2/10/21. Resident#5 injury of unknown origin acquired on 1/12/21, investigated and APS/OLC were notified on 2/12/21. 2. DON/Designee will interview each Nursing Home Resident to ensure other Residents are free from abuse or neglect.	4/2/21

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F 607	Continued From page 9 and written up for "Intimidating a Resident [#15]" Resident #15 an 85 year old woman, was admitted to the facility on 10/18/19 with diagnoses of but not limited to dementia without behavioral disturbance, anemia, chronic kidney disease, anxiety, major depressive disorder, falls, and atherosclerotic heart disease. Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/21/20, an quarterly assessment, coded Resident #15 as having a BIMS (brief interview of mental status) score of 10 out of a possible 15. This score indicates moderate cognitive impairment. The MDS codes the resident as needing extensive assistance with physical assistance of 1 person for toileting, hygiene, dressing and bed mobility. She requires limited assistance with physical assistance of 1 person for walking in room, and transfers. She requires supervision for eating meals. The Resident uses a walker to aid in mobility. On 2/9/21 approximately 1:00 PM Resident #15 was asked about abuse and neglect in the facility, she stated "There was one aide that wasn't nice but I told her to leave. She hasn't been around lately." On 2/10/20 during clinical record review it was discovered that the following entry was made in the progress notes: "1/1/21 at 9:18 PM - At 430 PM [Resident #15 name redacted] came out from her room and was ambulating with her rollator. She passed by the nurse's station and stated 'Someone banged my face and head in the bars this morning.' Writer asked if she can recall the name of the person and she stated 'I don't know.'	F 607	If a resident can't respond, a skin check will be done. 3. DON/Designee will in-service certified nursing assistants and licensed staff regarding abuse and neglect required compliance, stressing the importance of notifying DON/NHA immediately to facilitate the 2-hour reporting rule after the allegation is made. 4. DON/Designee will interview on the subject of "Abuse and Neglect" a sample group of twelve (12) residents weekly for a period of 4 weeks, thereafter monthly for a period of three (3) months. 5. Results of audit will be forwarded to QA Committee for three (3) consecutive months, when a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	

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"

On 2/10/21 at 11:41 an interview was conducted with the DON and the Administrator who was asked about an incident involving Resident #15 and LPN A. The Administrator stated it happened when she was out sick. She stated that "The DON called me at home." When asked what day she was notified she stated she wasn't sure. She also stated 2 CNA's that work night shift reported the incident. When asked who they reported it to she stated "They called me at home. I told the DON to do the investigation."

The Administrator submitted a "Corrective Action Plan" for LPN A excerpts are as follows:

"Employee Name: [redacted] Department: Nursing Date: 1/28/21 Date of Occurrence: 1/1/21 Location: Nursing Time: 11 pm -7 am
"Action Taken: Written Counseling"

"Description of Issue: [box checked] Policy Violation [box checked] other: Mental Intimidation."

"Explanation: It was reported to Acting DON by Administrator on 1/6/21 of an incident involving resident # [medical record number redacted] on the morning of 1/1/21. The report stated that Resident was refusing care which was reported to the Charge Nurse, [LPN A name redacted]. At that time, Charge Nurse and CNA both went in to care for Resident. Per report, Resident continued to be resistant to care and Charge Nurse began to pull down Residents clothes while Resident was in bed and was speaking to Resident in a loud and uncalm voice. When Charge Nurse was pulling Resident's clothes off, the bed was

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unlocked on one side and began to move with the headboard hitting the wall. Charge Nurse locked the bed and continued pulling clothes off, kicking the soiled depends and clothing on the floor at which time she was bumping or hitting the walker and rocking chair with her feet which in turn was hitting the wall and the furniture in the Resident's room. Resident yelled at Charge Nurse to stop and Charge Nurse responded that they were there to help her and she was fighting them and telling them that they were hitting her furniture. Charge Nurse then stated "This is how we hit furniture" and grabbed the walker or the rocking chair and was hitting it against the wall or the china dresser. CNA approached the Resident and took over washing her up and changing her clothes and Charge Nurse exited the room, however she was still talking to the Resident in a loud and Unocal manner. Per CNA, Resident at this time was reported to be shaking and walked outside of her room and sat in recliner on the unit. Another staff member came to see what all the loud voices was about and to see if everything was okay. The Charge Nurse said everything was Okay."

"On the night of 1/2/21 staff reported that when they knocked on the Resident's door, Resident jumped, seemed scared and was shaking. She reported to the staff that 'the black woman with the round thing on her head' came into her room and kept hitting her head on the wall. At a later time that same night Resident reported the same thing and also said ' I think it was T, (which is what she calls the Charge Nurse), but why would she do that?' At a later time, a staff member stated that Resident approached her and stated the night nurse [name redacted], who wears that knot on her head, hit her in the arm and the head.

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LITTLE SISTERS OF THE POOR IN RICHMOND	1503 MICHAEL ROAD RICHMOND, VA 23229

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The staff member asked when that happened and was told it happened a few nights ago and that the nurse was hitting and kicking her bed and throwing her chair around. Staff also reports that Resident has been telling other people who will listen to her, including her family, that she was hit and kicked by the night nurse, [name redacted], and that she did not want to stay at [facility name redacted] anymore because she might be killed."

It was noted that the "Corrective Action Plan" had not been signed by the DON or the LPN. The DON was asked about why the document had not been signed and she stated "The LPN has been out of the facility on Administrative Leave." When asked was that due to this incident she stated, "Yes I believe so".

On 2/10/21 a review of the time clock punches for LPN A revealed that LPN A continued to work on the very same unit with the Resident until 2/1/21. On this date she was written up for "Sleeping on the job."

On 2/10/21 at approximately 3:00 PM an interview was conducted with the Administrator and she was asked if the LPN A was still an employee there and she stated that she is supposed to come in on Thursday (2/11/21) to sign the corrective action plan. The Administrator was then asked to provide the survey team with the entire investigation including witness statements.

The witness statement from CNA C was reviewed and an excerpt is as follows:
"1/14/21 - The incident started when I was cleaning and sanitizing the shower room, when I heard people screaming and yelling, so I

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immediately ran out and saw the nurse [LPN name redacted] standing at the opening of room 136, which is [Resident #15 name redacted] room. The nurse was leaning on the resident's door and the resident was standing inside with her walker extended out in front of the nurse and her aide [CNA name redacted] behind her.

I asked them was everything okay and the nurse said yes. When I was emptying my soiled linen cart the resident came to me and said the night nurse, [name redacted], who wear that knot on her head, hit her in the arm and head. I asked her when did this happen she said a few nights ago & the nurse was hitting and kicking her bed and throwing her chair around. I reported this to [Administrator name redacted] and she said she will report it to [DON name redacted] to investigate it, as time went by almost 2 weeks, I heard nothing, so I then called Mother and she stated she had heard something about it and she will look into it better. I wasn't sure if anyone was looking into the matter."
"[Resident #15 name redacted] was telling anyone including her family, who will listen to her, that she was hit and kicked by the night nurse, and that she didn't want to stay at [facility name redacted] anymore because she might be killed."

A review of the Abuse and Neglect Policy read:

Page 9 Paragraph F Protection"
Abuse Policy Requirements: It is the policy of this HOME that the resident(s) will be protected from the alleged offender(s).

"Procedure:
Immediately upon receiving a report of alleged "abuse", the Administrator, and / or designee will

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coordinate delivery of appropriate medical and or psychological care and attention. Ensuring safety and wellbeing for the vulnerable individual are of utmost priority. Safety, security and support of the Resident, their roommate, if applicable and other Residents with the potential to be affected will be provided. This should include as appropriate:"

1. Procedures must be in place to provide the Resident with a safe, protected environment during the investigation.

a. The alleged perpetrator will immediately be removed and the Resident protected. Employees accused of alleged abuse will be immediately removed from the Home and will remain removed pending the results of a thorough investigation. (Decision of the extent of immediate disciplinary action will be made by the Administrator and/or designee)."

2. For Resident #13 LPN B failed to implement facility policies and procedures by not immediately reporting an allegation of abuse.

Resident # 13 a 97 year old woman, was admitted to the facility on 12/06/19, with diagnoses of but not limited to hypertension, malignant neoplasm of pancreas, diabetes, UTI, prosthetic heart valve, and age related macular degeneration.

Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/4/20, an annual assessment, coded Resident #13 as having a BIMS (brief interview of mental

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status) score of 14 out of a possible 15. This score indicates no cognitive impairment. The MDS codes the resident as needing extensive assistance with all aspects of ADL care with the exception of eating. Resident #13 is able to feed herself with only supervision. The Resident uses a walker for aid in short distance mobility and a wheelchair for longer distances.

On 2/10/21 at approximately 10:00 AM Surveyor C reported the following observation.

At 9:20 AM Resident #13 was in wheel chair next to the medication cart. Resident #13 stated "Somebody kicked me." LPN C asked "Who kicked you?" Resident replied "I don't know". LPN C assisted the Resident to lift her right pant leg to reveal a dressing on right shin. LPN C then stated to the resident "No one kicked you" and went on to tell Resident that she had a dressing on her shin from a skin tear. Another staff member then approached Resident and rolled her down the hall in wheel chair.

At 10:40 AM, Surveyor B interviewed Resident #13 after she returned from physical therapy. The Resident was asked about the injury to her right shin and she stated "Somebody kicked me, I don't remember who." When asked about abuse or neglect she stated "I cannot stand that nurse from last night we had a fight." When asked what happened she stated "I can't stand her she is rude and she just would not leave me alone, so we got into a fight. She is not a good nurse and she drops stuff and then picks it up off the floor and gives it to you. That's not sanitary or wise these days. She has no patience. I was kicking at her to get her to leave me alone. They know I don't like her and don't want her in my room."

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On 2/10/21 a review of the clinical record revealed the following progress note:
" 2/10/21 at 12:59 AM - Resident call bell was on, and staff went to answer the call bell, resident stated she want to go to BR, staff got resident up in the w/c and assisted resident to the bathroom and while assisting resident back to bed she refused to allow staff to apply pillow under her legs and was insisting on keeping her legs outside the bed sa [sic] staff was assisting to put the legs back to bed resident became physically aggressive and started kicking and swinging at staff was verbally aabusive [sic] and told staff she hate her, redirected and assured resident that staff is here to help and to assure her safety."

On 2/10/21 at approximately 10:58 AM an interview was conducted with the Administrator who was asked if she was aware of an allegation of abuse by Resident #13. She stated that she had not heard of this but would start an investigation.

Immediate Jeopardy was called on 2/10/21 at 3:26 PM, and the Administrator was notified.

Immediate Jeopardy Abatement Plan is as follows:
"All staff on evening shift, 3pm-11pm, for 2/10/21 will be in -serviced on Resident Rights and Abuse and Neglect on 2/10/21. Staff for night shift, 11pm -7 am, will be in serviced before their shift on 2/10/21.

Dayshift staff will be in-serviced before their shift on 2/11/21. There will be a mandatory all staff meeting on 2/11/21 at 12 noon for training on Resident's Rights and Abuse and Neglect. All

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afore-mentioned staff will be provided a copy of the homes policy regarding Resident Rights and Abuse and Neglect at the time of the meeting. All other staff will be trained over the phone or in person before working with residents.

LPN B has been removed from schedule and statement requested from this person regarding incident with Resident #13 on 2/10/21. Per policy, LPN B will remain removed pending the results of a thorough investigation and disciplinary action will be made by the Administrator.

LPN C has been called for a statement about her conversation with Resident #13 this morning 2/10/21. She has provided documentation of the incident with Resident #13 on 2/10/21.

Interviewing every Nursing Resident (24 total) to determine if any abuse, neglect, or resident rights violations have occurred. This has been completed by 2/10/21 by 445 pm. Body checks will be completed by 10 AM on 2/11/21 for cognitively impaired residents.

The Abatement Plan will be completed by 4PM on 2/11/21"

The survey team verified education in service sheet checks, interviews, and completed skin assessments were reviewed.

The Immediate Jeopardy was removed on 2/12/21 at 5:30 PM.

3. For Resident #5, the facility staff failed to implement their abuse policy when an injury of

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unknown source was identified on 01/12/2021.

Resident #5, a 98-year old female, was admitted to the facility on 04/26/2013. Diagnoses for Resident #5 included but were not limited to atherosclerosis and peripheral vascular disease.

Resident #5's most recent Minimum Data Set with an Assessment Reference Date of 01/06/2021 was coded as an annual assessment. The Brief Interview for Mental Status was coded as "99" meaning unable to complete the interview. Cognitive Skills for Daily Decision Making were coded as moderately impaired. Short-term and Long-term memories were coded as "memory problem." Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff.

On 02/11/2021 at approximately 8:45 A.M., the clinical record was reviewed. A nurse's note dated 01/12/2021 at 6:46 A.M. documented, "Note Text: cna reported to writer that she noted discoloration to right hand between 2nd and 3rd fingers, denies pain will continue to monitor the area." The subsequent nurse's notes through 01/18/2021 at 2:26 P.M. were reviewed and the injury of unknown origin to the right hand was not addressed.

A nursing skin assessment dated 01/30/2021 at 4:03 P.M. did not document a skin issue on the right hand as indicated in the nurse's note dated 01/12/2021.

On 02/12/2021 at approximately 9:20 A.M., a copy of the facility-reported incident and the investigation documentation associated with this injury of unknown origin to the right hand were

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requested.

On 02/12/2021 at approximately 11:15 A.M., an interview with the Director of Nursing was conducted. When asked about a facility-reported incident and the investigation documentation associated with this injury of unknown origin, the Director of Nursing stated that it was not reported investigated or reported to the state agency. The Director of Nursing stated the staff were re-educated and a facility-reported incident will be sent to the state agency.

When asked about expectation from staff when an injury of unknown origin is discovered, the Director of Nursing stated the expectation is that the nurse report it as soon as possible so "we can send in a FRI [facility-reported incident] and "begin the investigation." The Director of Nursing also stated the expectation includes assessing and interviewing residents and staff associated with the injury and "notify all the proper people and the doctor."

The facility staff provided a copy of their policy entitled, "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property." In Section E entitled, "Investigation" under the header "Abuse Policy Requirements", it was documented, "It is the policy of the Home that reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated." In Section E, Part 2 and subpart (a), it was documented, "Investigation of injuries of Unknown Origin or Suspicious injuries: must be immediately investigated to rule out abuse: (a) Injuries include but are not limited to, bruising of the inner thigh,

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F 607	Continued From page 20 chest, face, and breast, bruises of an unusual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable to trauma." In Section G entitled, "Reporting and Response" under the header, "Abuse Policy Requirements", an excerpt documented, "It is the policy of this Home that "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of Resident property) are reported per Federal and State law." In summary, Resident #5 had an injury of unknown source to her right hand between the 2nd and 3rd fingers (identified on 01/12/2021) and the facility staff failed to implement their abuse policy to report and investigate the matter. On 02/12/2021 at approximately 1:45 P.M., the administrator and Director of Nursing were notified of findings.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		4/2/21

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F 609	Continued From page 21 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, facility documentation and clinical record reviews the facility staff failed to report abuse to the state agency for 3 Residents (#15, #13, and #5) in a survey sample of 17 Residents. The findings included: 1. For Resident #15 the alleged abuse occurred on 1/1/21 and was not reported to the state agency until 2/10/21 when surveyors notified the Administrator that it had not been reported. Resident #15 an 85 year old woman, was admitted to the facility on 10/18/19 with diagnoses of but not limited to dementia without behavioral disturbance, anemia, chronic kidney disease, anxiety, major depressive disorder, falls, and atherosclerotic heart disease. Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/21/20, an quarterly assessment, coded Resident #15 as having a BIMS (brief interview of	F 609	1. LPN A was disciplined, written up and terminated on 2/11/21. Resident#15 continues her psychotherapy and psychiatry visits with LifeSource. APS/OLC were notified of Resident#15 allegation of abuse/mistreatment on 2/9/21. Resident#13 allegation of abuse/mistreatment was reported to APS/OLC on 2/10/21. Resident#5 injury of unknown origin acquired on 1/12/21, investigated and APS/OLC notification sent on 2/12/21. 2. DON/Designee will interview each Nursing Home Resident to ensure other residents are free from abuse or neglect. 3. DON/Designee will in-service staff on reporting of alleged violations, will instruct staff how to complete a FRI and fax to OLC/APS. 4. DON/Designee will interview a sample	

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F 609	Continued From page 22 mental status) score of 10 out of a possible 15. This score indicates moderate cognitive impairment. The MDS codes the resident as needing extensive assistance with physical assistance of 1 person for toileting, hygiene, dressing and bed mobility. She requires limited assistance with physical assistance of 1 person for walking in room, and transfers. She requires supervision for eating meals. The Resident uses a walker to aid in mobility. On 2/9/21 approximately 1:00 PM Resident #15 was asked about abuse and neglect in the facility, she stated "There was one aide that wasn't nice but I told her to leave. She hasn't been around lately." On 2/10/20 during clinical record review it was discovered that the following entry was made in the progress notes: "1/1/21 at 9:18 PM - At 430 PM [Resident #15 name redacted] came out from her room and was ambulating with her rollator. She passed by the nurse's station and stated 'Someone banged my face and head in the bars this morning.' Writer asked if she can recall the name of the person and she stated 'I don't know.' On 2/10/21 at approximately 11:00 AM an interview was conducted with the Administrator and she was asked if there were any FRI's involving this Resident she stated that there were not. When asked if there were any incidents involving this Resident and a staff member she stated "I'm not sure I think when I was out... something happened." On 2/10/21 at 11:41 an interview was conducted with the DON and the Administrator who was	F 609	of 12 residents weekly for a period of one (1) month and thereafter, monthly for a period of three (3) months, to ensure that residents are free from abuse/neglect and will report to State Agency within two (2) hours of knowledge of an allegation of abuse. 5. Results of the audit will be forwarded to the QA Committee for three (3)consecutive months, when a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	

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asked about an incident involving Resident #15 and LPN A. The Administrator stated it happened when she was out sick. "The DON called me at home." The DON was asked why this incident was not reported to the OLC (state agency) and she stated "I forgot."

The Administrator submitted the FRI to the OLC on 2/10/21 at 3:50 PM.

On 2/11/21 during the end of day meeting the Administrator was made aware of concerns and no further information was provided.

2. For Resident #13 the facility failed to report allegation of abuse.

Resident # 13 a 97 year old woman, admitted to the facility on 12/06/19, with diagnoses of but not limited to hypertension, malignant neoplasm of pancreas, diabetes, urinary tract infection, prosthetic heart valve, and age related macular degeneration.

Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/4/20, an annual assessment, coded Resident #13 as having a BIMS (brief interview of mental status) score of 14 out of a possible 15. This score indicates no cognitive impairment. The MDS codes the resident as needing extensive assistance with all aspects of ADL care with the exception of eating. Resident #13 is able to feed herself with only supervision. The Resident uses a walker for aid in short distance mobility and a wheelchair for longer distances.

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On 2/10/21 at approximately 10:00 AM Surveyor C observe the following interaction. "At 9:20 AM Resident #13 was in wheel chair next to the medication cart. Resident #13 stated "Somebody kicked me." LPN C asked "Who kicked you?" Resident replied "I don't know". LPN C assisted the Resident to lift her right pant leg to reveal a dressing on right shin. LPN C then stated to the resident "No one kicked you" and went on to tell Resident that she had a dressing on her shin from a skin tear. Another staff member then approached Resident and rolled her down the hall in wheel chair."

At 10:40 AM Surveyor B interviewed Resident #13 after she returned from physical therapy. The Resident was asked about the injury to her right shin and she stated "Somebody kicked me, I don't remember who." When asked about abuse or neglect she stated "I cannot stand that nurse from last night we had a fight." When asked what happened she stated "I can't stand her she is rude and she just would not leave me alone, so we got into a fight. She is not a good nurse and she drops stuff and then picks it up off the floor and gives it to you. That's not sanitary or wise these days. She has no patience. I was kicking at her to get her to leave me alone. They know I don't like her and don't want her in my room."

On 2/10/21 a review of the clinical record revealed the following progress note:
" 2/10/21 at 12:59 AM - Resident call bell was on, and staff went to answer the call bell, resident stated she want to go to BR, staff got resident up in the w/c and assisted resident to the bathroom and while assisting resident back to bed she refused to allow staff to apply pillow under her legs and was insisting on keeping her legs

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LITTLE SISTERS OF THE POOR IN RICHMOND	1503 MICHAEL ROAD RICHMOND, VA 23229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 25 outside the bed sa [sic] staff was assisting to put the legs back to bed resident became physically aggressive and started kicking and swinging at staff was verbally aabusive [sic] and told staff she hate her, redirected and assured resident that staff is here to help and to assure her safety." On 2/10/21 at approximately 10:58 AM an interview was conducted with the Administrator. She was asked if she was aware of an allegation of abuse by Resident #13. She stated that she had not heard of this but would start an investigation. The state agency was sent a FRI at 11:56 on 2/10/21. The Administrator was made aware of the concerns during the end of day meeting on 2/10/21, and no further information was provided. 3. For Resident #5, the facility staff failed to report an injury of unknown injury which was discovered by a certified nursing assistant on 01/12/2021. Resident #5, a 98-year old female, was admitted to the facility on 04/26/2013. Diagnoses for Resident #5 included but were not limited to atherosclerosis and peripheral vascular disease. Resident #5's most recent Minimum Data Set with an Assessment Reference Date of 01/06/2021 was coded as an annual assessment. The Brief Interview for Mental Status was coded as "99" meaning unable to complete the	F 609		

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F 609	Continued From page 26	F 609		

interview. Cognitive Skills for Daily Decision Making were coded as moderately impaired. Short-term and Long-term memories were coded as "memory problem." Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff.

On 02/11/2021 at approximately 8:45 A.M., the clinical record was reviewed. A nurse's note dated 01/12/2021 at 6:46 A.M. documented, "Note Text: cna reported to writer that she noted discoloration to right hand between 2nd and 3rd fingers, denies pain will continue to monitor the area." The subsequent nurse's notes through 01/18/2021 at 2:26 P.M. were reviewed and the injury of unknown origin to the right hand was not addressed.

On 02/12/2021 at approximately 9:20 A.M., a copy of the facility-reported incident and the investigation documentation associated with this injury of unknown origin to the right hand were requested.

On 02/12/2021 at approximately 11:15 A.M., an interview with the Director of Nursing was conducted. The Director of Nursing stated that it was not reported investigated or reported to the state agency. The Director of Nursing stated the staff were re-educated and a facility-reported incident will be sent to the state agency.

When asked about expectation from staff when an injury of unknown origin is discovered, the Director of Nursing stated the expectation is that the nurse report it as soon as possible so "we can send in a FRI [facility-reported incident] and "begin the investigation." The Director of Nursing also stated the expectation includes assessing

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and interviewing residents and staff associated with the injury and "notify all the proper people and the doctor."

The facility staff provided a copy of their policy entitled, "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property." In Section G entitled, "Reporting and Response" under the header, "Abuse Policy Requirements", it was documented, "It is the policy of this Home that "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of Resident property) are reported per Federal and State law. The Home will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two (2) hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury, or not later than twenty-four (24) hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the Home and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through establish procedures. In addition, local law enforcement will be notified for any reasonable suspicion of a crime against a Resident in the home."

In summary, Resident #5 had an injury of unknown source to her right hand between the 2nd and 3rd fingers (identified on 01/12/2021) and the facility staff failed to report. On 02/12/2021 at approximately 1:45 P.M., the

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F 609	Continued From page 28 administrator and Director of Nursing were notified of findings.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, facility documentation and clinical record review the facility staff failed to investigate, prevent and correct allegations of abuse in a timely manner for 3 Residents (#15, #13, and #5) in a survey sample of 17 Residents. The findings included: 1. For Resident #15 the facility failed to remove the alleged abuser from the resident pending investigation. Resident #15 an 85 year old woman, was	F 610	1. Facility investigated and APS/OLC were notified on 2/9/21 for Resident#15. LPN A was disciplined, written up and terminated on 2/11/21. For Resident#13, LPN C, LPN B were in-serviced on when to report accusations of abuse to DON/ADM immediately. The allegation of abuse/mistreatment was reported to APS/OLC on 2/10/21. For Resident#5, the facility staff investigated the injury of unknown cause acquired on 1/12/21 and notified APS/OLC on 2/12/21.	4/2/21

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F 610	Continued From page 29 admitted to the facility on 10/18/19 with diagnoses of but not limited to dementia without behavioral disturbance, anemia, chronic kidney disease, anxiety, major depressive disorder, falls, and atherosclerotic heart disease. Resident #15's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/21/20, an quarterly assessment, coded Resident #15 as having a BIMS (brief interview of mental status) score of 10 out of a possible 15. This score indicates moderate cognitive impairment. The MDS codes the resident as needing extensive assistance with physical assistance of 1 person for toileting, hygiene, dressing and bed mobility. She requires limited assistance with physical assistance of 1 person for walking in room, and transfers. She requires supervision for eating meals. The Resident uses a walker to aid in mobility. On 2/10/20 during clinical record review it was discovered that the following entry was made in the progress notes: "1/1/21 at 9:18 PM - At 430 PM [Resident #15 name redacted] came out from her room and was ambulating with her rollator. She passed by the nurse's station and stated 'Someone banged my face and head in the bars this morning.' Writer asked if she can recall the name of the person and she stated 'I don't know.' The Administrator submitted a "Corrective Action Plan" for LPN A excerpts are as follows: "Employee Name: [redacted] Department: Nursing Date: 1/28/21 Date of Occurrence: 1/1/21 Location: Nursing Time: 11 pm -7 am "Action Taken: Written Counseling"	F 610	2. DON/Designee will interview each Nursing Home Resident to ensure other Residents are free from abuse or neglect. 3. DON/NHA will conduct a thorough investigation of any alleged violations and report to State Agency within two (2) hours. Staff will be taken off the scheduled and placed on administrative leave. The results of all investigations will be reported to the Administrator and to other officials in accordance with State laws, including the State Survey Agency within 5 working days of the incident. If the alleged violation is verified, appropriate corrective actions will be taken. 4. DON/Designee will interview on the subject of "Abuse and Neglect" a sample of 12 Residents weekly for one (1) month and thereafter monthly for a period of three (3) months to ensure Residents are free from abuse or neglect. 5. Results of the audit will be forwarded to the QA Committee for three (3) consecutive months, when a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	

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"Description of Issue: [box checked] Policy Violation [box checked] other: Mental Intimidation."

"Explanation: It was reported to Acting DON by Administrator on 1/6/21 of an incident involving resident # [medical record number redacted] on the morning of 1/1/21. The report stated that Resident was refusing care which was reported to the Charge Nurse, [LPN A name redacted]. At that time, Charge Nurse and CNA both went in to care for Resident. Per report, Resident continued to be resistant to care and Charge Nurse began to pull down Residents clothes while Resident was in bed and was speaking to Resident in a loud and uncalm voice. When Charge Nurse was pulling Resident's clothes off, the bed was unlocked on one side and began to move with the headboard hitting the wall. Charge Nurse locked the bed and continued pulling clothes off, kicking the soiled depends and clothing on the floor at which time she was bumping or hitting the walker and rocking chair with her feet which in turn was hitting the wall and the furniture in the Resident's room. Resident yelled at Charge Nurse to stop and Charge Nurse responded that they were there to help her and she was fighting them and telling them that they were hitting her furniture. Charge Nurse then stated "This is how we hit furniture" and grabbed the walker or the rocking chair and was hitting it against the wall or the china dresser. CNA approached the Resident and took over washing her up and changing her clothes and Charge Nurse exited the room, however she was still talking to the Resident in a loud and Unocal manner. Per CNA, Resident at this time was reported to be shaking and walked outside of her room and sat in recliner on the unit. Another staff member came to see what all the

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loud voices was about and to see if everything was okay. The Charge Nurse said everything was Okay."

On 2/10/21 a review of the time clock punches for LPN A revealed that LPN A continued to work on the very same unit with the Resident until 2/1/21.

A review of the Abuse and Neglect Policy read:

Page 9 Paragraph F Protection"
Abuse Policy Requirements: It is the policy of this HOME that the resident(s) will be protected from the alleged offender(s).

"Procedure:
Immediately upon receiving a report of alleged "abuse", the Administrator, and / or designee will coordinate delivery of appropriate medical and or psychological care and attention. Ensuring safety and wellbeing for the vulnerable individual are of utmost priority. Safety, security and support of the Resident, their roommate, if applicable and other Residents with the potential to be affected will be provided. This should include as appropriate:"
1. Procedures must be in place to provide the Resident with a safe, protected environment during the investigation.
a. The alleged perpetrator will immediately be removed and the Resident protected. Employees accused of alleged abuse will be immediately removed from the Home and will remain removed pending the results of a thorough investigation. (Decision of the extent of immediate disciplinary action will be made by the Administrator and/or designee)."

On 2/11/21 during the end of day conference the

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Administrator was made aware of the concerns and no further information was provided.

2. For Resident #13, LPN B failed to immediately report an accusation of abuse to the Administrator.

Resident # 13 a 97 year old woman, admitted to the facility on 12/06/19, with diagnoses of but not limited to hypertension, malignant neoplasm of pancreas, diabetes, UTI, prosthetic heart valve, and age related macular degeneration.

Resident #13's most recent MDS (minimum data set) with an ARD (assessment reference date) of 12/4/20, an annual assessment, coded Resident #13 as having a BIMS (brief interview of mental status) score of 14 out of a possible 15. This score indicates no cognitive impairment. The MDS codes the resident as needing extensive assistance with all aspects of ADL care with the exception of eating. Resident #13 is able to feed herself with only supervision. The Resident uses a walker for aid in short distance mobility and a wheelchair for longer distances.

On 2/10/21 at approximately 10:00 AM surveyor C reported the following interaction.

"At 9:20 AM Resident #13 was in wheel chair next to the medication cart. Resident #13 stated "Somebody kicked me." LPN C asked "Who kicked you?" Resident replied "I don't know". LPN C assisted the Resident to lift her right pant leg to reveal a dressing on right shin. LPN C then stated to the resident "No one kicked you" and went on to tell Resident that she had a dressing

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F 610	Continued From page 33	F 610		

on her shin from a skin tear. Another staff member then approached Resident and rolled her down the hall in wheel chair."

At 10:40 AM surveyor B interviewed Resident #13 after she returned from physical therapy. The Resident was asked about the injury to her right shin and she stated "Somebody kicked me, I don't remember who." When asked about abuse or neglect she stated "I cannot stand that nurse from last night we had a fight." When asked what happened she stated "I can't stand her she is rude and she just would not leave me alone, so we got into a fight. She is not a good nurse and she drops stuff and then picks it up off the floor and gives it to you. That's not sanitary or wise these days. She has no patience. I was kicking at her to get her to leave me alone. They know I don't like her and don't want her in my room."

On 2/10/21 at approximately 10:58 AM an interview was conducted with the Administrator. She was asked if she was aware of an allegation of abuse by Resident #13. She stated that she had not heard of this but would start an investigation.

The Administrator was made aware of the concerns during the end of day meeting on 2/10/21, and no further information was provided.

3. For Resident #5, the facility staff failed to investigate an injury of unknown injury that was

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identified on 01/12/2021.

Resident #5, a 98-year old female, was admitted to the facility on 04/26/2013. Diagnoses for Resident #5 included but were not limited to atherosclerosis and peripheral vascular disease.

Resident #5's most recent Minimum Data Set with an Assessment Reference Date of 01/06/2021 was coded as an annual assessment. The Brief Interview for Mental Status was coded as "99" meaning unable to complete the interview. Cognitive Skills for Daily Decision Making were coded as moderately impaired. Short-term and Long-term memories were coded as "memory problem." Functional status for bed mobility and transfers were coded as requiring extensive assistance from staff.

On 02/11/2021 at approximately 8:45 A.M., the clinical record was reviewed. A nurse's note dated 01/12/2021 at 6:46 A.M. documented, "Note Text: cna reported to writer that she noted discoloration to right hand between 2nd and 3rd fingers, denies pain will continue to monitor the area."

On 02/12/2021 at approximately 11:15 A.M., an interview with the Director of Nursing was conducted. When asked about investigation documentation associated with this injury of unknown origin, the Director of Nursing stated that it was not investigated.

The facility staff provided a copy of their policy entitled, "Abuse, Neglect, Mistreatment and Misappropriation of Resident Property." In Section E entitled, "Investigation" under the header "Abuse Policy Requirements", it was documented, "It is the policy of the Home that

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F 610	Continued From page 35 reports of "abuse" (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated." In Section E, Part 2 and subpart (a), it was documented, "Investigation of injuries of Unknown Origin or Suspicious injuries: must be immediately investigated to rule out abuse: (a) Injuries include but are not limited to, bruising of the inner thigh, chest, face, and breast, bruises of an unusual size, multiple unexplained bruises, and/or bruising in an area not typically vulnerable to trauma." In summary, Resident #5 had an injury of unknown source to her right hand between the 2nd and 3rd fingers (identified on 01/12/2021) and the facility staff failed to investigate the matter. On 02/12/2021 at approximately 1:45 P.M., the administrator and Director of Nursing were notified of findings.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		4/2/21

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F 656	Continued From page 36 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure that Resident #24's Mental Health Care Plan had measurable goals. The facility staff failed to identify specific symptoms or behaviors related to depression, fatigue, racing thoughts, or ability to concentrate. The Findings included:	F 656	1.Care plan for Resident#24 related to Mental Health was updated on 2/16/21 and consultation with LifeSource for psychotherapy and psychiatry visits were added. 2. DON/NHA will read the 24/72 Hour report to identify specific medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessments and documentation so care	

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LITTLE SISTERS OF THE POOR IN RICHMOND	1503 MICHAEL ROAD RICHMOND, VA 23229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 37 Resident #24 was an 80 year old who, admitted to the facility on 5/1/20. Resident #24's diagnosis included Major Depressive Disorder, Dysthymic Disorder, Generalized Anxiety Disorder, Diabetes Mellitus Type 2, and Malignant Neoplasm of Left Breast. Resident #24's Admission Minimum Data Set, dated 5/5/20 documented that the Brief Interview Mental Status (BIMS) score was 14, indicating no cognitive impairment. Resident #24 had little interest or pleasure in doing things half or more days weekly, depression half or more days weekly, little energy, and trouble concentrating several days weekly. The Quarterly Minimum Data Set, dated 10/30/20 documented the BIMS score of 10, indicating a decline in cognitive functioning. It coded Resident #24 as having a depressed mood several days weekly. It also coded tiredness nearly daily, and trouble concentrating. On 2/12/21, Resident #24's clinical record contained a Medication Administration Record dated 2/1/21. She received 10 mg of Lexapro daily for depression. Resident #24's Clinical Record was reviewed revealing the Mental Health Care Plan. An excerpt read: "has depression r/t [related to] health status...will remain free of symptoms of depression, anxiety or sad mood through review date." The goals and interventions were not measurable in the Care Plan. On 12/16/21 at approximately 11:00 A.M., an interview was conducted with the facility Director of Nursing (Employee B). She was asked to	F 656	plans can be developed or update in a timely manner. 3. DON/NHA will in-service MDS Coordinator and licensed staff on developing/implementing comprehensive care plans and updating in a timely manner. NHA will attend care conference once a month to monitor progress. 4. MDS Coordinator with the IDT Team will work with the twelve (12)residents weekly for three (3)consecutive weeks to get appropriate interventions such as therapy or medications, thereafter monthly for three (3) months until proper resolution is achieved. 5. Results of the audit will be forwarded to the QA Committee for three (3)consecutive months, when a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	

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F 656	Continued From page 38 describe Resident #24's specific, measurable goals. She was unable to say whether Resident #24 had progressed, regressed, or remained the same. She was unable to determine if the treatment was effective. The DON stated that she would look into it. No further information was received that documented specific measurable goals and interventions.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		4/2/21

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F 657	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to revise the care plan for 1 resident (Resident #16) in a sample size of 17 residents. The findings included: For Resident #16 the facility staff failed to review and revise his care plan to include assessing the AV fistula (used for dialysis access). Resident #16, an 84 year old man with diagnoses of but not limited to end stage renal disease, dependent on dialysis, sleep apnea, Chronic Obstructive Pulmonary Disease, atrial fibrillation, asthma, hypertension and osteoarthritis of knees. Resident #16's most recent MDS coded as an annual with an ARD date of 10/27/19 coded the Resident as having a BIMS score of 12 out of 15 indicating moderate cognitive impairment. The Resident was coded as requiring extensive assistance with all aspects of ADL with physical assistance of 1 person, except for eating which only required supervision. The Resident is unable to ambulate and uses a wheelchair for mobility. On 2/11/21 during clinical record review it was noted that the Resident was a dialysis patient with an AV Fistula. He had an order dated 3/6/20 to assess for thrill and bruit every shift (thrill is palpating the site to feel the blood moving freely and bruit is auscultating with a stethoscope to assess for patency). A review of the Residents care plan revealed this was not addressed.	F 657	1. Care plan for Resident#16 was updated/revised to include assessing the AV fistula. 2. Comprehensive review of the care plan items per discipline. Resolve interventions that are no longer pertinent to the care of the Resident. Update/revise care plans as necessary. Inform all parties, including families of changes in plan of care. 3. DON/Designee will in-service MDS Coordinator and licensed staff on care plan timing and revision. NHA will attend care conference once a month to monitor progress. 4. . MDS Coordinator with the IDT Team will work with the twelve (12)residents weekly for three (3)consecutive weeks to get appropriate interventions such as therapy or medications, thereafter monthly for three (3) months until proper resolution is achieved. 5. Results of the audit will be forwarded to the QA Committee for three (3) consecutive months, when a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	

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F 657	Continued From page 40 On 2/11/21 LPN D (the wound care nurse) was asked if there was anything special you had to do for Residents receiving dialysis. She stated that when a Resident is on dialysis his vitals and weights should be done before and after dialysis, his AV Fistula site should be checked for bleeding, his labs should be reviewed, and the nurses should be checking for bruit and thrill each shift. On 2/11/21 an interview was conducted with the DON at approximately 2:00 PM and she was asked what should be on the care plan and she responded "The care plan should address anything that involves taking care of the resident for example pain, falls, any adaptive equipment, feeding, any behaviors, any wounds, or anything that would direct you how to care for the Resident". When asked if the care and assessment of an AV Fistula should be on there and she stated yes it should. On 2/11/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686		4/2/21

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F 686	Continued From page 41 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to identify and treat a Stage 3 sacral pressure wound for 1 Resident (Resident #18) in a sample size of 17 residents. This is harm. The findings included: Resident #18, a 77-year old male, was admitted to the facility on 07/21/2017. Diagnoses included but were not limited to type 2 diabetes mellitus and dementia. Resident #18's Minimum Data Set with an Assessment Reference Date of 12/21/2020 was coded as a quarterly assessment. The Brief Interview for Mental Status was coded as "11" out of possible "15" indicative of moderate cognitive impairment. Functional status for bed mobility was coded as requiring extensive assistance from staff. Urinary continence was coded as frequently incontinent. Bowel continence was coded as occasionally incontinent. On 02/09/2021 at approximately 2:47 P.M., Resident #18 was observed sleeping in bed lying supine and leaning to the right with the head of the bed elevated approximately 30 degrees. Resident #18 had a wedge under his head and pillows on each side of the bed. On 02/09/2021 through 02/11/2021, Resident #18's clinical record was reviewed. An excerpt of	F 686	1. For resident#18, stage 3 sacral pressure wound is healed. Staff is continuing ongoing prevention treatments. 2. DON/Designee will conduct skin assessments for all Residents to determine if no further areas of concern are to be addressed regarding skin integrity. 3. DON/Designee will in-service all licensed staff regarding skin integrity, proper care of pressure ulcers, proper documentation and notification of physician and receiving orders for pressure ulcer care. 4. DON/Designee will conduct weekly audits for a period of one (1) month, and for the following three (3) months, conduct monthly audits of Residents' skin assessments. 5. Results of the audit will be forwarded to the QA Committee for three (3) consecutive months, when a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	

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a nursing skin assessment dated 01/24/2021 at 9:45 A.M. under the header "Skin Evaluation" and sub-header "site" documented, "Coccyx." Beside this site under the sub-header "Description", it was documented, "2x2x1 stage 3 open area per wound doctor." A physician's order for zinc oxide paste to "apply to sacrum topically" had a start date of 12/18/2020 and an end date of 12/23/2020. A physician's order for calcium alginate to "apply to sacrum topically" had a start date of 12/24/2020 and an end date 02/05/2021.

On 02/11/21 at approximately 2:05 P.M., this surveyor and Licensed Practical Nurse D (LPN D) entered Resident #18's room to perform a skin assessment. LPN D stated that [Resident #18] had a healed stage 3 sacral wound. LPN D asked Employee J, a physical therapist, to assist with positioning. LPN D and Employee J assisted Resident #18 to reposition to his left side to assess sacral region. When the facility staff removed the brief, it was noted Resident #18 had a bowel movement in the brief but it did not obstruct the view of the sacral region. There was no dressing and no evidence of paste or cream on the buttocks or sacral region. The skin in the sacral region was reddened with an open area and slough at the center of the wound. When asked about assessment findings, LPN D stated that the wound physician saw [Resident #18] "a few days ago" and that [Resident #18] had a healed stage 3 sacral pressure wound. LPN D also stated that now it looks like [Resident #18] needs a treatment plan. LPN D also stated she would notify the wound doctor.

On 02/11/2021 at approximately 4:05 P.M., LPN D provided wound physician notes and nursing notes associated with the finding. When asked

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how often skin assessments are performed, LPN D stated the nurses perform skin assessments once a month and document them in the electronic health record. LPN D also stated that "the CNA's [certified nursing assistants] do skin checks with baths" and document them in a book on the unit.

A wound physician note dated 02/03/2021 under the header "Stage 3 Pressure Wound Sacrum" and sub-header "Wound Progress", it was documented, "Resolved. Anatomic location of previously existing wound examined today: epithelialized and resolved. Follow up only as needed."

On 02/11/2021 at approximately 5:15 P.M., the facility staff provided a copy of the CNA skin check sheets for Resident #18. A document filled in by Certified Nursing Assistant A (CNA A) dated 02/10/2021 at 8:45 P.M. entitled, "Pressure Ulcer Identification Pocket Pad" documented the following header: "CNA please complete for your unit, Check areas during your rounds, dressing and bathing, You are the first set of eyes that sees the skin, be sure to check feet, heels, buttocks and all other areas especially pressure areas, Please feel free to write on this sheet and use descriptions and circle or mark site on the image below and turn in to your nurse so they can follow-up, thanks." "Place the patient's/resident's name on the top of the pad, date it, and place an "X" on the area of concern. Give this to the nurse and ask him or her to check the patient/resident. They will follow-up as needed." There was an "X" marked on the sacral region with the word "Discoloration" written beside it. On the bottom right side of the page, it was documented, "Noted RN [registered nurse] 02/10/2021."

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A nurse's note written by LPN D dated 02/11/2021 at 2:31 P.M. (approximately 30 minutes after the wound observation with this surveyor) documented, "Upon checking residents [sic] buttocks, noticed sacrum wound stage 3 pressure area appeared reopened formally resolved on 02/03/2021 with [wound physician company name] wound specialist [physician name] in person, sacrum wound area red, 1.0 x 1.0cm [centimeter], partial thickness skin loss noted but no bone, tendon or muscle tissues are exposed, area is without drainage or slough, resident stated he had no pain, PT [physical therapist name] assisted in turning and repositioning of resident, contacted [wound doctor name] to complete telemed visit for re-opened pressure wound to sacrum."

An excerpt of a nurse's note written by LPN D dated 02/11/2021 at 3:01 P.M. documented, "Resident evaluated by [wound doctor name and company] wound specialist via telemed for re-opened stage 3 pressure wound to sacrum, per forms 2 x 2 x 0.1 cm, 'Patient with a re-opened stage 3 wound, when healed used zinc paste as prevenative [sic] measure, please resume q day [every day] alginate dressing with foam which has worked in the past, [sic]' "

A nurses note written by LPN D dated 02/11/2021 at 3:25 P.M. documented, "Stage 3 pressure sacrum wound claened [sic] and dry, no drainage no signs of infection noted, calcium alginate with foam dressing applied to scarum [sic], no pain noted during dressing change, eveing [sic] nurse present and notified of new orders."

A nurse's note written by LPN D dated 02/11/2021

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at 3:32 PM documented, "Resident on pressure relieving mattress, wedge placed under resident buttocks, reisdent [sic] currently facing the window, notified cna [certified nursing assistant] to continue to turn the resident and reposition q 2hr [every two hours] and as needed, contniue [sic] back to bed after meals."

A wound physician note dated 02/11/2021 under the header "Focused Wound Exam (Site 4) Stage 3 Pressure Wound Sacrum" included but not limited to the following sub-headers and input:
"Etiology: Pressure
MDS 3.0 Stage: 3
Duration: > [greater than] 1 days [sic]
Wound size (L x W x D)[length x width x depth]: 2 x 2 x 2 x 0.1 cm [centimeters].
Surface area: 4.00 cm²
Exudate: Moderate Serous
Slough: 20%
Granulation tissue: 60%
Other viable tissue: 20% (dermis).
Additional Wound Detail: Patient with reopened stage 3 wound. When healed a prevention order was put in place using zinc paste. Please resume algiante [sic] and foam which has worked well in the past."
Dressing Treatment Plan Primary Dressing: Alginate calcium apply once daily for 30 days Secondary Dressing: Foam Silicone bdr [border] & faced apply three times per week for 30 days Reason for No Debridement: Telemedicine."

On 02/12/2021 at approximately 11:15 A.M., an interview with the Director of Nursing was conducted. In reference to another Resident, the Director of Nursing stated that "a skin assessment by a CNA" was completed. When questioned about CNA's doing skin assessments,

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the Director of Nursing stated, "Well, it's not a skin assessment, the CNA's are just looking to see if they see discolorations and then they report it to the nurse." When asked about policy for the frequency of skin assessments, the Director of Nursing stated that nurses complete skin assessments once a month and the CNA's fill out the sheet once a week or when giving [residents] a bath. When informed of discovering a stage 3 sacral pressure wound during a skin assessment with this surveyor on 02/11/2021, the Director of Nursing stated [Resident #18] was up in his chair longer than usual on the previous day (02/10/2021) due to a doctor's appointment so the re-opening of the stage 3 sacral wound "may be due to that."

On 02/12/2021 at approximately 1:45 P.M., the administrator was notified of the wound observation (discovery of a stage 3 sacral pressure wound with slough in the wound bed) with this surveyor and facility staff on 02/11/2021.

On 02/16/2021 at approximately 8:15 A.M., the facility staff provided further documents which included the following:

A handwritten statement entitled, "Statement from CNA that had [Resident #18] on 2/11/21 from 6AM - 2PM" documented, "I got [Resident #18's name] down and up 4 times yesterday 02/11/21 and I applied cream on his bottom each time. He ate, was cleaned up from bowel movements and urinations several times. The statement was signed by CNA E and dated 2/12/21. Below that handwritten statement, there was another handwritten statement dated 2/15/21 and documented, "[CNA E's name] stated that she changed him again after lunch he was dry." That

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statement was signed by Registered Nurse A (RN A).

A handwritten statement written by CNA A dated 2/12/21 but not timed documented, "On 2/11/2021 (no time included) while helping a resident to the bathroom, the nurse told me that [Resident #18's name] needed to be changed. When I finished helping the resident I went to change [Resident #18's last name]. He was incontinent of stool and urine I wash him up [sic] an [sic] put calmosptine [sic] on his bottom and around his wounds. The dressing was still in place."
A typewritten statement dated 2/15/21 signed by Employee J, Physical Therapist, documented, "On Thursday, February 11, 2021 Physical Therapist was asked to assist the wound care nurse in turning a patient in bed so his skin could be assessed. Therapist observed the patient sacral region had white epithelial scar tissue with blanchable pink borders/periwound & appeared to be healing wound. The skin surrounding the wound area, wound borders and the wound itself appeared clean. The skin on patient's buttocks was clean and intact, as there were no other observable wounds noted. Physical therapist also observed that the patient had just begun to have a bowel movement when the nurse remove the diaper for the patient's skin to be assessed. Upon initially removing the diaper it appeared to be clean, dry and free of stool. Therapist was unable to observe the perianal scan due to patient having just begun to have a bowel movement." This statement contradicts what LPN D and the wound physician documented in the clinical record.

In summary, the facility staff failed to identify and treat a stage 3 sacral pressure wound until it was discovered during a skin assessment with the

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F 686	Continued From page 48 wound nurse and this surveyor on 02/11/2021. According to the CNA sheet completed by CNA A on 02/10/2021 at 8:45 P.M., there was discoloration in the sacral region and a registered nurse (unnamed) was made aware on 02/10/2021. There was no evidence in the clinical record the sacral region was then assessed by a nurse or findings documented.	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility documentation review and clinical record review, the facility failed to provide respiratory care therapy consistent with infection control measures for 1 Resident (Resident # 11) in a survey sample of 17 Residents. The findings included: For Resident # 11, the facility staff failed to change the water bottle attached to an oxygen concentrator weekly. The date on the water bottle attached to the oxygen concentrator was 1/29/2021. There was no date noted on the nasal cannula tubing.	F 695	1. Resident #11 water bottle attached to the oxygen concentrator was changed and the date was placed. Nasal cannula tubing was changed and the date was placed. 2. DON/Designee will obtain a list of O2 orders and ensure that all appropriate water bottles and nasal cannula tubing changed weekly and dated. 3. DON/Designee will in-service nursing staff to ensure that residents have oxygen concentrators with water bottles attached and nasal cannula tubing are changed and dated weekly.	4/2/21

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	49E151	A. BUILDING _____ B. WING _____	02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SISTERS OF THE POOR IN RICHMOND	1503 MICHAEL ROAD RICHMOND, VA 23229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 49 Resident # 11 was an 95 year old admitted to the facility on 09/10/2019 with diagnoses of, but not limited to: Pneumonia, Chronic Pulmonary edema, Heart Failure, Sarcoidosis, Malignant Neoplasm of the Stomach, hypertension, and Peripheral Vascular Disease. The most recent (Minimum Data Set) MDS was a Quarterly assessment with an (Assessment Reference Date) ARD of 12/16/2020 coded Resident # 11 as having a (Brief Interview of Mental Status) BIMS score of 14 indicating No Cognitive Impairment. Resident # 11 required assistance of one staff person with activities of daily living. On 2/9/2021 at 3:09 PM during tour of the facility, Resident #11 was observed in her room sitting a recliner. Oxygen was provided at 2 liters per minute via a nasal cannula. Surveyor B observed the water bottle on the oxygen concentrator was dated 1/29/2021. It was 11 days since the water bottle had been changed. There was no date noted on the nasal cannula tubing. Review of clinical record was conducted on 2/9/2021 and 2/10/2021. Review of the Physicians Orders revealed an order dated 3/16/2020 for "O2 (oxygen) at 2 L (liters) via N/C (nasal cannula) every shift for COPD (Chronic Obstructive Pulmonary Disease)." Review of the care plan revealed a focus area "has oxygen therapy related to COPD (Chronic Obstructive Pulmonary Disease). Interventions	F 695	4. DON/Designee will audit O2 concentrators for replacement dates and ensure nasal cannula tubing and water bottles changed weekly for three (3) months, thereafter monthly for a period of three (3) months. 5. Results of the audit will be forwarded to the QA Committee for three (3) consecutive months, when a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	

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F 695	Continued From page 50 included "Administer oxygen via nasal prongs/mask @ 2 Liters continuously Date initiated 10/08/2019. Follow facility protocol for infection control (O2 filter cleaning/changing, O2 tubing changing, etc.) Date initiated 10/08/2019." On 2/11/2021 at approximately 10:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) F who stated the facility policy was to change the oxygen tubing and water bottle every 7 days. LPN G stated changing equipment weekly would help prevent infections. On 2/16/2021 at 2 PM, an interview was conducted with the Director of Nursing who stated the facility policy was to change the oxygen/respiratory equipment every 7 days. The Director of Nursing stated it was important to change the respiratory equipment weekly to prevent the potential spread of infection. During the end of day debriefing with Administrative staff on 2/16/2021, the Administrator, Director of Nursing were informed of the findings. The Administrator and Director of Nursing (DON) stated the expectation was to change the oxygen equipment and water bottle weekly and document the date on a label. The DON stated the date on the water bottle would indicate the date the water bottle was changed. There should be a label placed on the oxygen tubing noting the date when changed. No further information was provided.	F 695		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40	F 740		4/2/21

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F 740	Continued From page 51 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide Resident #24 with necessary behavioral health care and services to attain or maintain the highest practicable mental and psychosocial well-being. The facility staff failed to ensure that Resident #24 received mental health services as required by her Care Plan. There was a 4-month delay in mental health assessment and treatment from May 19, 2020 [date of the Care Plan] until September 29, 2020. The Findings included: Resident #24 was an 80 year old who, admitted to the facility on 5/1/20. Resident #24's diagnosis included Major Depressive Disorder, Dysthymic Disorder, Generalized Anxiety Disorder, Diabetes Mellitus Type 2, and Malignant Neoplasm of Left Breast. Resident #24's Admission Minimum Data Set, dated 5/5/20 documented that the Brief Interview Mental Status (BIMS) score was 14, indicating no cognitive impairment. Resident #24 had little interest or pleasure in doing things half or more	F 740	1. Resident#24 had continuous interactions with the activity department since 4/26/20. Resident#24 continues to be on the case load with LifeSource for psychotherapy and psychiatry visits. 2. DON/NHA will read the 24/72 hour report to identify the need for behavioral health services, so LifeSource can be consulted. 3. DON/NHA will in-service MDS Coordinator and Social Services Staff on identifying the Residents' need for behavioral health services. 4. DON/Designee will interview twelve (12) residents weekly for four (4) weeks to ensure their psychotherapy and behavioral health needs are being met, thereafter monthly for a period of three (3) months. 5. Results of audit will be forwarded to QA Committee for three (3) consecutive months, when a determination will be	

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F 740	Continued From page 52 days weekly, depression half or more days weekly, little energy, and trouble concentrating several days weekly. The Quarterly Minimum Data Set, dated 10/30/20 documented the BIMS score of 10, indicating a decline in cognitive functioning. It coded Resident #24 as having a depressed mood several days weekly. It also coded tiredness nearly daily, and trouble concentrating. The review of Resident #24's Clinical Record revealed the Mental Health Care Plan. An excerpt read, "5/6/20. Depression r/t (related to) health status...Arrange for psych / [Previous provider] consult. Follow-up as indicated." From 9/29/20, through 2/2/21, Resident #24 received weekly psychotherapy visits from her former outpatient provider however, no psychotherapy visits were provided from 5/6/2020 to 9/28/2020. On 12/16/21, at approximately 11:00 A. M. an interview occurred with the facility Director of Nursing (Employee B). The surveyor asked why Resident #24 had not received timely psychiatric evaluation and treatment as required by her Mental Health Care Plan in May 19, 2020. Psychiatric services did not occur until 9/29/20, indicating a delay of 4 months. The DON stated that she would look into it. There was no documentation of the reason for the delay in evaluation and treatment. In addition, during that 4-month period there were no Social Services provided.	F 740	made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		4/2/21

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F 812	Continued From page 53 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to store, prepare, and serve foods in accordance with professional standards for food service safety. The facility staff failed to monitor temperatures on 02/04/21 for the dairy walk-in cooler, the walk-in freezer, the bread walk-in cooler, the produce walk-in cooler, and the misc. walk-in cooler.; failed to monitor a sanitation sink on 02/07/2021 and 02/08/21; and failed to monitor dishwater temperatures on 02/03/21, 02/04/21, 02/07/21, and 02/08/21; On 02/09/2021 at approximately 12:25 P.M., Surveyor A and Surveyor C toured the kitchen with head cook, Employee C. This surveyor and	F 812	1. NHA/Designee will in-serviced Dietary staff on daily expectations for monitoring refrigerator temperatures, sanitation sink and dishwasher temperatures. 2. Dietary supervisor/Designee will ensure that temperatures are taken daily and documented everyday. He will also ensure best practices are maintained by staff for cold food temperature standards. 3. Dietary supervisor/Designee will in-service all dietary staff regarding the proper procedure for temperature readings and proper documentation.	

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F 812	Continued From page 54 Surveyor A observed the Refrigerator Temperature Checklist for the month of February 2021. There were temperature values for 4 refrigerators (dairy walk-in cooler, bread walk-in cooler, produce walk-in cooler, and the misc. walk-in cooler) and one freezer recorded for each day with the exception of 02/04/2021. For 02/04/2021, there were no temperature values recorded, the input for each column was marked with an "X." When asked about the expectation for monitoring refrigerator temperatures, Employee C stated that the temperatures should be written in. On 02/09/2021 at approximately 12:40 P.M., this surveyor and Surveyor A observed the sanitation sink PPM [parts per million] log for the week beginning 02/07/2021. The PPM values were recorded daily at 6:30 A.M., 10:30 A.M., 2:30 P.M., and 4:00 P.M. with the exception of 02/07/2021 at 2:30 P.M., 02/07/2021 at 4:00 P.M., and 02/08/2021 at 6:30 A.M. When asked about the expectation for checking the sanitation sink, Employee C stated that "they probably just forgot to sign it." On 02/09/2021 at approximately 12:45 P.M., this surveyor and Surveyor A observed the dishwasher wash/rinse temperature log for the month of February 2021. There were wash and rinse temperature values recorded daily at 7:00 A.M., 1:00 P.M., and 7:00 P.M. with the exception of 02/03/2021 at 7:00 A.M., 02/04/2021 at 7:00 A.M., 02/07/2021 at 7:00 A.M., and 02/08/2021 at 7:00 A.M. On 02/10/2021 at approximately 8:45 A.M., Employee D, the Dietary Manager, was notified of finding. When asked about the expectation for	F 812	4. Dietary supervisor/Designee will audit weekly for a period of one (1) month thereafter monthly for a period of three (3) consecutive months, to ensure temperatures are taken and documented properly. 5. Results of the audit will be forwarded to the QA Committee for three (3) consecutive months, when a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	

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F 812	Continued From page 55 monitoring temperatures of the refrigerators and the dishwasher cycles, Employee D stated that the temperatures should be checked so we know what they are. On 02/10/2021 at approximately 9:00 A.M., the administrator was notified of findings and a copy of their related kitchen policies were requested. The facility staff provided a copy of their policy entitled, "Dish Machine Temperature Log." Under the header "Policy" it was documented, "Dishwashing staff will monitor and record dish machine temperatures to assure proper sanitizing of dishes." The facility staff provided a copy of their policy entitled, "Cleaning Dishes/Dish Machine." Under the header, "Policy", it was documented, "All flatware, serving dishes, and cookware will be cleaned, rinsed, and sanitized after each use. The dish machines will be checked prior to meals to assure proper functioning and appropriate temperatures for cleaning and sanitizing." The facility staff provided a copy of their policy entitled, "Food Safety and Sanitation." In Section 4 entitled, "Food Storage" subpart (a), it was documented, "Refrigerated food is stored at or below 41 degrees F [Fahrenheit]."	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/2/21

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F 880	Continued From page 56 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 57 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to implement infection control practices to help prevent the spread of infection. The findings included: Two facility staff members in the dining room failed to appropriately wear masks. On 2/9/21 at 12:15 PM it was observed by surveyors A & B that Employee G was noted to be feeding a Resident with her cloth mask below her nose. When surveyors went to speak to her she adjusted her mask to appropriately cover her nose and mouth. Employee H was observed walking from the kitchen into the dining room with mask below her chin. Once in the dining room she looked at the surveyors and pulled her mask	F 880	1. In-service will be provided to Employee G and Employee H on the CDC's "Facemask's Do's and Don'ts." 2. IP/Designee will conduct dining room observations to ensure staff have face masks fully covering their noses and mouths. 3. IP/Designee will in-service and licensed staff and certified nursing assistants regarding proper face mask coverage. 4. DON/IP/Designee will conduct for a period of one (1) month weekly audits and for the following three (3) months conduct monthly audits of staff's proper face mask covering.	

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F 880	Continued From page 58 up over her nose and mouth. Per CDC "Facemask's Do's and Don'ts" https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/fs-facemask-dos-donts.pdf "Clean your hands and put on your facemask so it fully covers your mouth and nose. DO secure the elastic bands around your ears. DON'T wear your facemask under your nose or mouth. DON'T touch or adjust your facemask without cleaning your hands before and after." On 2/16/21 at approximately 11:00 AM an interview was conducted with the Administrator. She was asked about the expectation of staff wearing masks she stated that masks should be worn at all times covering the mouth and nose. She stated I will re-in-service them when told about Employee G & H not wearing masks appropriately. On 2/16/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided	F 880	5. Results of the audit will be forwarded to the QA Committee for three (3) consecutive months, when a determination will be made if there is a need for further audits and additional action plans. Corrective action plan will be completed on April 2, 2021.	
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12.	F 943		4/2/21

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F 943	Continued From page 59 §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to ensure that required training for abuse and neglect were completed for 2 nurses on staff (LPN A, and LPN C) who were involved in investigations of allegations of abuse during survey. The facility further failed to identify that contracted nursing staff (LPN B) was trained on abuse. The findings included: The Facility failed to ensure mandatory annual abuse annual training for 2 facility staff Licensed Practical Nurses (LPN A & LPN C), and a contracted nurse (LPN B) involved in allegations of abuse. On 2/10/21 while investigating an allegation of abuse, the staff training records were reviewed and it was found that for LPN A, and LPN C they did not have the required training on abuse and neglect, and for LPN C the facility did not inquire about her training from the agency she worked for. LPN A was employed by the facility and her training record showed that she received abuse and neglect training in 7/23/16 7/30/17 and 9/26/18 there was no record of any abuse training after 9/26/18.	F 943	1. LPN A was disciplined, written up and terminated on 2/11/21. LPN C and contracted Nurse LPN B were in-serviced on Abuse, Neglect and Exploitation. 2. DON/Designee will ensure all staff have abuse, neglect and exploitation in-service. All new hires and current staff will also be in-serviced on abuse, neglect and exploitation on a yearly basis. Ensure all agency staff have abuse, neglect and exploitation training before working a shift. 3. DON/Designee will in-service all staff regarding abuse, neglect and exploitation. 4. DON/Designee will conduct for a period of one (1) month weekly audits and for the following three (3) months monthly audits off all new hires, agency and current employees, to ensure that in-service have been provided for abuse, neglect and exploitation. 5. Results of the audit will be forwarded to the QA Committee for three (3) consecutive months, when a determination will be made if there is a need for further audits and additional action plans.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E151	A. BUILDING _____ B. WING _____	02/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE SISTERS OF THE POOR IN RICHMOND	1503 MICHAEL ROAD RICHMOND, VA 23229

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 943	Continued From page 60 For LPN C her training record revealed that she had received abuse and neglect training on 12/18/14, 9/5/15, 12/5/16, 4/13/18 and 12/5/19. There were no record of any abuse training after 12/5/19 On 2/16/21 at approximately 11:00 AM an interview was conducted with the Administrator and she was asked if the facility provided all staff training on abuse and neglect and she answered yes. She was asked how often this was done and she stated upon hire and yearly after that. When asked if the facility had provided abuse and neglect training to LPN B she stated no. She indicated that she would have to get those records from the agency that LPN B works for. When asked if she verified LPN's training with the Agency before putting her on the schedule stated that she did not. When asked does she routinely verify agency staff training she stated that she did not. On 2/16/21 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 943	Corrective action plan will be completed on April 2, 2021.	