State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH2656	A. BUILDING: _____ B. WING _____	12/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIERRA FALLS CHURCH	2100 POWHATAN STREET FALLS CHURCH, VA 22043

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 11/30/21 through 12/01/21. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey. The census in this 160 licensed bed facility was 17 at the time of the survey. The survey sample consisted of 3 resident reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: 12VAC5-371-75 (B)(3) Based on staff interview and facility documentation review, the facility staff failed to obtain a criminal record report from the Virginia Department of State Police within 30 days after hire for 3 employees, the Facility Administrator, CNA C, and Employee E, in a sample of 20 employee records reviewed. The findings included: 1. The Facility Administrator was hired 11/30/20. The Facility Administrator's criminal background check was dated 2/19/21. Therefore, from 11/30/20-2/19/21, facility staff was unaware of the Facility Administrator's criminal background	F 001	12VAC 5-371-75 (B)(3) (1). All reviewed Personnel files (except 3) had Criminal Record checks completed showing the date requested, the date researched by Virginia State Police, but did not show date returned to the facility in a timely manner. No resident was found to be affected by the deficent practice. All three employees have completed record checks, are in good standing. (2). The Human Resource Manager has established a tracking tool to record the receipt of the completed Criminal Record. The Human Resources Manager will use criminal history checks directly on-line. This method will allow the Human Resources Manager to complete the criminal history check in a timely manner.	January 14th, 2022

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

Administrator 01-03-2022

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F 001	Continued From page 1 status. 2. CNA C was hired 1/12/21. CNA C's criminal background check was dated 2/19/21. Therefore, from 1/12/21-2/19/21, facility staff was unaware of CNA C's criminal background status and was permitted to provide direct care to Residents. 3. Employee E was hired 1/11/21. Employee E's criminal background check was dated 2/19/21. Therefore, from 1/11/21-2/19/21, facility staff was unaware of Employee E's criminal background status. On 11/30/21, an interview was conducted with the Human Resources Director who confirmed the hire dates for the 3 referenced facility staff members. The Human Resources Director stated, "We get criminal background checks on everyone before they are hired to be sure there is no criminal history, no history of abuse or barrier crimes, we want to make sure that they can be trusted and to ensure the safety of our residents". The Human Resources Director verified that the Facility Administrator, CNA C, and Employee E did not have a criminal background report within 30 days of their respective hire dates. A review of the facility's policy entitled, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation", dated 01/01/2021, subtitle, "Compliance Guidelines--1. Screening", read, "The facility will screen employees for a history of abuse, neglect, or mistreating residents by attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries". No further information was provided.	F 001	Continued From Page 1 (3). Education of all department managers will be conducted by the Administrator to include the regulation requirement and the new tracking process to assure that all criminal checks are completed in a timely manner (4). The Human Resources Manager is responsible to process and track new hire criminal record checks. The Administrator will check the criminal background check log monthly for 3 months, then random checks thereafter. (5). January 14th, 2022	January 14th, 2022 January 14th, 2022 January 14th, 2022

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F 001	Continued From page 2 12VAC5-371-110(J) Based on staff interview, clinical record review and facility documentation review, the facility staff failed to offer and/or administer vaccinations (flu and/or pneumonia) to 2 Residents, Resident #1 and #2, in a sample of 3 Residents. 1. For Resident #1 the facility staff failed to offer and/or administer the pneumococcal vaccination. 2. For Resident #2 the facility staff failed to offer and/or administer the flu and pneumococcal vaccinations. The findings included: 1. For Resident #1 the facility staff failed to offer and/or administer the pneumococcal vaccination. On 11/30/21, a clinical record review was conducted of Resident #1's EHR (electronic health record). This review revealed no record of pneumonia vaccination status for Resident #1. On 12/1/21, a review was conducted of Resident #1's paper chart. This review revealed no evidence/record of any vaccination information with regards to pneumonia vaccination. On 12/1/21 at approximately 9 AM, the DON (director of nursing) was asked to provide any evidence of pneumonia vaccination records for Resident #1. On 12/1/21 at approximately 4 PM, the DON confirmed she had no information regarding Resident #1's pneumonia vaccination status or	F 001	12VACS-371-110(J) (1). Resident #1 -. The responsible party has now been contacted, offered the Pneumovax for the resident, and declined its administration, signing an informed consent. Resident #2 has been offered the Influenza and Pneumococcal Vaccine, and has declined both vaccines, signing a declination statement. (2). A 100% audit of all resident records will be completed by the nursing supervisior to determine if each resident was offered and/or received (or declined) the Influenza vaccine and Pneumococcal vaccines. Findings of the audit will be reported to the Director of Nursing or her designee. Discrepancies will be corrected by the nursing supervisor, and recorded in the electronic chart, to include a signed consent/ or decline, which will be kept in the written record. (3). Charge nurses will complete an Admission Checkllist of all new admissions to determine if vaccines have been offered/received and/or declined. The nurses documentation in the electronic record will reflect their findings and actions regarding both vaccines for the new admission. Education will provided by the nursing supervsior, to all RNs,and LPNs, on the New Admission Chart Audit tool, and documentation of Immunizations in the electronic record. (4).The Nursing supervisor will review all New Admission records, Chart Audit tool, and progress note documentation in the electronic record for Immunizations, with in 48 hours of admission. Discrepancies in these reviews will be reported to the Director of Nursing or her designee, by the nursing supervisior.	January 14, 2022 January 14, 2022 January 14, 2022 January 14, 2022

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F 001	Continued From page 3 record of it being offered. 2. For Resident #2 the facility staff failed to offer and/or administer the flu and pneumococcal vaccinations. On 11/30/21, a clinical record review was conducted of Resident #2's EHR (electronic health record). This review revealed no record of pneumonia vaccination status for Resident #2 and flu vaccine was noted as "not eligible". There was a physician order dated 9/29/21, that read, "Fluzone High-Dose Quadrivalent Suspension Prefilled Syringe 0.7 ML (Influenza Vac High-Dose Quad) Inject 0.7 cc intramuscularly one time only for Immunization". Review of the MAR (Medication Administration Record) revealed a blank to indicate this immunization was not given. On 12/1/21, a review was conducted of Resident #2's paper chart. This review revealed no evidence/record of any vaccination information with regards to flu or pneumonia vaccinations or why Resident #2 would not have been eligible for the flu vaccine. On 12/1/21 at approximately 9 AM, the DON was asked to provide any information regarding the flu and pneumonia vaccine offering for Resident #2. On 12/1/21, in the afternoon, the DON stated that Resident #2 was a fairly new admission when they had the flu vaccination clinic and they were not aware of her vaccine history. She further stated that she was not aware of any reason why the record stated "not eligible". On 12/1/21, in the afternoon, the DON stated the	F 001	, by the nursing supervisior designee. The summary of the discrepancies and their corrections will be reported quarterly to the Quality Assurance/Performance Improvement Committee. (5). January 14th, 2022	

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F 001	Continued From page 4 facility doesn't really have a process in place for offering such vaccinations and she would have to research her options. The DON also stated that the purpose of and importance of vaccinations is, "To keep Resident's healthy and prevent diseases". Review of the facility policy titled, "Pneumococcal Vaccine" read, "1. Each resident will be assessed for pneumococcal immunization upon admission...2. Each resident will be offered a pneumococcal immunization unless it is medically contraindicated...7. The Resident's medical record shall include documentation that indicates at a minimum, the following: a. The resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization. b. The resident received the pneumococcal immunization or did not receive due to medical contraindication or refusal". Review of the facility policy titled, "Influenza Vaccination" read, "1. It is the policy of this facility, in collaboration with the medical director, to have an immunization program against influenza disease with national standards of practice. 2. Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated...9. The resident's medical record will include documentation that the resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal...". On 12/1/21 at 2:30 PM, during an end of day meeting, the facility Administrator and DON were	F 001		

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F 001	Continued From page 5 made aware of the findings. No further information was provided prior to conclusion of the survey. 12VAC5-371-210(E) Based on staff interview and facility documentation review, the facility staff failed to verify the professional license, prior to providing direct resident care, for 1 licensed professional nurse, LPN B, in a sample of 20 employee records reviewed. The facility staff failed to verify the professional license was active and in good standing for LPN B prior to allowing LPN B to provide direct resident care. The findings included: On 12/1/21, a review of LPN B's employee record and clinical staffing schedule was conducted. LPN B was hired on 3/12/21. LPN B's professional license verification was dated 4/6/21. Therefore, from 3/12/21-4/6/21, facility staff was unaware if LPN B's license was active and in good standing. LPN B was permitted to provide direct care to Residents beginning on 3/13/21. An interview was conducted with the Human Resources Director who confirmed the hire date for LPN B. The Human Resources Director stated, "The purpose of obtaining a license verification is to make sure that we are hiring qualified people to take care of our residents and to ensure there is no disciplinary action on their license".	F 001	12VAC 5-371-210(E) (1). Required Licenses are verified through the Virginia Department Health Professions. However the verification was not consistent prior to orientation start date on one employee. the one employee's license was checked and is in good standing No resident was found to be affected by the deficient practice (2) The Human Resources Manager will complete a 100 percent audit on all existing Licensed Employees by January 14th 2022. All applicant Licensed Employees will be Verified by Human Resources Manager after the interview and before orientation and start date. (3) All department Managers will be Inserviced by the Administrator on the processing of all new hire prospects. The Human Resource Manager will be responsible for the process of timely License verification. The Administrator will randomly check once per month for three months the timely verification of Licensed Employees completed by the Human resources Manager (4) The Human Resources Manager will report any discrepancies to the Administrator prior to the licensed Employee being hired. All licensed Employees will be verified by human Resources to assure applicant in in good standing.	January 14, 2022 January 14, 2022 January 14, 2022 January 14, 2022

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F 001	Continued From page 6 A review of the facility's policy entitled, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation", dated 01/01/2021, subtitle, "Compliance Guidelines--1. Screening", read, "The facility will screen employees for a history of abuse, neglect, or mistreating residents by attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries". No further information was provided. 12VAC5-371-210(F)(1) Based on staff interview and facility documentation review, the facility staff failed to verify certification, prior to providing direct resident care, for 2 certified nurse aides, CNA B and CNA C, in a sample of 20 employee records reviewed. The findings included: A review of employee records and clinical nursing schedules for CNA B and CNA C was conducted and revealed the following: 1. CNA B was hired 4/23/21. CNA B's certification was verified on 9/3/21. Therefore, from 4/23/21-9/3/21, facility staff was unaware if CNA B's certification was active and in good standing. CNA B was permitted to provide direct care to Residents beginning on 5/4/21 2. CNA C was hired 1/12/21. CNA C's certification was verified on 2/5/21. Therefore, from 1/12/21-2/5/21, facility staff was unaware if CNA	F 001	Continued From page 6 (5). January 14th, 2022 12VAC5-371-210(F)(1) (1) Certified Employees were verified thru the Virginia Department of health Professions. Howevver the verifications were not consistent prior to orientation start date on two employees. The two Certified Employees Verification have been made and both are in good standing. No resident was found to be affected by the deficient practice (2) The Human Resources Manager will complete a 100 percent audit on all existing Licensed Employees by January 14th 2022. All applicant Licensed Employees will be Verified by Human Resources Manager after the interview and before orientation and start date. (3) All department Managers will be Inserviced by the Administrator on the processing of all new hire prospects. The Human Resource Manager will be responsible for the process of timely License verification. The Administrator will randomly check once per month for three months the timely verification of Licensed Employees completed by the Human resources Manager	

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F 001	Continued From page 7 C's certification was active and in good standing. CNA C was permitted to provide direct care to Residents beginning on 1/13/21. An interview was conducted with the Human Resources Director who confirmed the hire dates for CNA B and CNA C. The Human Resources Director stated, "The purpose of obtaining a license verification is to make sure that we are hiring qualified people to take care of our residents and to ensure there is no disciplinary action on their license". A review of the facility's policy entitled, "Compliance with Reporting Allegations of Abuse/Neglect/Exploitation", dated 01/01/2021, subtitle, "Compliance Guidelines--1. Screening", read, "The facility will screen employees for a history of abuse, neglect, or mistreating residents by attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries". No further information was provided. 12VAC5-371-220(C)(5) Based on staff interviews and clinical record review, the facility staff failed to provide nutritional supplements as ordered for 2 Resident (Resident #1 and #2) who were identified as being at risk for weight loss, in a survey sample of 3 Residents. The findings included: 1. On 11/30/21, a clinical record review was conducted for Resident #1. This review revealed a physician order that read, "MED PASS 2.0 Give	F 001	Continued From page 7 (4) The Human Resources Manager will report any discrepancies to the Administrator prior to the licensed Employee being hired. All licensed Employees will be verified by human Resources to assure applicant in in good standing. (5). January 14th, 2022 12VAC5-371-220(C)(5) (1). Resident #1, #2, orders for Med Pass supplement have been reviewed and revised per the Dietician and MD. Resident # 1 has a new MD order for Med Pass 2.0- Give 120 cc PO at 2 pm and 6 pm, QD. Resident #2-Med Pass 2.0 PRN order has been discontinued. (2). A 100% audit of Med-Pass supplement orders will be completed by the nursing supervisor to determine if present MD orders for supplement administration is being followed for residents with such orders. Discrepancies in the audit will be reported to the Director of Nursing, or her designee. The Dietician and MD will be informed of discrepancies, and asked for	January 14, 2022 January 14, 2022

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F 001	Continued From page 8 120 ml by mouth three times a day as needed if meal intake is less than 50%. As needed for Supplement THREE TIMES A DAY" dated 4/30/21. On 10/27/21, the RD (registered dietician) saw Resident #1 and made the following reference in her progress note, "She receives med pass 2.0 @ 120 ml TID if she consumes < 50% of her meals". Review of the chart revealed that Resident #1 consumed less than 50% of meals at the following frequency: September 2021- 23 occurrences, October 2021- 18 occurrences and in November 2021- 17 occurrences. Review of the MAR (Medication Administration Records) revealed that in September 2021, only 3 occasions did the staff administer Med Pass supplement as ordered. In October 2021, on 1 occasion the Med Pass was given. In November 2021, Resident #1 was given the med pass on 1 occasion. 2. On 11/30/21, a clinical record review was conducted for Resident #2. This review revealed a physician order that read, "MED PASS 2.0 Give 120 ml by mouth three times a day as needed if meal intake is less than 50%. As needed for supplement three times a day" dated 9/22/21. Review of the chart revealed that Resident #2 consumed less than 50% of meals at the following frequency: September 2021- 4 occurrences, October 2021- 4 occurrences and in November 2021- 17 occurrences. Review of the TAR (Treatment Administration	F 001	Continued From Page 8 recommendations, and MD orders. Responsible parties will be updated by the charge nurse of any new MD orders, rec'd. (3). Education will be provided by the nursing supervisor to RNs, LPNs, and nursing assistants regarding Meal Consumption, documentation, and the administration of Med-Pass 2.0 supplement 120 cc. New Hires will have this education as part of their orientation. 4). Our electronic charting system now ALERTS the nurse of < 50% meal consumption of 2 meals in 24 hours, cueing the nurse to administer Med Pass 2.0 120cc PO. Nursing Supervisors will check on the POC (Point-of Care) documentation for meal consumption <50% each day, to include the administration record for dispensing the Med Pass supplement, Daily. The Director of Nursing / or her designee will be advised of discrepancies in documentation, by the nursing supervisor. Summaries of these daily checks, their findings and remedies will be reported quarterly, to the QA/PI committee by the director of Nursing or her designee. (5). January 14th, 2022	January 14, 2022

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F 001	Continued From page 9	F 001		

Records) revealed that the order for med pass was noted, but never administered in September, October or November 2021.

On 12/1/21 at approximately 10:00 AM, the DON (Director of Nursing) was made aware of the findings and given the opportunity to provide any additional information she may have had.

On 12/1/21 at 10:10 AM, an interview was conducted with CNA E. CNA E stated that she charts Resident's meal consumption amounts in the computer and reports to the nurse when a Resident doesn't eat.

On 12/1/21 at 10:13 AM, an interview was conducted with LPN D. LPN D was asked about how the nurse knows when a Resident consumes less than 50 % of meals so she would know to administer the med pass supplements. LPN D said, "The nurses check POC (point of care) and they [the CNA's] fill in and they [the CNA's] report to the nurse".

On 12/1/21 at 10:43 AM, LPN D said to Surveyor C, "I found out that the computer only sends a notification to the nurse if a Resident consumes less than 50% for 2 consecutive meals. We will have to change the notification or the order so they match".

Review of the facility policy titled, "Nutritional and Dietary Supplements" read, "2. The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs....9. Supplements may be provided by dietician recommendation as allowed by physician standing order".

On 12/1/21, during an end of day meeting the

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F 001	Continued From page 10 facility Administrator and DON were advised of the findings. No further information was provided prior to the end of survey. 12VAC5-371-220(F) Based on staff interviews and clinical record review, the facility staff failed to provide evidence of 3 Residents (Resident #1, #2 and #3) receiving a shower twice weekly, in a survey sample of 3 Residents. On 11/30/21 and 12/1/21, clinical record reviews were conducted for Residents #1, #2, and #3. The entire clinical record was reviewed and no evidence of showers being provided twice weekly was noted. On 12/1/21 during mid-morning, the DON was made aware that Surveyor C was unable to find any records of when showers were provided for the 3 Residents in the sample. The DON and LPN D confirmed that they could not find any record of this information either and would have to contact the EHR (electronic health record) software vendor to made revisions. On 12/1/21, the DON confirmed that evidence of showers being provided twice weekly was not available for any of the Residents. On 12/1/21 at 2:15 PM, the facility policy titled, "Bath, Shower/Tub" was received and reviewed. This policy stated, "...Documentation: 1. The date and time the shower/tub bath was performed. 2. The name and title of the individual(s) who	F 001	12VACS-371-220(F) (1). Resident # 1- MD has ordered Daily Bedbaths-no showers due to significant bilateral knee and hip contractures. Resident #2 is scheduled for showers two days per week,. Resident #3 refuses showers, requsting bedbaths. MD advised and resident now has an order to have complete bedbaths daily-no showers. (2). Our electronic record system is being reconfigured allowing nursing assistants to more definitive choices for bathing/showering documentation. 100% audit of all "Tasks" for bathing are being reviewed by the nursing supervisor, editing and adding further instruction for each nursing assistant and LPN/RN . (3). Education will be provided to all RNs, LPNs, and Nursing assistants regarding these documentation enhancements, by the Director of Nursing or her designee. This amended documentation process will be included in New hire orientation, and will be closely monitored daily by the nursing supervisor. If discrepancies are determined, timely re-education for individuals will be provided by the supervisor. (4). Discrepancies will be reported to the Director of Nursing. Summary of daily	January 14, 2022 January 14, 2022 January 14, 2022 January 14, 2021

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	NH2656	A. BUILDING: _____ B. WING _____	12/01/2021

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F 001	Continued From page 11 assisted the resident with the shower/tub bath. 3. All assessment data obtained during the shower/tub bath. 4. How the Resident tolerated the shower/tub bath. 5. If the resident refused the shower/tub bath, the reason(s)". On 12/1/21, during the end of day meeting the facility Administrator was made aware of the lack of evidence of Resident #1, #2 and #3 receiving two showers weekly. No further information was provided prior to survey exit. 12VAC5-371-250(A)(3) Based on staff interview, facility documentation review and clinical record review the facility staff failed to conduct an assessment of mental functioning for 2 Residents (Resident #1 and #3) in a survey sample of 3 Residents. The findings included: On 11/30/21, clinical record reviews were conducted of Resident #1 and #3's electronic health record. This review revealed the following: 1. Resident #1 had an MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/26/21, which was coded as a quarterly assessment. This assessment noted that section C for cognitive patterns was coded as the Resident interview and staff interviews were "not assessed". 2. Resident #3 had an MDS assessment with an ARD of 8/17/21, which was coded as an admission assessment. This assessment section	F 001	Continued From page 11 monitoring and actions required to maintain compliance in nursing assist care documentation of showers twice a week will be collected and maintained by the Director of Nursing. This summary information will be provided quarterly to the Quality Assurance/Performance Improvement Committee, by the director of Nursing or her designee. (5). January 14th, 2022 12VAC5-371-250 (A)(3) (1). Resident # 1-QR assessment with ARD date 7/26/21, has had a Significant Correction completed, as of 12/28/21; Resident # 3 has had a Significant Correction assessment completed as of 12/28/21, both for section " C", completed by the newly hired MDS Coordinator. 2). The newly hired MDS Coordinator, as of October 20,2021, is an RN who is trained and certified as an MDS Coordinator. The newly hired Social Worker, as of November 22, 2021, will be trained by the MDS coordinator on her assigned sections, "C and D", by the completion date. A 100% audit of MDS assessments will be completed of, Sections " C and D" by the Social Worker and MDS Coordinator on current residents, to determine that interviews of either	January 14, 2022 January 14, 2022

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F 001	Continued From page 12 C for cognitive patterns was coded as "not assessed" for both the Resident and staff interviews. On 12/1/21 at 12:38 PM, an interview was conducted with Employee G, the Social Worker. Employee G confirmed that she completes section C of the MDS. She stated that she was not working at the facility at the time the above referenced assessments for Resident #1 and #3 were completed. However, she stated, "I have print outs of all of the questions and I go ask them. If resident is not interviewable, I go to the nurses and CNA's and read through the charts". Employee G stated there is never an instance that she would not do a Resident or staff assessment. She does confirm she has the RAI (resident assessment instrument) manual and uses that for guidance on how to code the MDS. On 12/1/21, attempts were made to reach the MDS Coordinator but she was not able to be reached. On 12/1/21 at 1:03 PM, an interview was conducted with the DON. The DON confirmed the facility follows the RAI manual. When asked about section C she stated, "If the Resident is not interviewable the staff assessment should be done. I would expect one of the two to be interviewed". Review of the facility policy titled, "Minimum Data Set of the Resident Assessment Instrument", was conducted. This policy stated, "All staff members responsible for completion of the MDS receive training on the assessment and data entry in accordance with the MDS RAI Instruction Manual. A copy of the MDS RAI Instruction Manual is maintained by the Resident Assessment	F 001	Continued From page 12 the resident or staff occurred during the ADR of the assessment, per the RAI guidelines Findings of this audit will be reported to the Director of Nursing or her designee. (3). The MDS Coordinator will review the timely completion responses of Section "C". Any discrepancies noted by the MDS coordinator will be reported to the Director of Nursing, or her designee, to assist in completion resolve. Education of the RAI guidelines will be conducted by the MDS coordinator for the department managers involved in the MDS section completion, by the completion date. (4). The Director of Nursing or her designee will participate in the monitoring and communicating with the MDS Coordinator, reviewing accuracy and timely completion, to include the Interdisciplinary Team , Responsible Party and care planning process . Newly hired staff for departments involved in MDS assessment completion, RN's , LPNs, and Nursing assistants will be educated on documentation that is utilized for accurate MDS completion. Discrepancies found in the monitoring of MDS completion, accuracy will be reported to the Administrator, by the Director of Nursing or her designee. (5). January 14th, 2022	January 14, 2022 January 14, 2021

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F 001	Continued From page 13 Coordinator". On 12/1/21 the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.16" was reviewed and the following guidance was provided on pages C1-C2, "Interact with the resident using his or her preferred language. Be sure he or she can hear you and/or has access to his or her preferred method for communication. If the resident appears unable to communicate, offer alternatives such as writing, pointing, sign language, or cue cards. 2. Determine if the resident is rarely/never understood verbally, in writing, or using another method. If rarely/never understood, skip to C0700-C1000 Staff Assessment of Mental Status.....Attempt to conduct the interview with ALL residents". On 12/1/21, during an end of day meeting, the facility Administrator was made aware of the findings. No further information was received. 12VAC5-371-300(A) Based on observation, staff interview and facility documentation review, the facility staff failed to secure medications stored in 2 medication carts in a survey sample of 2 medication carts in use. The findings included: On 11/30/21 at approximately 1:30 PM, two medication carts were observed at the nursing station. Both carts were observed to be unlocked and Surveyor C was able to open multiple	F 001	12VACS-371-300A (1). At the time when the LPN realized she had left the med cart unlocked, unattended, by the surveyor, she locked the cart, acknowledging her error. The LPN made the Director of Nursing aware of her mistake. (2). All licensed nurses have been in serviced on Medication Storage by the Director of Nursing , to include the locking of a Med cart when not being used or when in use, keeping the care in direct sight of the med nurse.	January 14, 2022 January 14, 2022

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F 001	Continued From page 14 drawers and have access to hundreds of medications stored within. No staff members were observed in sight. On 11/30/21 at 1:48 PM, LPN D came to the nursing station and was asked why Surveyor C was able to open the drawers of the medication carts. LPN D said, she had gone to answer a Resident's call light and failed to secure the carts and medications within. LPN D said, "They should have been locked to prevent any patient from getting in it". On 11/30/21 at 2:28 PM, the DON was made aware of the observation and said she was aware. The DON said, "She [referring to LPN D] went quickly to answer a call light, she did tell me and she feels horrible about it". The DON stated the carts are to be locked when not being used/accessed by the nurse because, "You don't want anyone to get access to any meds". On 11/30/21, during an end of day meeting the facility Administrator was made aware of the findings. On 12/1/21, the facility policy titled, "General guidelines for medication storage" was received and reviewed. This policy read, "2. Only licensed nurses, the Consultant Pharmacist, and those authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access". No further information was received. 12VAC5-371-300(I)	F 001	Continued From page 14 (3). The Nursing supervisor is responsible for periodic checking throughout his or her shift that the medication cart is locked when Not in use, as well as the location, use and security of the medication cart while the nurse administers the medications. Discrepancies found during the monitoring of medication carts storage will be reported to the Director of Nursing or her designee. (4). The consultant Pharmacist has been advised of this finding during survey, and will periodically review with each nurse during Medication Pass review, the Medication Storage guidelines. The Director of Nursing will maintain Pharmacy reports of Medication carts, Medication Med Pass Reviews for nurses, and recommendations and findings will corrected, at the time of the finding. (5). January 14th, 2022 12VAC5-371-300 (I)	January 14, 2022 January 14, 2021

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F 001	Continued From page 15 Based on staff interview and clinical record review the facility staff failed to respond to a medication regime review conducted by a registered pharmacist for one Resident (Resident #1) in a survey sample of 3 Residents. The findings included: On 11/30/21, a review of the electronic health record of Resident #1 was conducted. This review revealed an entry in the nursing notes dated 11/9/21, that indicated the RPH (registered pharmacist) had conducted a medication regime review (MRR) and made recommendations to the physician. No further details of the recommendations were noted in the chart. On 12/1/21, a review of the paper health record for Resident #1 was conducted. There was no further evidence in the chart of the pharmacy medication regime review conducted 11/9/21. On 12/1/21, at approximately 9:15 AM, Surveyor C requested that the facility provide a copy of the MRR for Resident #1. On 12/1/21, in the afternoon the DON (Director of Nursing) provided Surveyor C with the MMR which read, "Patient has an order for Lotrisone cream to mouth area from 8/9/21. Recommend evaluate whether this order/treatment has been completed. If so, please discontinue". The physician signed and agreed to discontinue this treatment on 12/1/21. Review of the physician orders and TAR (treatment administration record) for Resident #1 revealed an order dated 6/9/21, that read, "Lotrisone Cream 1-0.05 % (Clotrimazole-Betamethasone) Apply to corners	F 001	by January 14,2022.Continued From page 15 (1) Resident #1 The MD addressed the recommendation on 12/1/21, agreed to discontinue the treatment, signing the MMR. (2)A 100% Audit will be completed by the director of Nursing or her designee, by January 14,2022, of the current MMR follow-up with the attending MD's to determine if any other resident is affected. Findings of the audit will be addressed with the attending MD, and pharmacist. (3) Presently the MMR from the consultant pharmacist is printed and maintained on the written chart. Moving forward, MMRs will be monitored by the nursing supervisor for completion by the MD, and will be responsible for documenting the acknowledgement of orders or changes the MD makes in the electronic chart, before filing it in the written chart. (4) The Director of Nursing will be advised of any discrepancies to this timely response by MD's to the Pharmacist MMR, and will then advise the Medical Director and Administrator of any physician delinquent in response . The Director of Nursing is responsible to maintaining the documentation of monitoring physician timely response to the pharmacy recommendations. (5). January 14th, 2022	January 14, 2022 January 14, 2022 January 14, 2022 January 14, 2021

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F 001	Continued From page 16 of the mouth topically every day shift for redness until redness resolved". The TAR indicated this was being applied daily through 11/30/21. Observation of Resident #1 conducted on 11/30/21 and 12/1/21, revealed no redness to the corners of the mouth. On 12/1/21 at 3:28 PM, the DON was asked about the delay in responding to MMRs. The DON said, "The doctor received it but didn't see it. I spoke with the pharmacist and suggested she email them to him directly. He has had some issues and hasn't been able to come in. I knew we had received these and so we faxed it to him". On 12/1/21, during an end of day meeting, the facility Administrator was made aware of the findings. No further information was provided. 12VAC5-371-340(A) Based on observation, staff interview and facility documentation review the facility staff failed to store food in a manner to identify the food item and the date prepared in 5 of 6 food storage areas inspected. The findings included: On 11/30/21 at 3:50 PM, observations were made in the facility kitchen. Surveyor C was accompanied by Employee F, the dietary manager. In the dry storage the following items were observed to be opened and not secured in a	F 001	12VAC5-371-340(A) (1). No resident were indicated to have been affected by the deficient practice. All unprotected open food items were discarded on 11-30-2021. No items will be kept in the Bulk storage containers but the item itself. All open items will be labeled and all scoops will be kept outside of the storage bins in a clear plastic bucket (2). The Dietary Employees, Food Service Managers, Cook and Dietary Aids have been inserviced by the Dietitian on correct labeling of all opened food items with the date opened and the use by date to assure that all out dated items will be discarded. No resident has been affected by out dated/stored food items or contamination. All new Dietary Staff hired will	January 14, 2022 January 14, 2022

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F 001	Continued From page 17 manner to protect from environmental contaminates: cornbread mix, country style gravy mix and chicken gravy mix. In the walk-in freezer the following items were observed to be opened and not secured in a manner to protect from environmental contaminates: chicken patties, asparagus, pearl onions and cauliflower. In the stand-alone cool beside the stove there was a cooked sausage patty and what Employee F identified as French toast that were not labeled to indicate when prepared or the use by date. In the stand alone freezer there was an item covered in saran wrap that Employee F identified as cookie dough. This item had no labeling to indicate the product and no date to indicate when it had been opened or a use by date. In the stand alone cooler there were approximately 15 bowls of tossed salad and approximately 6 bowls of fresh fruit. There was not labeling to indicate when these had been prepared or when they were to be used/consumed by. Also observed were bulk storage containers containing items that were not labeled. Employee F, the dietary manager identified these items as bread crumbs and the other as sugar. Both bins had the scoops stored in the contents and the handle of the scoops were laying across the contents/touching the surface of the food items. Employee F confirmed all of the observations as they were being made and his response was, "I'm sorry".	F 001	Continued From page 17 be inserviced by the Dietitian. (3). A new policy regarding food storage has been implemented to ensure that all food items stored in dietary are free from enviromental contaminates. All Dietary Employees Have been inserviced by the Dietitian and will be overseen by the Food Service Manager for the next 3 months. The dietitian will conduct random checks thereafter. (4) The Dietitian will conduct random weekly checks to ensure that policy for food storage is being followed. The Food Service Manger will make daily rounds to oversee the policy is being followed. If the Food Service Manger is absent, the Cook will monitor. The corrective date will be ongoing. If a discrepancy occurs it will be reported immediately to the facility Administrator. (5). January 14th, 2022	January 14, 2022 January 14, 2022

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F 001	Continued From page 18 Review of the facility policy titled, "Food Safety Requirements" read, "1. Food safety practices shall be followed throughout the facility's entire food handling process. This process begins when food is received from the vendor and ends with delivery of the food to the resident. Elements of the process include the following: a. Procurement (obtaining) of food from sources approved or considered satisfactory by federal, state and local authorities. b. Storage of food in a manner that helps prevent deterioration or contamination of the food, including from growth of microorganisms..." This policy also read, "3 c. "Refrigerated storage...iv. Labeling, dating, and monitoring refrigerated food, including, but limited to leftovers, so it is used by its use-by-date, or frozen/discarded". Review of the regulatory code section 12VAC5-421-480, read, " Food storage containers; identified with common name of food. Except for containers holding food that can be readily and unmistakably recognized such as dry pasta, working containers holding food or food ingredients that are removed from their original packages for use in the food establishment, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the food". The CFR [Federal code] read, "3-305.11 Food Storage"..."D. A date marking system that meets the criteria...(2) Marking the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded...". "Section 3-501.17 Ready-to-eat, Time/temperature control for safety food, date marking" read, "(A)...refrigerated, ready-to-eat, time/temperature control for safety food prepared	F 001		

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F 001	Continued From page 19 and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises...". Section "3-304.12 In-use Utensils, Between-Use Storage" read, "During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: (A)..In the food with their handles above the top of the food and the container". On 11/30/21 and on 12/1/21, during end of day meetings the facility Administrator was made aware of the findings. No further information was provided. 12VAC5-371-360(E) Based on staff interview and clinical record review, the facility staff failed to maintain an accurate and complete clinical record for one Resident (Resident #2) in a survey sample of 3 Residents. The findings included: On 11/30/21, a clinical record review was conducted of Resident #2's electronic health record. This review revealed Resident #2 had a displaced bicondylar fracture of her right tibia that had not been repaired. A nursing note entry on 11/10/21 at 5:35 AM, was noted that read, "Heard resident talking from her room at approximately 3:00 am, and found her lying on her floor mat next to her bed. She had disrobed, and removed her soiled brief, with smeared BM on her body where she had attempted to clean herself.....Plan for next shift to call MD and RP to make aware of occurrence".	F 001	12VACS-371-360-E (1) Resident #2 A progress note was entered to reflect details of RP and MD notification. (2) A 100% audit of incidents for past 90 days will be conducted by the nursing supervisor, to determine that documentation of timely notification of MD and Responsible Party are located in the progress notes. The Director of Nursing will be notified of the findings. Discrepancies will be corrected by the nursing supervisor completing the audit. (3) Education will be conducted to all Licensed Nurses regarding documentation in the progress notes of all incidents, to include notification of the MD and Responsible party of the particulars of the incident, actions taken at the time of the occurrence, and steps to keep it from reoccurring. Newly Hired nurses will have education on the electronic record	January 14, 2022 January 14, 2022 January 14, 2022

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F 001	Continued From page 20 There were no further entries in the clinical record to indicate the MD (physician) or RP (responsible party/family) had been made aware of the incident. On 12/1/21, the DON (Director of Nursing) was made aware of the lack of evidence that the MD and RP had been notified of the incident on 11/10/21. On 12/1/21, the DON provided Surveyor C with a risk management document that read, "PRIVILEGED AND CONFIDENTIAL- NOT PART OF THE MEDICAL RECORD". This document indicated that the MD and RP were notified of the incident later in the day on 11/10/21. At this time an interview was conducted with the DON who confirmed that this document was not part of the clinical record and this notification should have been recorded in the clinical record, therefore rendering the clinical record incomplete. On 12/1/21, during an end of day meeting, the facility Administrator was made aware of the findings. No further information was provided.	F 001	Continued From page 20 documenting incidents in progress notes, to include family and MD notification of event, and actions taken to prevent it's reoccurrence. (4) Nursing supervisors will be responsible for monitoring daily the incident occurences, and progress note documentation of notifications of MD and Responsible Parties. Discrepancies found in notation of incidents in progress notes, to include MD and RP notification, will be reported to the Director of Nursing or her designee. Summary of occurences, and findings of audits will be maintained by the Director of nursing or her designee, and reported to the QA/PI committee quarterly. (5). January 14th, 2022	January 14, 2022