STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495319	A. BUILDING ______ B. WING ______	C 03/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VIRGINIAN	**9229 ARLINGTON BLVD** **FAIRFAX, VA 22031**

(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 3/8/22 through 3/10/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/8/22 through 3/10/22. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints (VA00054498 substantiated with deficiency, VA00053452 unsubstantiated) were investigated during the survey. The census in this 81 certified bed facility was 65 at the time of the survey. The survey sample consisted of 32 resident reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578		4/22/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/01/2022

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

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review and clinical record review the facility staff failed to uphold a Resident's desire to formulate an Advance directive for one Resident (Resident #69) in a survey sample of 32 Residents. The findings include: For Resident #69, the facility staff failed to ensure a Do Not Resuscitate (DNR) order was written as per the Resident's desire.	F 578	No resident was adversely affected by this finding. Resident #69 had discharged from facility prior to survey, therefore no corrections were made to the Electronic Medical Record for this resident. All residents have the potential to be affected by this practice, therefore Unit Managers or designees will perform audit of all resident code statuses, for their assigned unit(s) to ensure proper order and documentation of all code status.	

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F 578	Continued From page 2 Review of the closed electronic clinical record was conducted on 3/8/2022-3/10/2022. Resident # 69 was admitted to the facility on 11/6/2020 and discharged on 11/18/2020. On 3/10/2022 at 9:43 am, review of Resident #69's clinical chart revealed a signed DNR (do not resuscitate) form. Review of Resident # 69's Physicians Orders on Admission revealed documentation of an order on 11/6/2020 for Full Code Status (meaning CPR would be performed in the event of cardiopulmonary arrest). Review of the Physicians Progress notes revealed documentation of DNR (Do Not Resuscitate) status. Further review of the clinical record revealed documentation of DNR status listed on the care plan. Review of the Social Worker (Employee K) admission notes dated 11/9/2020 revealed documentation of the excerpt "Rt (resident) prefers to have DNR code status and has current advance directives on file." On 3/10/2022 at 11:30 a.m., an interview was conducted with the Director of Nursing who stated she was unable to find a copy of the DNR (Do Not Resuscitate) documentation. The Director of Nursing stated "if somebody expresses they want their code status changed to DNR, the Social Worker or Physician would go over it with the resident, sign it and have the resident sign the forms. A copy would be placed in the chart and	F 578	DON or designee to re-educate Social Services and all Licensed Nurses on code status documentation requirements. For three months, Unit Managers or designee will audit of all new admissions, to their assigned unit(s) within 72 hours to ensure proper code status documentation. For three months, Unit Managers or designee will perform monthly audits of all resident records for their assigned unit(s), to ensure proper code status documentation.	

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F 578	Continued From page 3 the order would be changed." During the end of day debriefing on 3/10/2022, the Facility Administrator and Director of Nursing were informed of the findings. The Administrator and Director of Nursing stated the clinical record should be representative of the resident's preferred code status or Advance Directive. Review of the facility policy titled, "Do Not Resuscitate Order" with a revision date of April 2017 read, "Do Not Resuscitate Orders must be singed by the resident's attending physician on the physician's order sheet maintained in the resident's record". No further information was provided.	F 578		
F 607 SS=D	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 staff interview and facility documentation review, the facility staff failed to implement their abuse policy for 2 employees (CNA D and LPN D) out of a survey sample of 5	F 607	No resident was adversely affected by this finding. CNA D and LPN D were immediately	4/22/22

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F 607	Continued From page 4 employees. Specifically, CNA D and LPN D did not receive annual abuse training in 2021. The findings included: On 03/09/2022, the facility staff provided a copy of training transcripts for Certified Nursing Assistant D (CNA D) and Licensed Practical Nurse D (LPN D). According to the training transcripts for CNA D (date of hire 11/25/2009), the most recent abuse training occurred on 03/06/2020. According to the training transcripts for LPN D (date of hire 10/29/2018), the most recent abuse training occurred on 06/13/2019. On 03/10/2022 at approximately 11:45 A.M., the administrator and Director of Nursing were notified of findings. The Director of Nursing stated they would look into it. According to their facility policy entitled, "Abuse" in Section 3 entitled, "Training" it was documented, "Each new staff member shall receive an orientation and training .... reporting abuse and neglect, ... These shall be reviewed annually." On 03/10/2022 at approximately 12:50 P.M., he Director of Nursing acknowledged the lack of annual abuse training for CNA D and LPN D. The Director of Nursing then stated, "We'll be working on that." On 03/10/2022 at approximately 2:00 P.M., the administrator and Director of Nursing stated they had no further documentation or information to submit.	F 607	made aware on their noncompliance with the required training, and began working toward compliance, on 3/10/2022. All residents have the potential to be affected by this practice, therefore Department Directors or designee to perform audit of all staff transcripts to identify and address any other evidence of noncompliance with required training. Department Directors or designee will monitor compliance with training, each month, indefinitely.	
F 657	Care Plan Timing and Revision	F 657		4/22/22

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F 657 SS=D	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation the facility staff failed to review and revise the care plan for 1 Resident #58 in a survey sample of 32 Residents. The findings included: For Resident #58 the facility staff failed to review	F 657	Care Plan for Resident #58 updated immediately, to ensure hourly rounds were displaying as a task to be signed off hourly, in the Electronic Medical Record (EMR). All residents have the potential to be affected by this practice, therefore Unit	

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F 657 Continued From page 6

and revise the care plan to include measurable objectives and timeframes for interventions.

On 3/9/22 a review of the clinical record revealed that Resident #58 had 2 falls since his admission on 2/16/22.

The first fall occurred on 2/22/22 at 4:45 AM, the progress note read:

"2/22/22 at 5:20 AM - Writer was sitting at nurse's station at 0445. Heard a small voice yelling out, "Help Help." As I got up from behind nurses station and looked up both hallways, I observed resident lying-in the floor in prone position in front of [room number redacted] doorway. He was alert and verbal. Aspen collar intact. Resident assessed and was able to assist with repositioning himself into supine position. Neck and upper extremities supported at all times. Resident observed lifting both legs high in the air and bending his knees w/o being instructed to. Tolerated AROM to all extremities w/o c/o pain or discomfort. Neuro checks done and all were WNL. PEARL, bilateral hand grasps equal in strength. v/s 96.9 75 20 148/72 O2 sats 96%. Resident assisted into a sitting position w/o complaints. Then into standing position. Transferred into a wheelchair and was assisted back into bed. Resident observed with 4 skin tears in total on complete head to toe assessment. Rt elbow ST measuring 3.2x3cm."

A review of the care plan revealed that the facility initiated the following interventions after the first fall.

"Approach Start Date: 02/22/2022 -Round on resident Q1H for safety -Certified Nurse Aide

F 657

Managers or designee will perform audit of all care plans for their assigned unit(s), for approaches that should be displayed on the electronic Point of Care (ePOC), for documentation of intervention in the EMR (i.e. hourly checks).

DON or designee to re-educate all Licensed Nurses, that upon entering a care plan that requires an ongoing intervention that it be set up to show display on the ePOC. Re-educate all licensed nursing assistants, on the expectation of hourly rounds and properly document in the ePOC.

For three months, Unit Managers or designee will perform monthly audit of all care plans for their assigned unit, for approaches that should be displayed on the POC.

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F 657	Continued From page 7 (CNA), Nursing." On 3/10/22 at 11:00 AM an interview was conducted with the DON who was asked when the hourly checks started and ended. She stated she could not find the records of the hourly checks being done. She stated in her opinion it was because it was not put in as "Display on POC" so it was not in the system for the CNA's and or Nurses to check off. She was asked based on the care plan could you tell when the hourly checks were to end. She stated she could not tell from the care plan. She stated "In my opinion the care plan should have had the hourly checks quantified with a start and stop date." On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge	F 661		4/22/22

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F 661	Continued From page 8 medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to complete a discharge summary for one Resident (Resident # 69) in a sample size of 27 Residents. The findings included: On 03/09/2022, a review of Resident # 69's closed record revealed that Resident #69 was discharged from the facility on 11/18/2020. There was no evidence in the clinical record that a discharge summary was completed. On 03/09/2022 at 3:00 p.m., the Director of Nursing (DON) was interviewed. When asked about the discharge summary for Resident #69, the DON looked into Resident # 69's electronic health record and stated that normally the provider would write a note and document the events around the discharge. The DON stated she was unable to locate the discharge summary in the clinical record.	F 661	No resident was adversely affected by this finding. Resident #69 had discharged from facility prior to survey, therefore no corrections were made to the Electronic Medical Record for this resident. All residents have the potential to be affected by this practice, therefore DON or designee will implement and educate all licensed nurses on new process for providing compliant discharge summaries to residents. For three months, DON or designee will perform audit of all discharges, to ensure compliance with new process.	

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F 661	Continued From page 9 On 03/10/2022, two attempts were made to speak with Resident # 69's physician via the telephone without success. On 03/10/2022 during the end of day debriefing, the facility Administrator and Director of Nursing were informed of the findings. The facility provided a written statement signed by Resident #84's physician. An excerpt of the statement documented, "No discharge summary done at this facility." No further documentation was provided.	F 661		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation, and during the course of an investigation the facility staff failed to ensure Residents are free from accidents and hazards for 2 Residents (#21 & #58) in a survey sample of 32 Residents resulting in harm for Resident #21. The findings included: 1. For Resident #21 the facility staff failed to transfer the Resident using the required number	F 689	All residents have the potential to be affected by this practice, therefore DON and Unit Manager have created discrete, dignity-respecting signage to be displayed above the bed of a resident requiring a two person assist. By 3/16/2022, DON and Unit Manager performed an audit of all residents for those requiring a two person assist, to include but not limited to Resident #21, and displayed the signage above their bed. On 3/16/2022, began educating all staff on the purpose and	4/22/22

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F 689	Continued From page 10 of staff as indicated on the MDS and the care plan, subsequently she sustained a skin tear requiring sutures, which became infected; this is harm. On 3/9/22 a review of the clinical record revealed that Resident #21 sustained an injury to her right leg while transferring from wheel chair to bed on 2/7/22. The Resident was transferred by one staff member. The most recent MDS with an ARD of 1/24/22 revealed that Section G coded the Resident as #3 " -Extensive Assistance of #3 -2 or more persons Physical Assistance. " Resident #21 was coded with moderate cognitive impairment. The care plan read as follows: "Approach start date 1/17/22 - I need extensive assistance with transfers. I need 2 person staff support with transfers." Resident #21 was taken to the Emergency Room and required sutures to close the 7 cm x 6 cm x 0.1 cm skin tear. The Resident was sent back to the facility with instructions for wound care. Excerpts from the hospital ER Record are as follows: "2/7/22 at 11:01 PM - Well-appearing [age and gender redacted] coming to us from facility with skin tear/ laceration to the right lateral mid shin. Is quite extensive tear and goes fairly deep. There is some oozing from the wound as well. The muscle been a skin avulsion [sic] as well as the wound does not entirely come together. The wound is been repaired by the physician assistant. Please see her note for the procedure. The skin is quite think in this area and I do feel	F 689	expectations of this signage. DON or designee will educate all staff. DON or designee to create orientation guide, to be given to all agency staff upon reporting for their shift, to include the meaning behind this signage. For three months, Unit Managers or designee will perform weekly audits of all residents requiring two person assist on their unit(s), to ensure signage and care plan are in place, and being followed. Care Plan for Resident #58 updated on 3/11/2022 with more appropriate approach to prevent falls (if resident willing, keep him in dining room while awake). Unit Managers or designee will perform audit of all care plans for their assigned unit(s), for appropriateness and make necessary changes. Will also audit for approaches that should be displayed on the electronic Point of Care (ePOC), for documentation of intervention in the EMR (i.e. hourly checks). DON or designee to re-educate all licensed nurses, that when entering a care plan that requires an ongoing intervention that it be set up to show display on the ePOC. Re-educate all licensed nursing assistants, on the expectation of hourly rounds and properly document in the ePOC. For three months, Unit Managers or designee will perform monthly audit of all care plans for their assigned unit, for	

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F 689	Continued From page 11 that it is possible that the wound will not heal well. I think there is a chance that there could be dehiscence or even wound degradation and so therefore of counseled the family that she needs very close follow-up with the wound care team. They state they have one at the facility where she is staying. Have also counseled them follow-up with [Hospital name redacted] in the next couple of days to make sure that this wound is healing well. Family is comfortable with plan for discharge home knows to return to the ER sooner if there are any new or worsening symptoms. Will give prescription for antibiotics as well."The Resident returned to the facility. However on 2/17/22, the wound physician noted signs of infection and wrote new orders. Excerpts from the RN note written on 2/17/22 at 2:08 PM read as follows: "Right lateral shin 9 cm x 7 cm x 3 cm with light purulent drainage and 100% necrosis. New order to cleanse area with Dakin's solution, pat dry, pack with Dakin's solution-soaked gauze and cover with and ABD and wrap with Kerlix and ace wrap daily. New order for Rocefin [sic] IV ABT daily. New orders transcribed and emergency contact acknowledged via telephone." Excerpts from the Nurse Practitioner note entered on 2/17/22 at 3:20 PM read: "Patient seen and examined, her right shin wound was observed with notable signs of infection, suture line skin is partially loosened & necrotic with underlying hematoma. She was seen by wound team and hematoma was evacuated, sutures removed. exacerbated with wound care." On 3/9/21 at approximately 3:00 PM an interview was conducted with the DON who stated that the	F 689	approaches that should be displayed on the POC.	

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F 689	Continued From page 12	F 689		

injury was sustained with a staffing agency CNA who was providing care and transferred her without assistance of a second person. The DON stated the resident has fragile skin and has "a history of injuring her legs during transfer."

On 3/10/22 at approximately 11:15 AM an interview was conducted with LPN B who was asked where the CNAs get information on how each Resident needs to be transferred. LPN B stated that the CNA's look in the care plan.

On the afternoon of 3/9/22 an interview was conducted with CNA C who stated that on 2/7/22 he asked the Resident if she could help with the transfer and she stated that she could. He stated that he used extreme care however when he transferred her to the bed he noticed she had a skin tear to her right leg. He stated he immediately notified the LPN.

On the afternoon of 3/9/22 an interview was conducted with CNA D who stated that she found the skin tear on 3/22/22 when she was undressing the resident for bed. She stated the wound had dried blood on it when she discovered it. She denied having knowledge of how the wound occurred.

On 3/10/21 at approximately 11:00 AM an interview was conducted with CNA B who was asked how a CNA knows each Resident needs to be transferred. CNA B stated that she will ask the Resident or ask another CNA or nurse.

On 3/10/22 at approximately 10:45 AM an interview with Resident #21 was conducted and she stated "As far as I can remember I hit my leg on the wheel chair...."

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On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #58 the facility staff failed to provide adequate supervision (hourly checks as stated in care plan) to ensure Resident safety after initial fall on 2/22/22.

On 3/9/22 a review of the clinical record revealed that Resident #58 had 2 falls since his admission on 2/16/22.

The first fall occurred on 2/22/22 at 4:45 AM, the progress note read:

"2/22/22 at 5:20 AM - Writer was sitting at nurse's station at 0445. Heard a small voice yelling out, "Help Help." As I got up from behind nurses station and looked up both hallways, I observed resident lying-in the floor in prone position in front of [Room number redacted] doorway. He was alert and verbal. Aspen collar intact. Resident assessed and was able to assist with repositioning himself into supine position. Neck and upper extremities supported at all times. Resident observed lifting both legs high in the air and bending his knees w/o being instructed to. Tolerated AROM to all extremities w/o c/o pain or discomfort. Neuro checks done and all were WNL. PEARL, bilateral hand grasps equal in strength. v/s 96.9 75 20 148/72 O2 sats 96%. Resident assisted into a sitting position w/o complaints. Then into standing position. Transferred into a wheelchair and was assisted back into bed. Resident observed with 4 skin

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tears in total on complete head to toe assessment. Rt elbow ST measuring 3.2x3cm."

A review of the care plan revealed that the facility initiated the following interventions after the first fall.

"Approach Start Date: 02/22/2022 -Round on resident Q1H for safety -Certified Nurse Aide (CNA),
Nursing."

The second fall the Resident sustained was one day later on 2/23/22 at approximately 4:34 AM the progress note read

"2/23/22 at 4:34 AM - Writer was sitting at nurses station and heard someone yelling out "Help Help." Writer immediately got up from nurses station and immediately went into [Room number redacted], turned the light on and observed resident kneeling at the side of his roommates' bed. Aspen collar on and resident was observed still connected to his IV. Neuro check done and all WNL. Resident asked by writer, "Why are you on the floor, resident replied, "I don't know, I'm crazy." Skin abrasion observed on RT mid back. Resident assisted back into bed by three staff. Bed kept in lowest position at all times. v/s 96.7 78 20132/76 O2 sats 97% [MD name redacted] was made aware and no new orders received. Call was placed to resident's son [name redacted] and message was left on voicemail to call facility when available."

On 3/10/22 at 11:00 AM an interview was conducted with the DON who stated she could not find the records of the hourly checks being done. She stated in her opinion it was because it

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F 689	Continued From page 15 was not put in as "Display on POC" so it was not in the system for the CNA's and or Nurses to check off. When asked if this meant the checks were not being done she stated they were not. On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		4/22/22

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psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from unnecessary psychotropic medications for 2 Residents (#'s 53 & 58) in a survey sample of 32 Residents.

The findings included:

1. For Resident # 53 the facility failed to ensure the Resident's PRN Xanax order did exceed 14 days without Resident being seen by physician and a new prescription being written.

On 3/19/22 a review of the clinical record revealed that among Resident # 53's orders was an order for Xanax written by the facility medical doctor (MD) that read:

Provider's Plan of Correction:

No resident was adversely affected by this finding. PRN Psychotropic medication for Resident #58 discontinued due to non-use. PRN Psychotropic medication for Resident #53 renewed by geriatric psychiatrist.

All residents have the potential to be affected by this practice, therefore DON or designee to re-educate all licensed nurses on regulation. DON or designee to update Admission Checklist to include information on how to be certain any new admissions with psychotropic medications comply with the regulation. Education will also include having nurse put an end date of 14 days on any PRN psychotropic medications, as well as an order on the

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"Received date: 2/8/22 Start date 2/9/22 End Date: Open Ended [no stop date]
Drug Name: Alprazolam 0.5 mg [Xanax]
Give 1 tablet nightly as needed."

The clinical record also included a consult from the Psychiatric MD to D/C Seroquel, keep Abilify and Maintain Wellbutrin as well as the PRN Xanax 0.5 mg order.

On 3/9/22 an interview was conducted with the DON who was asked if she was aware of regulations regarding the administration of as needed (PRN) psychotropics. She stated she was aware that they should be only prescribed for 14 days and then had to be re-evaluated by the physician. When asked about the Xanax order for Resident # 53 she stated she would have to look to see if pharmacy did a medication review and had it changed to scheduled. Upon review of the pharmacy consults she did not find any pharmacy recommendations for changes to the original order written on 2/8/22.

On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

2. For Resident #58 the facility staff failed to ensure the Resident's PRN Ativan order did not exceed 14 days without Resident being seen by physician and a new prescription being written.

A review of the clinical record for Resident #58 revealed a PRN order for Lorazepam (Ativan) that read:

F 758

Medication Administration Record, at 10 days, to remind the nurse to address this end date with the physician on day 10.

DON or designee to perform an audit of all residents taking psychotropic medications, to ensure all PRN psychotropic medications have an end date, or renewal of order by physician, when appropriate.

For three months, DON or designee will perform audits on all new admissions within 72 hours and correct deficiencies immediately, as well as weekly audits on all psychotropic medications and correct deficiencies immediately.

DON or designee will continue to review Pharmacy Consultation recommendations as well as discuss psychotropic medication usage at each quarterly QAA meeting, indefinitely.

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F 758	Continued From page 18 "Lorazepam - Tablet; 0.5 mg; am: 1 Tab; oral Every 6 Hours - PRN PRN 1, PRN 2, PRN3, PRN 4 Start Date 2/16/22 End Date: Open ended [no stop date]" The clinical record also included a consult from the Psychiatrist dated 2/23/22 under "Psych Meds" the following were listed: Trazadone 25 mg at hs [hour of sleep] Neurontin 200 mg every 8 hrs. Melatonin 10 mg every hs A review showed there was no mention of Lorazepam in the Psychiatry Consult. On 3/9/22 an interview was conducted with the DON who was asked if she was aware of regulations regarding the administration of PRN psychotropics. She stated she was aware that they should be only prescribed for 14 days and then had to be re-evaluated by the physician. When asked about the Lorazepam order for Resident #58 she stated she would check into the order. The DON presented the Psychiatric Consult dated 2/23/22. She also stated she did not find any pharmacy recommendations for the original order written on 2/16/22. On 3/10/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 758		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		4/22/22

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(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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F 842	Continued From page 20 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and clinical record review, the facility staff failed to maintain an accurate clinical record for two Residents (Resident #219, Resident #69) in a sample size of 32 Residents. The findings included: 1) For Resident #219, there was conflicting information in the clinical record regarding a wound treatment of an inner vs outer ankle. On 03/08/2022 and 03/09/2022, Resident #219's	F 842	No resident was adversely affected by this finding. Documentation corrected immediately. All residents have the potential to be affected by this practice, therefore DON or designee to re-educate staff on importance of correct site and laterality. For three months, during weekly At Risk meeting, as well as during wound rounds, Wound Nurse or designee to audit all wound documentation, to ensure correct	

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F 842	Continued From page 21 clinical record was reviewed. A physician's order dated 03/06/2022 documented, "APPLY FOAM DRESSING TO BILATERAL OUTER ANKLE STAGE 1 BONY AREA. REMOVE WHEN SOILED TO PREVENT SKIN BREAKDOWN. Special Instructions: DISCONTINUE WHEN RESOLVED." On 03/09/2022 at approximately 2:35 P.M., this surveyor and Licensed Practical Nurse F (LPN F) entered Resident #219's room for a wound observation. LPN F removed Resident #219's soft boot on the left foot to reveal a foam dressing on the left medial (inner) ankle. LPN F lifted the foam dressing to reveal a reddened area. The skin on the left lateral (outer) ankle was intact and without redness. LPN F removed Resident #219's soft boot on the right foot to reveal a foam dressing on the right medial (inner) ankle. LPN F lifted the foam dressing to reveal a reddened area. The skin on the right lateral (outer) ankle was intact and without redness. At approximately 2:45 P.M., this surveyor and LPN F observed the above physician's order in the electronic health record. LPN F indicated the order was a "mistake" because the redness was on the inner ankles, not outer ankles. LPN F stated she would notify the physician. At approximately 2:55 P.M., this surveyor observed LPN F apply a foam dressing to the bilateral inner ankles. On 03/09/2022 at approximately 4:15 P.M., the administrator and Director of Nursing were notified of findings. The Director of Nursing indicated that the nurse was entering a new order. On 03/10/2022, the physician's orders were reviewed. A physician's order dated 03/09/2022	F 842	location and laterality of all wounds, and correct any deficiencies immediately.	

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F 842	Continued From page 22 documented, "Apply skin prep twice daily to inner ankles for preventative measures." On 03/10/2022 at approximately 2:00 P.M., the administrator and Director of Nursing indicated there was no further information or documentation to submit.	F 842		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility	F 883		4/22/22

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F 883	Continued From page 23 must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility documentation review, the facility staff failed to provide and/or document pneumonia vaccination status for 2 Residents (Resident #43 and #59) in a survey sample of 5 Residents reviewed for immunizations. The findings included: 1. For Resident #43, who had consented to receive the pneumonia vaccine, the facility staff failed to administer the vaccine prior to surveyor intervention.	F 883	No resident was adversely affected by this finding. Resident #43 was consented and given pneumococcal vaccine immediately upon discovery of deficiency. All residents have the potential to be affected by this practice, therefore DON or designee will re-educate all licensed nurses on importance of entering correct immunization information, and offering vaccines to residents, upon admission, when appropriate.	

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F 883	Continued From page 24 Resident #43 was admitted to the facility on 11/9/21. On 11/9/21, the facility staff inquired about vaccination status of Resident #43 and noted the following: 1. "When did the Resident last receive a flu or pneumococcal vaccination?" "Unknown date" was recorded for flu and pneumonia both. 2. "Signed Consent has been obtained for this Resident to receive the following vaccinations", was noted as "yes". Review of the electronic health record revealed no indication that the vaccines were administered. On 12/26/2021, Resident #43 was discharged to the hospital and returned on 1/5/2022. On 1/5/22, the facility staff recorded the following information regarding vaccination status. 1. "When did the Resident last receive a flu or pneumococcal vaccination?" "No Known Dates or Proof for Flu, Pneumococcal, or Shingles Vaccinations". 2. "Signed Consent has been obtained for this Resident to receive the following vaccinations:" "Pneumococcal Vaccine - Already received, Influenza Vaccine - Already received". Review of the clinical record revealed no indication that the flu or pneumococcal vaccinations being administered. On 1/27/22, Resident #43 was discharged to the hospital. On 2/3/22, Resident #43 was readmitted and vaccination status was assessed	F 883	DON or designee to update Admission Checklist to include reminder to document immunizations as well as to offer and administer vaccinations when appropriate. Unit Managers or designee to perform an audit of all pneumonia vaccines on their assigned unit(s), and correct any deficiencies immediately. For three months, Unit Managers or designee to audit all new admissions to their assigned units within 72 hours and correct any deficiencies immediately.	

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as:
1. When did the Resident last receive a flu or pneumococcal vaccination?" "Influenza- Already received. Pneumococcal - No"
2. "Signed Consent has been obtained for this Resident to receive the following vaccinations:" "Pneumococcal Vaccine - Yes, Influenza Vaccine - No".

Review of the MAR for February revealed an order, "Pneumococcal vaccination- Q5 [every] years." Offer both PCV-13 and PPSV23 vaccinations (document both separately if declined). If accepted, receive M.D. order and schedule PCV-13 immunization first, followed by PPSV23 immunization one year later". The administration of this immunization was recorded as "Not Administered: Resident unavailable". There were no nursing notes to indicate why Resident #43 was not administered the vaccine or why unavailable was noted.

On 3/8/22, the DON (Director of Nursing) was asked to provide any evidence she had regarding Resident #43's immunization.

On 3/9/22, the DON stated that Resident #43 would receive the pneumonia vaccine that day.

On 3/10/22, review of the nursing notes for Resident #43 revealed an entry that read, "Resident given Prevnar-13 pneumococcal vaccine into left deltoid. Lot number-EJ4560. Expiration date- 07/01/2023. Resident tolerated procedure well. Will continue to monitor."

2. For Resident #59, the facility staff failed to

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confirm and document the pneumonia vaccination status in the clinical record.

Resident #59 was admitted to the facility on 2/17/22.

Review of the clinical record for Resident #59 revealed that on 2/17/22, Resident #59 was assessed by facility staff for his immunization status. This information read, "When did the Resident last receive a flu or pneumococcal vaccination? Pneumococcal - Needs verification".

On 3/9/22, the DON (Director of Nursing) was asked about Resident #59's pneumococcal vaccination status.

On 3/10/22, the DON provided the survey team with a document that indicated Resident #59 received the pneumonia vaccine "outside of care setting" [meaning outside of the facility], "date unknown, vaccine type unknown".

The DON also stated this information has now been included in the clinical record of Resident #59.

On 3/10/22, during an interview with the DON, she confirmed that immunization status should be documented in the clinical records of Residents and Resident #59's status was not previously documented appropriately.

A review of the facility policy titled, "Pneumococcal Vaccine", was conducted. This policy read, "1. Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within

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F 883	Continued From page 27 thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. 2. Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission...4. Pneumococcal vaccines will be administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician approved pneumococcal vaccination protocol". On 3/9/22, during an end of day meeting, the facility Administrator and DON were made aware of the findings. No further information was provided.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine;	F 887		4/22/22

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F 887	Continued From page 28 (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and	F 887		

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F 887	Continued From page 29 related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to document in the clinical record a Resident's COVID-19 status for two Residents (Resident #59 and #30) in a survey sample of 5 Residents reviewed for immunizations. The findings included: 1. For Resident #59, the facility staff failed to document in the clinical record, the Resident's COVID vaccination status. Resident #59 was admitted to the facility on 2/17/22. On 3/8/22, a review of the entire clinical chart revealed no documentation regarding Resident #59's immunization status with regards to COVID-19. There was no documentation to support that the Resident was educated on the COVID-19 immunization and offered to be vaccinated. On 3/8/22, the DON (Director of Nursing) was notified that no COVID vaccine information for Resident #59 was noted. On 3/9/22, the DON stated, "The family gave us the dates but the admissions didn't have a card to upload". The DON was asked if the vaccination status should be documented in the clinical record regardless if the vaccine card is available or not, and the DON stated, "Yes".	F 887	No resident was adversely affected by this finding. COVID vaccination information for Resident #30 was uploaded from the Virginian Assisted Living Electronic Medical Record (EMR) to the Health Care Center EMR. All residents have the potential to be affected by this practice, therefore DON immediately re-educated Admissions team on uploading a copy of COVID vaccination card for all residents, including those coming from The Virginian Assisted or Independent Living Facility. For three months, DON or designee to perform weekly audit all records for presence of COVID card.	

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On 3/10/22 at 8:32 AM, an interview was conducted with LPN D. LPN D stated, "We document in the progress notes" when asked where immunization information is found. LPN D stated, "Knowing immunization status is very important so we know they have gotten the vaccination and we can check them". LPN D was asked if she needs to know a Resident's COVID immunization status in the event a Resident experiences a change in condition and needs to be sent to the hospital. LPN D said, "Yes, when we send them out EMS [emergency medical services] will ask for all of those documents/information, so they can take precautions. We have to protect the Resident and the people providing care".

2. For Resident #30, the facility staff failed to document in the clinical record if the Resident received all COVID vaccinations.

On 3/8/22, a clinical record review was conducted. This review revealed evidence that Resident #30 had received 1-dose of a multi-dose COVID vaccine, Pfizer on 10/14/21. There was no further documentation to indicate if the Resident received the second dose, was educated and offered the second dose following admission, or if the Resident declined the second dose.

On 3/8/22, the DON was made aware of the findings and stated, "I know what happened, and it is in her assisted living chart".

On 3/9/22, the DON stated that Resident #30's

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clinical chart had now been updated to reflect that she was fully vaccinated for COVID-19.

On 3/9/22, the DON was asked if she thought the vaccination status should be noted in the clinical record and she said, "It was supposed to have been".

A review of the facility policy titled, "COVID-19 Vaccine - Residents" was conducted. This policy read, "1. The COVID-19 vaccine will be offered to residents, unless the vaccine is medically contraindicated or the resident has already been immunized...2. Residents may obtain their COVID-19 vaccines from their personal physicians or at other community locations. Documentation of previous vaccination will be provided to the facility. 3. Booster doses of the COVID-19 vaccine will be offered to all residents if eligible. New admissions and residents who are not yet eligible will be offered the booster vaccine within 30 days of the resident being admitted or becoming eligible... 4. Residents will be offered the vaccine at the time of the resident's admission to the facility (healthcare center) and will be administered when available in the facility (healthcare center). 5. Prior to the vaccination, the resident (or resident's legal representative) will be provided information and education regarding the benefits and potential side effects of the COVID-19 vaccine. Provision of such education will be documented in the resident's medical record. A copy of the vaccine fact sheet provided may be retained in the resident's file. 6. In those situations where COVID-19 vaccination requires multiple doses the resident (or resident's legal representative) will be provided with current information regarding those additional doses, including any changes in

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F 887	Continued From page 32 the benefits or risks and potential side effects, associated with the COVID-19 vaccine before requesting consent for administration of any additional doses....9. Documentation in the resident's medical record will include at a minimum: That the resident or resident representative was provided education regarding the benefits and potential risks associated with the COVID-19 vaccine; and each dose administered, including additional doses or boosters, or If the resident did not receive the vaccine due to medical contraindications, religious beliefs, or refusal; and The COVID-19 vaccination status of the resident..." On 3/9/22, during an end of day meeting the facility Administrator and DON were made aware of the findings. No further information was provided.	F 887		