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 _____	08/04/2022

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 state complaint survey was conducted 8-2-22 through 8-4-22. Corrections are required for compliance Virginia Rules and Regulations for the Licensure of Nursing Facilities. One licensure complaint was investigated during survey The census in this 160 bed facility was 20 at the time of the survey.	F 000	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions sets forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-180. Infection control. A. The nursing facility shall establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. Based on observations, staff interviews, and facility documentation review, the facility staff failed to maintain an infection control program related to the proper wearing/removing personal protective equipment (PPE) for 2 Residents (Resident #3, Resident #53) in a sample size of 16 Residents. 1. For Resident #3, a known COVID-19 positive Resident on isolation precautions, the facility staff failed to do the following: a) doff (remove) their PPE before exiting the room on 08/03/2022 and b) properly wear their PPE while giving care on 08/04/2022. 2. For Resident #53, a known COVID Positive	F 001	F001: 12VAC5-371-180 as cross reference to F880 1. CNA B is no longer working at the facility. CNA D will be given an individualized in-service by the DON on the appropriate donning and doffing of PPEs. Residents #3/# 53 have fully recovered from the Covid infection without complications and the facility is no longer in an outbreak. 2. All residents are at risk. 3. The DON/Appropriate designee will in-service the facility staff on the following: a) Proper donning and doffing of PPEs b) Handwashing standard of practice 4) The DON/appropriate designee will complete a weekly audit of one Unit per week to ascertain that they are adhering to the appropriate use of PPEs and proper handwashing consistently. Any noted deficient practice will be corrected immediately as appropriate. The weekly audit findings of the DON/designee will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5) Date of compliance: 9/12/2022	9/12/22

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

Administrator 08-26-2022

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F 001	Continued From page 1 Resident who is on isolation precautions, the facility staff failed to properly wear PPE in the Residents room and failed to perform proper hand washing prior to exiting the room. The findings included: 1. For Resident #3, a known COVID-19 positive Resident on isolation precautions, the facility staff failed to do the following: a) doff (remove) their PPE before exiting the room on 08/03/2022 and b) properly wear their PPE while giving care on 08/04/2022. On 08/03/2022 at approximately 12:50 P.M., this surveyor observed the signage on Resident #3's room door which included but were not limited to the following signs: a) The CDC guidance on how to safely remove PPE. An excerpt of the sign documented, "Remove all PPE before exiting the patient room ..." b) CDC sign for Contact Precautions. An excerpt of the sign document, "Everyone must ...Put on gown before room entry. Discard gown before room exit." On 08/03/2022 at 12:55 P.M., this surveyor, Surveyor E, and the Director of Nursing (DON) observed Certified Nursing Assistant B (CNA B) exit Resident #3's room with an isolation gown on (not tied in the back), no gloves, and carrying a disposable food tray toward the tray cart down the hall. The DON told CNA B to return to the room to remove the isolation gown and dispose of the lunch tray in the room. At approximately 1:00 P.M., CNA B exited the room. When asked why they left the room with the isolation gown on and	F 001		

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F 001	Continued From page 2 the disposable tray, CNA B stated, "I forgot I was supposed to leave it in the room." On 08/04/2022 at 9:15 A.M., this surveyor observed CNA D giving care to Resident #3. CNA D's gown was untied, off the shoulders and hanging down around the wrists. CNA D then looked up and saw this surveyor making the observation from the hall. CNA D then reached for the gown and pulled it up over their shoulders and tied the top and bottom ties in the back of the gown. CNA D then approached the trash can in the room, removed the PPE, washed their hands, and exited the room. When asked what happened with the gown, CNA D stated that the ties were loose and when they bent over the bed to straighten the sheets for Resident #16, the gown fell off. On 08/03/2022, the facility staff provided a copy of their policy entitled, "Novel Corona Virus Prevention and Response." In Section 5(f)(g)(i) entitled, "Interventions to prevent the spread of respiratory germs within the facility:" it was documented, "Educate staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection. Promote easy and correct use of personal protective equipment (PPE) by: posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE." 2. For Resident #53, a known COVID Positive Resident who is on isolation precautions, the facility staff failed to properly wear PPE in the Residents room and failed to perform proper	F 001		

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F 001	Continued From page 3 hand washing prior to exiting the room. On 8/3/22 at 12:10 PM, CNA B was observed coming out of Resident # 53's room with N-95 mask below his nose. Resident #53 is known to be COVID positive. This surveyor, and LPN B were preparing to enter the room of Resident #53. This surveyor asked LPN B (charge nurse) if she saw any problems with the way CNA B was wearing his mask. LPN B stated he needs to cover his nose. CNA B adjusted his mask. LPN B asked him to assist her in the room with Resident #53. The Surveyor, LPN B and CNA B all donned PPE and entered the Resident's room. LPN B gave Resident #53 his medication in ice cream, and some spilled down his chin. LPN B asked CNA B to get her a napkin or paper towel. CNA B doffed his PPE by reaching behind him to unfasten the gown at the top and bottom removing the gown then the gloves. He kept his and face shield on and started to leave the room. LPN B told him not to leave the room but to get the paper towel from the bathroom. CNA B, who is only wearing a mask and face shield, got the paper towel, dampened it, gave it to LPN B and then leaned on the top rails of Resident #53's bed. He stood there a few more minutes to see if the nurse would need him and then left the room without washing his hands. Note: CDC Signs for proper donning and doffing PPE were posted on the Resident's door. The Surveyor and LPN B doffed PPE in the correct order and washed hands prior to leaving the room. On 8/3/22 at approximately 12:25 PM an interview was conducted with CNA B, who when asked about hand washing prior to leaving the	F 001		

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F 001	Continued From page 4 Resident's room, stated that he forgot. On 8/4/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided	F 001		

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E 000	Initial Comments An unannounced Initial Emergency Preparedness Survey was conducted 8-2-22 through 8-4-22. Corrections are required for compliance with 42 CFR Part 483.73 emergency preparedness regulations. No emergency preparedness complaints were investigated during the survey. The census in this 160 bed facility was 20 at the time of the survey.	E 000	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions sets forth in the plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of	E 015	1. The contracts for water supply, pharmaceutical supplies, and waste disposal will be reviewed by the Administrator with the respective providers and updated accordingly to reflect provision for services during an emergency, particularly an extended emergency. 2. All current and future residents are at risk. 3. The Administrator will be in-serviced by the Regional Director of Clinical Services on the need for the provision of sufficient water supply, adequate pharmacy services, and waste disposal during an emergency. 4. The Administrator/appropriate designee will audit monthly the emergency water supply availability, pharmaceutical supplies accessibility, and waste disposal management provision for a potential emergency to ensure that there are adequate response resources at the facility. Any noted inadequacy will be rectified immediately as appropriate. The result of the Administrator's audits will be	9/12/22

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Administrator 08-26-2022

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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E 015	Continued From page 1 provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to develop a plan for water provisions, pharmaceutical provisions, and waste disposal in the event of an emergency at the facility. The findings included: On 08/04/2022 at 1:20 P.M., this surveyor and the Administrator reviewed the facility's Emergency	E 015	forwarded to the QAPI committee for review and recommendation until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	

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E 015	Continued From page 2 Preparedness Plan. When asked about water provisions for the Residents and staff during an emergency, the Administrator there was a five day supply of water on hand in the event of an emergency for their current census of 20 Residents. When asked if there was an agreement with a company in place in the event of an extended emergency or in preparation of larger Resident census, the Administrator stated there were no arrangements. When asked about the provision of pharmaceutical supplies for Residents in the event of an emergency, the Administrator indicated there was no agreement in place with a pharmacy to provide Resident medications in the event of an emergency. When asked about provisions for waste disposal in the event of an emergency, the administrator indicated there were no provisions or arrangements planned for waste disposal.	E 015		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years	E 023	1. Facility has developed a policy that will protect and maintain the privacy and confidentiality of resident information during an emergency, including possible evacuation from the facility. 2. All residents are at risk. 3. The Regional Director of Clinical Services will in-service the Administrator and all the other Department Heads on the developed policy and procedures on the protection of resident information during an emergency. The Department Heads will in turn in-service their respective staff members on the same policy and procedures.	9/12/22

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E 023	Continued From page 3 [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to develop a plan for to preserve Resident confidentiality and secure and maintain availability of records. The findings included: On 08/04/2022 at 1:20 P.M., this surveyor and the Administrator reviewed the facility's Emergency Preparedness Plan. When asked about how Resident information would be protected and maintained during an emergency, the Administrator was unable to provide evidence a	E 023	4. The Administrator or appropriate designee will perform a monthly audit to ensure that staff are adhering to the policy developed on the protection of resident information during an emergency. Any noted deficient practice will be corrected immediately as deemed appropriate. The findings of the Administrator's audit will be forwarded to the QAPI committee for review and recommendation until it is determined by the committee that the problem no longer exists. 5. Date of compliance: 9/12/2022	

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E 023	Continued From page 4 policy and procedure was developed to protect Resident information and confidentiality in the event of an emergent evacuation of Residents from the facility.	E 023		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.	E 024	1. The Administrator will work with the Department Heads and develop a plan for emergency staffing strategies. 2. All residents are at risk. 3. The Administrator will in-service all the Department Heads on the developed plan for staffing strategies during an emergency. The Department Heads will in turn educate their respective staff members on the developed plan for emergency staffing strategies. 4. The Administrator/Appropriate designee will perform a monthly audit of the developed staffing strategies during an emergency to assess its continuing viability. Any noted inadequacy will be rectified accordingly and as appropriate. The outcome of the Administrator's audit will be forwarded to the QAPI committee for further review and recommendation until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	9/12/22

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E 024	Continued From page 5 *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to develop a plan for emergency staffing strategies. The findings included: On 08/04/2022 at 1:20 P.M., this surveyor and the Administrator reviewed the facility's Emergency Preparedness Plan. When asked about emergency staffing strategies, the Administrator failed to provide evidence emergency staffing strategies had been developed.	E 024		
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the	E 025	1. The Administrator will work with the Company's Home Office to obtain a contractual arrangement with a medical transportation company(ies) that can evacuate the residents from the building during an emergency. 2. All residents are at risk. 3. The Administrator will provide an in-service to the Department Heads on the contracted transportation arrangement and policy for residents' evacuation during an emergency. The Department Heads will in turn in-service their respective staff members on the provisions in the transportation contract(s) and policy for residents' evacuation during an emergency.	9/12/22

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E 025	Continued From page 6 policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to develop a plan for transportation arrangements in the event of an evacuation. The findings included: On 08/04/2022 at 1:20 P.M., this surveyor and the	E 025	4. The Administrator/Appropriate designee will review monthly the contract continuing viability to provide the transportation need of the residents during an emergency. Any noted inadequacy will be rectified accordingly and as appropriate. The outcome of the Administrator's review will be forwarded to the QAPI committee for further review and recommendation until it is determined by the committee that the problem no longer exists. 5. Date of compliance: 9/12/2022	

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E 025	Continued From page 7 Administrator reviewed the facility's Emergency Preparedness Plan. When asked about arrangements with other facilities to send or receive Residents in the event of an emergency, the Administrator stated there are no agreements with other facilities. The Administrator stated that in the event of an emergency, the VHASS (Virginia Healthcare Alerting and Status System (VHASS) would be contacted to determine the disposition of Residents. When asked about transportation arrangements for Residents evacuating the facility in the event of an emergency, the Administrator stated there were no plans developed or agreements in place for transportation services in the event of an emergent evacuation.	E 025		
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities	E 041	1. The Administrator will develop and sign a contractual agreement with an appropriate provider that can refuel the current generator in an emergency. 2. All residents are at risk. 3. The Administrator will in-service Department Heads on the contractual agreement on refueling the generator during an emergency. The Department Heads will in turn educate their respective staff members on the contractual provisions for refueling the generator during an emergency. 4. The Administrator/Appropriate designee will perform a monthly review of the contract continuing viability to service the refueling need of the facility' s generator during an emergency. Any noted inadequacy will be rectified accordingly and as appropriate. The outcome of the Administrator's review will be forwarded to the QAPI committee for further review	9/12/22

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E 041	Continued From page 8 Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:	E 041	and recommendation until it is determined by the committee that the problem no longer exists. 5. Date of compliance: 9/12/2022	

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E 041	Continued From page 9 http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to develop a plan to keep the generator operational during an emergency. The findings included:	E 041		

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E 041	Continued From page 10 On 08/04/2022 at 1:20 P.M., this surveyor and the Administrator reviewed the facility's Emergency Preparedness Plan. When asked about the plan for keeping the generator operation during an emergency, the Administrator stated they currently have a portable generator which would last for 5 days to power only the red sockets for 160 beds. The Administrator stated there is a new generator on order that would cover the whole building. When asked if there were agreements in place to refuel the generator in the event of a prolonged emergency, the Administrator indicated there was no agreement in place.	E 041		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid Initial survey was conducted 8-2-22 through 8-4-22. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 160 bed facility was 20 at the time of survey. The survey sample consisted of 16 Residents and 8 staff reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550	1. The DON will provide an individualized in-service to LPN B on the need to respect the dignity of Resident #53 by not referring to the resident as a feeder. 2. All residents are at risk. 3. DON/Appropriate designee and the Director of Social Services will complete an in-service with all of the staff on resident' rights, including the observance of their dignity.	9/12/22

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F 550	Continued From page 11 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review, and facility documentation, the facility staff failed to ensure Residents are treated with dignity for 1 Resident (#53) in a Survey Sample of 16 Residents. The findings included:	F 550	4. The Director of Social Services will complete rounds on one Unit per week to observe the treatment of residents requiring feeding assistance as it relate to their dignity. Any noted deficient practice will be rectified immediately as appropriate. The findings of the Director of Social Services' weekly rounds will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	

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F 550	Continued From page 12	F 550		

For Resident #53, the facility staff referred to the Resident as "A Feeder" while speaking to the Surveyor as well in progress notes in his clinical record.

On 8/3/22 at approximately 12:00 PM while observing medication administration for Resident # 53, LPN B stated she was unsure of how the Resident would take his medication. She stated she usually crushes the medications but she was not sure how he would take the capsule of neurontin. When asked how she usually does it, she stated that she usually opened the capsule, "But I am not sure if I should do that or not." She further stated that Resident #53 is a "Feeder and has trouble swallowing at times. Sometimes he does ok sometimes he doesn't." She then proceeded to get ice cream and put the whole pills in the ice cream.

When asked what she meant by the term "Feeder" she stated that meant someone has to feed him he cannot feed himself. Surveyor E said "You mean he requires assistance with meals? LPN B said , "Yes that is what I mean."

After donning PPE and going to the bedside the nurse did not address the Resident by his name she said "I'm going to give you your medicine now ok?' The Resident was non verbal and just continued looking at the television. The Resident accepted the medication in the ice cream swallowed it without incident and the nurse said, "Thank you" and doffed PPE washed her hands and left the room.

A review of the clinical record revealed the following excerpt from Resident #53's progress notes:

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F 550	Continued From page 13 "5/14/2022 16:48 Note Text: Resident is alert and oriented to self. He is a feeder, ate >75% of his meals today. Resident took his meds as ordered, no S/S of pain or discomfort noted" On 8/5/22 at approximately 4:00 PM an interview was conducted with the DON who stated it is not acceptable to call a Resident "a feeder" nor is it acceptable for a nurse to fail to address a Resident by his or her name." When asked why she stated that is a dignity issue. On 8/5/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 550		
F 563 SS=F	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny	F 563	1. The notice of visitation restriction at the facility main entrance was removed on 8/4/2022. The facility is now open 24 hours for residents' visitation. 2. All residents are at risk. 3. DON/Appropriate designee and the Director of Social Services will complete an in-service with all facility staff on residents' rights, including the right to visitation. 4. The Director of Social Services will perform a monthly audit on residents' visitation to ascertain that there has been no restriction for them to be visited. Any noted deficient practice will be rectified immediately as appropriate. The findings of the Director of Social Services' monthly audit will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	9/12/22

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F 563	Continued From page 14 or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, representative interview, staff interview, and facility documentation review, the facility staff restricted resident rights for visitation for all Residents. The findings included: The CMS (Centers for Medicare and Medicaid Services) memorandum entitled, "QSO-20-39 NH REVISED" updated on 03/10/2022, documented the following excerpt: "Visitation is allowed for all Residents at all times." On 08/02/2022 at approximately 11:30 A.M., a sign posted on the front door of the facility documented, "Visting [sic] hours 11:00AM-6:00PM." The sign was observed on the front door on 08/03/2022 and 08/04/2022 as well. On 08/02/2022 at 1:45 P.M., the Responsible Party (RP) for Resident #16 was interviewed. When asked about visiting hours, the RP stated that visiting hours were from 11:00 A.M. until 6:00 P.M. Resident #16's RP also stated that they would like to have more liberal visiting hours and be able to have more time for visits. The RP added that it limits visitation for people who work	F 563		

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F 563	Continued From page 15 during the day. On 08/04/2022 at approximately 8:45 A.M., the front desk receptionist, Employee H, was interviewed. When asked about visiting hours, Employee H stated that visiting hours were from 11:00 A.M. until 6:00 P.M. and that the front doors were locked at 6:00 P.M. On 08/04/2022 at 10:00 A.M., Registered Nurse B (RN B) was interviewed. When asked about visiting hours, RN B stated there were no restrictions on visiting hours. When asked about the process if a visitor arrived after 6:00 P.M. when the front doors were locked, RN B stated that the visitor would ring the bell, a staff member would screen the visitor, then the visitor would be allowed in. On 08/04/2022 at approximately 4:00 P.M., the Administrator, Director of Nursing, and Regional Corporate Nurse were notified of findings. When asked about the visiting hours, the administrator stated the visiting hours were 11:00 A.M. through 6:00 P.M. which was implemented when the previous Director of Nursing worked at the facility. The Regional Corporate Nurse then stated that there were no restrictions to visitation and there may be a miscommunication.	F 563		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584	1. Resident #8's room was organized on 8/4/2022 by Employee E. Employee E is now a fulltime staff member at the facility. 2. All residents are at risk. 3. The DON/Appropriate designee will in-service the nursing and housekeeping staff on the requisite organization and cleanliness of residents' rooms.	9/12/22

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F 584	Continued From page 16 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, clinical record review and facility documentation the facility staff failed to ensure a clean comfortable homelike environment for 1 Resident (#8) in a survey	F 584	4. The DON/Social Services Director/Housekeeping Supervisor will perform a 10% weekly audit of current residents' rooms to ascertain that they are organized and cleaned. Any noted disorganization/uncleanliness will be corrected immediately as appropriate. The findings of the weekly audit of the DON/Social Services Director/Housekeeping Supervisor will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	

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F 584	Continued From page 17	F 584		

sample of 16 Residents.

The findings included:

For Resident #8 the facility staff failed to assist her in cleaning and organizing her room as she is physically unable to do so, and they told her she could not hang up her personal artwork in her room.

On 8/2/22 at approximately 12:00 PM the Surveyor E knocked on the door and was told to enter. Upon entering the room it was noted that the bed was filled with several large folded blankets and a box. A large display table with 2 levels contained various pieces of artwork pottery and ceramic masks, paintings were tucked between the table and the dresser. Resident #8 was sitting in a recliner chair and she greeted the surveyor. The Resident immediately apologized for the clutter on the bed and dresser.

Resident #8 stated she had resided at the facility since 4/19/22 and was unhappy about a couple of things. Resident #8 stated that she had diagnoses of rheumatoid arthritis, fibromyalgia, chronic pain syndrome, history of back and neck surgeries and was on oxygen related to COPD. The Resident stated since she moved in she has been asking for someone to help her get her room cleaned and organized however no one had done so yet. She stated that she has asked the Social Worker and that she said she would help her but as of yet it had not been done.

The Resident stated that she would like to get her paintings put up on her walls but the former DON had told her she was not allowed to "put holes in the walls with nails." The Resident stated "I want

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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) COMPLETION DATE
F 584	Continued From page 18 to display my own things." Resident #8 explained that she was an artist and she used to make pottery and ceramic masks and would like to display them. On the morning of 8/3/22 a review of Resident #8's care plan revealed the following: FOCUS: The resident is Moderate, risk for falls r/t Deconditioning, Psychoactive drug use, impaired mobility, impaired balance and generalized weakness. Date Initiated: 04/20/2022 GOAL: The resident will not sustain serious injury through the review date. Date Initiated: 04/20/2022 INTERVENTIONS: The resident needs a safe environment with even floors free from spills and/or clutter; . Date Initiated: 04/20/2022 On 8/4/22 at 3:59 PM an interview was conducted with Employee E, who was asked about assisting Resident #8 with getting her room cleaned and organized. Employee E stated that currently only works part time, she stated that she met with the Resident today and told her she would try to help her get things organized. On 8/4/22 during the end of day meeting the Administrator was made aware of the concerns no further information was provided.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		

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F 656	Continued From page 19 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656	1. Resident #8 care plan will be reviewed and updated to reflect her use of a recliner to sleep instead of a bed. 2. All residents are at risk for the omission of care plan revision. 3. The DON will in-service the interdepartmental team (IDT) on care plan reviewing and updating to comprehensively capture the care regimen of the residents 4. The DON/Appropriate designee will perform a weekly audit of 10% of the current residents' care plans to ascertain that they are current and comprehensive. Any noted inadequate care plan will be corrected immediately as appropriate. The weekly audit findings of the DON will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	9/12/22

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F 656	Continued From page 20 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview observation, clinical record review and facility documentation the facility staff failed to develop and implement a comprehensive care plan for 1 Resident (#8) in a survey sample of 16 Residents. The findings included: For Resident #8 the care plan does not address Resident #8 sleeping in a recliner instead of her bed. On 8/2/22 at approximately 12:40 PM an interview was conducted with Resident #8 stated that she did not sleep in the bed. She stated that it is her preference to sleep in her recliner due to her mobility issues and pain. She further explained that no one "Makes her bed." Resident #8 stated that they make the bed and change the sheets however she does not sleep in the bed. She stated the staff never fluff the pillows behind her or change the sheet under her (referring to recliner where she sleeps). Resident #8 stated that she can feel every wrinkle in the pad and sheet under her. She also stated that it has been a month since anyone has offered to make up recliner with fresh linens. She stated that she has been at the facility since 4/18/22 and has only had the recliner linens changed a handful of times. A review of the care plan revealed that the comprehensive care plan did not give any information about Resident #8's preference for sleeping in the recliner.	F 656		

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F 656	Continued From page 21 On the morning of 8/4/22 an interview was conducted with LPN B who stated she was aware of the Resident not sleeping in her bed stating that Resident #8 prefers to sleep in her recliner. When asked who changes the linens on the recliner LPN B stated she thought the CNA's did it. On 8/4/22 at approximately 10:50 AM an interview was conducted with CNA B who stated that the CNA's make the bed. CNA B was asked when CNA's change the linens in the chair and fix the pillows and CNA B stated they will do it when the Resident asks them to. On 8/4/22 an interview was conducted with the DON about care planing and she stated that the comprehensive care plan should outline everything you need to know to care for the Resident, including meds, treatments, preferences, and types of assistance needed. She also stated the care plan should be updated quarterly and as needed with changes in condition, treatment or care needs. On 8/4/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that	F 657	1. Resident #16 care plan will be reviewed and revised to reflect her tendency to pull the PICC line. Resident #16 has not removed her PICC line since last reported incident on 6/24/2022. 2. All residents with PICC/IV lines are at risk.	9/12/22

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F 657	Continued From page 22 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 observation, representative interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to revise the care plan for one Resident (Resident #16) in a sample size of 16 Residents. For Resident #16, the facility staff failed to revise the care plan to include a goal and interventions after Resident #16 pulled out her peripherally-inserted central catheter (PICC) on 06/24/2022. The findings included: On 08/02/2022 at 1:45 P.M., the Responsible Party (RP) for Resident #16 was interviewed. When asked if they were notified for changes in Resident #16's condition, the RP stated, "Yes"	F 657	3. The DON will in-service the interdepartmental team on the revision of care plan with every change in residents' condition. 4. The DON/Appropriate designee will perform a weekly audit of the care plans of all current residents with PICC/IV lines to ascertain that their tolerance of the IV therapy line is reflected in their comprehensive care plan accurately. Any noted inadequate care plan will be corrected immediately as appropriate. The weekly audit findings of the DON will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	

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F 657	Continued From page 23	F 657		

and explained that the facility staff called him when Resident #16 pulled her PICC line out. When asked what the facility staff implemented to mitigate that happening again, the RP stated that [Resident #16]'s arm is wrapped to prevent her from fiddling with it.

On 08/03/2022, Resident #16's clinical record was reviewed. Resident #16's admission Minimum Data Set dated 06/14/2022 coded the Brief Interview for Mental Status as "2" out of possible "15" indicative of severe cognitive impairment.

An excerpt of a nurse's note dated 06/24/2022 at 7:25 A.M. documented, "Around 5:15am picc line was out, sticked on the side of the bed. NO bleeding noted."

The care plan was reviewed. There was no evidence the care plan was revised to include goals and interventions for this behavior of pulling out the PICC line catheter.

On 08/04/2022 at 9:30 A.M., Certified Nursing Assistant D (CNA D) was interviewed. When asked if Resident #16 had any behaviors, CNA D stated "No." When asked if Resident #16 ever pulled at the PICC line catheter, CNA D indicated they hadn't seen Resident #16 pulling at the PICC line catheter and was unaware Resident #16 had a history of pulling out the PICC line catheter.

On 08/04/2022 at approximately 9:35 A.M., this surveyor and Registered Nurse B (RN B) entered Resident #16's room to observe the PICC line site. The PICC line site was in the antecubital region (where the arm bends at the elbow) of the right arm and dressed with a transparent

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F 657	Continued From page 24 dressing. A gauze wrap was observed at Resident #16's right wrist. The PICC line catheter was exposed and accessible to Resident #16. When asked if this is how the PICC line site dressing should look, RN B stated "No." RN B explained that the gauze wrap slipped down and that Resident #16 had pulled out her PICC line before so the gauze wrap should cover the PICC line site and catheter. RN B then obtained a new gauze wrap and completely covered the PICC line site and catheter. On 08/04/2022, the facility's policy entitled, "Care Plan Revisions Upon Status Change" was reviewed. In Section 1, it was documented, "The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change." On 08/04/2022 at approximately 3:45 P.M., the Administrator and Director of Nursing (DON) were notified of findings. At 4:15 P.M., the DON indicated there was no further information or documentation to submit.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff ailed to initial and date the PICC (peripherally-inserted central catheter) line site dressing as observed on 08/04/2022 for one	F 658	1. Resident #16 PICC line dressing has been initialed and dated with every change of dressing since the observation on 8/4/2022. 2. All residents with IV lines are at risk. 3. All nurses will be in-serviced by the DON/appropriate designee on PICC line dressing change protocol, including appropriately initialing and dating the dressing when completed.	9/12/22

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F 658	Continued From page 25 residents (#16) in a survey sample of 16 residents. The findings include: On 08/03/2022, Resident #16's clinical record was reviewed. A physician's order dated 07/11/2022 documented, "PICC-LINE DRESSING CHANGE EVERY 7 DAYS AND AS NEEDED PER PROTOCOL. every day shift every Tue[Tuesday] for IV Therapy for 8 Weeks." The Treatment Administration Record entry associated with this order was signed off as administered on 08/02/2022. On 08/04/2022 at approximately 9:35 A.M., this surveyor and Registered Nurse B (RN B) entered Resident #16's room to observe the PICC line site. The PICC line site was in the antecubital region (where the arm bends at the elbow) of the right arm and dressed with a transparent dressing. The transparent dressing was not initialed or dated. When asked about the expectation, RN B indicated that the PICC dressing should be dated. According to Lippincott "Nursing Procedures", Seventh Edition, 2016, under the header "Changing the dressing on a central venous access catheter", an excerpt documented, "Label the dressing with the date, the time, and your initials." On 08/04/2022 at approximately 3:45 P.M., the Administrator and Director of Nursing (DON) were notified of findings. At 4:15 P.M., the DON indicated there was no further information or documentation to submit.	F 658	4. The DON/Appropriate designee will perform a weekly audit of all current residents with PICC/IV lines to ascertain that the dresses are initialed and dated when changed. Any noted anomaly will be corrected immediately as appropriate. The weekly audit findings of the DON will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	

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F 679	Continued From page 26	F 679		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and clinical record review the facility staff failed to provide activities to meet the interests of the Resident for 1 Resident (#8) in a survey sample of 16 Residents. The findings included: For Resident #8 the facility staff failed to provide the Resident with painting materials, or craft projects. On 8/2/22 at approximately 12:00 PM, Surveyor E knocked on the door and was told to enter. Upon entering the room it was noted that the bed was filled with several large folded blankets and a box. A large display table with 2 levels contained various pieces of artwork pottery and ceramic masks, paintings were tucked between the table and the dresser. Resident #8 was sitting in a recliner chair and she greeted the surveyor. The Resident immediately apologized for the clutter on the bed and dresser.	F 679	1. Resident #8 will be provided with painting materials and supported by the appropriate Interdepartmental team (IDT) to engage in craft projects as tolerated 2. All residents are at risk. 3. The Administrator/appropriate designee will in-service the Activities/Social Services Departments on capturing, documenting, and implementing resident activity preferences and needs. 4. The Activities/Social Services Department/Appropriate designee will perform a 10% weekly audit of all current residents to ascertain that their preferences and need for activities are taken into consideration. Any noted deficiency will be corrected immediately as appropriate. The weekly audit findings of the Activities/Social Services Departments will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	9/12/22

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F 679	Continued From page 27	F 679		

Resident #8 stated that she would like to have some form of Art Projects to do. When asked if she had expressed that to the Activities Director she stated that they had done an evaluation when she was admitted but no one has offered her more than Bingo, word search, and coloring sheets. Resident #8 stated " I feel like my mind is going because I sit in this room day after day with just the TV for company. Nothing to interest me or keep me occupied."

A review of the care plan revealed the following entry from the Activities director:

"FOCUS:
[Resident #8 name redacted] is independent for meeting emotional, intellectual, physical, and social needs
Date Initiated: 04/20/2022 [Activities Director name redacted]

GOAL:
[Resident #2 name redacted] will maintain involvement in cognitive stimulation and social activities as desired through review date.
Date Initiated: 04/20/2022[Activities Director name redacted]

INTERVENTIONS:
The resident needs assistance/escort to activity functions. Date Initiated: 04/20/2022 (Activities Director)
The resident prefers the following TV channels: TCM, Paramount movies, news Date Initiated: 04/20/2022[Activities Director name redacted]
The resident's preferred activities are: Watching television/movies, going outdoors when weather is nice, and arts and crafts. Date Initiated:

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F 679	Continued From page 28 04/20/2022 [Activities Director name redacted]." On the afternoon of 8/3/22 an interview was conducted with the Social Worker who stated that Resident #2 was an accomplished artist and would be bored by bingo, word searches and coloring pages. She stated that Resident #2 was articulate and bright and not suffering from any cognitive decline so she would speak to the Activities Director about some sort of art projects. On 8/4/22 several attempts were made to contact the Activities Director without success. On 8/4/22 during the end of day meeting the Administrator was made aware of the concerns no further information was provided.	F 679		
F 689 SS=D	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, representative interview, staff interview, and clinical record review, the facility staff failed to ensure the environment remained free of accident potential for one Resident (Resident #16) in a sample size of 16 Residents. For Resident #16 (with a known behavior and history of pulling out the peripherally-inserted central catheter (PICC)), the	F 689	1. The DON will assess the adequacy of the current wrapping intervention to prevent Resident #16 from pulling her PICC line. Resident #16 has not removed her PICC line since last reported incident on 6/24/2022. 2. All residents with PICC/IV lines are at risk. 3. The DON will in-service the nurses on wrapping techniques to prevent the dislodgement of a PICC/an IV line by a resident 4. The DON/Appropriate designee will perform a weekly audit of all current residents with PICC/IV lines to ensure that any resident with PICC/IV line has appropriate intervention to prevent possible dislodgement. Any noted inadequate intervention will be rectified immediately as appropriate.	9/12/22

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F 689	Continued From page 29 facility staff failed to ensure the intervention of wrapping the PICC line site was effective and in place. The PICC line was exposed and accessible to Resident #16 on 08/04/2022. The findings included: On 08/02/2022 at 1:45 P.M., the Responsible Party (RP) for Resident #16 was interviewed. When asked if they were notified for changes in Resident #16's condition, the RP stated, "Yes" and explained that the facility staff called him when Resident #16 pulled her PICC line out. When asked what the facility staff implemented to mitigate that happening again, the RP stated that [Resident #16]'s arm is wrapped to prevent her from fiddling with it. On 08/03/2022, Resident #16's clinical record was reviewed. Resident #16's admission Minimum Data Set dated 06/14/2022 coded the Brief Interview for Mental Status as "2" out of possible "15" indicative of severe cognitive impairment. An excerpt of a nurse's note dated 06/24/2022 at 7:25 A.M. documented, "Around 5:15am picc line was out, sticked on the side of the bed. NO bleeding noted." The care plan was reviewed. There was no evidence the care plan was revised to include goals and interventions for this behavior of pulling out the PICC line catheter. On 08/04/2022 at 9:30 A.M., Certified Nursing Assistant D (CNA D) was interviewed. When asked if Resident #16 had any behaviors, CNA D stated "No." When asked if Resident #16 ever	F 689	The weekly audit findings of the DON will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	

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

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F 689	Continued From page 30 pulled at the PICC line catheter, CNA D indicated they hadn't seen Resident #16 pulling at the PICC line catheter and was unaware Resident #16 had a history of pulling out the PICC line catheter. On 08/04/2022 at approximately 9:35 A.M., this surveyor and Registered Nurse B (RN B) entered Resident #16's room to observe the PICC line site. The PICC line site was in the antecubital region (where the arm bends at the elbow) of the right arm and dressed with a transparent dressing. The transparent dressing was not initialed or dated. A gauze wrap was observed at Resident #16's right wrist. The PICC line catheter was exposed and accessible to Resident #16. When asked if this is how the PICC line site dressing should look, RN B stated "No." RN B explained that the gauze wrap slipped down and that Resident #16 had pulled out her PICC line before so the gauze wrap should cover the PICC line site and catheter. RN B then obtained a new gauze wrap and completely covered the PICC line site and catheter. On 08/04/2022 at approximately 3:45 P.M., the Administrator and Director of Nursing (DON) were notified of findings. At 4:15 P.M., the DON indicated there was no further information or documentation to submit.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law	F 755	1. The narcotic counting sheet has been signed accordingly since the noted empty spaces on 8/3/2022. 2. All residents are at risk. 3. The DON will review all current Controlled medication books weekly for two weeks. The result of the review will be used for individualized remediation for identified nurses with deficient practices. The DON/appropriate	9/12/22

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F 755	Continued From page 31 permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility record review the facility staff failed to implement a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. There were 17 empty spaces where one or both nurses did not sign off for the narcotic count between 7/3/22 and 8/3/22. The findings included: For the facility the facility staff failed to ensure the system of verifying narcotics was completed by	F 755	designee will also provide an in-service to all nurses on the standard protocol and documentation in managing controlled substances/medications. 4. The DON/appropriate designee will complete a monthly audit of one controlled medication book on each Unit to ascertain that standard protocol and documentation in managing controlled medications are followed across all shifts. Any noted deficient practice will be rectified immediately as appropriate. The monthly audit findings of the DON will be forwarded to the QAPI committee for further review and recommendation until it is determined by the committee that the problem no longer exists. 5. Date of Compliance: 9/12/2022	

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F 755	Continued From page 32 the oncoming and off-going nurses both counting and signing the narcotic book. On 8/3/22 at 09:02 AM, an interview was conducted with LPN C who stated that he had already finished all of his medication pass for the morning. On 08/03/22 at 09:34 AM an interview was conducted with LPN B who was asked the process for signing off narcotics. LPN B stated the oncoming and offgoing nurses count together to be sure that the count is correct. They both sign the narcotic count sheet before the keys are handed over. A review of the "Narcotic Book" revealed that nurses were not signing off on narcotic counts together. There were 17 empty spaces where one or both nurses did not sign off for the narcotic count between 7/3/22 and 8/3/22. LPN B stated the empty spots are where the "agency nurses" do not sign the book. When asked why the agency nurses do not sign the narcotics sign off sheet she stated she did not know. On 08/03/22 at 09:40 AM - LPN C was observed signing the individual Resident Narcotic sheets after he stated he had completed his medication pass. (Meaning he pulled the medication, gave it to the Resident prior to the interview at 9:02 AM and at 9:40 AM was signing that he had pulled the medication.) 08/03/22 09:42 AM - Interview with DON who stated it is the expectation that all oncoming and off going nurses perform narcotic counts at the beginning and end of shift. This includes agency staff. All medications are to be signed off as they	F 755		

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F 755	Continued From page 33 are removed from the narcotic drawer not at the end of med pass. When asked why this is the practice she stated that if they wait until after they have completed their med pass they may forget to sign it out and it will create a discrepancy in the count. On 8/4/22 at the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 755		
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;	F 758	1. Resident #2 diagnosis for the referenced psychotropic medication was updated to accurately reflect her current indication for use. 2. All current residents on psychotropic medications are at risk. 3. The DON will in-service the nurses on appropriate indication/diagnosis for use of all psychotropic medications. 4. The DON/Appropriate designee will audit weekly all psychotropic medications used by current residents to ascertain that they have appropriate indication for continuing use. Any noted improper indication for use will be clarified with the prescribing physician and updated accordingly. The weekly audit findings of the DON will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of compliance: 9/12/2022	9/12/22

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F 758	Continued From page 34 §483.45(e)(3) Residents do not receive 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 observation, interview, clinical record review and facility documentation the facility staff failed to ensure Residents were free from unnecessary psychotropic medications for 1 Resident (#2) in a survey sample of 16 Residents. The findings included: Resident #2 was prescribed Remeron (an antidepressant) "For appetite stimulation." On 8/2/22 at 12:43 PM Resident # 2, was observed in her room alone with the lunch tray in front of her head of bed elevated to 45 degrees. Resident #2 was eating a cookie from her tray.	F 758		

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F 758	Continued From page 35	F 758		

The sandwich, and juice untouched. The soup still covered in the bowl.

A review of the clinical record revealed progress notes from the RD that read:

"4/21/22 -Resident requires set-up and assistance with meals. Mechanical soft with pureed meats and thin liquids."

On 8/3/22 during clinical record review it was discoursed that Resident #2 had an order that read as follows:

"Mirtazepine Tablet 15 MG [Trade name Remeron; an antidepressant] Give 1 tablet by mouth at bedtime for appetite stimulant -Start Date- 04/06/2021 2000"

On 8/4/22 at approximately 1:00 PM an interview was conducted with the RD who stated that Resident #2 did not currently have a significant weight loss but her BMI was low for her age. When asked if she required assistance with meals she stated that she did require assistance as she could manage "finger foods" but could not manage a spoon and fork on her own. When ask if she needed to be fed by staff, the RD stated that she did.

On 8/4/22 at approximately 1:45 PM an interview was conducted with the DON who was asked about the prescribing of Remeron for appetite stimulant, the DON stated she would look into it as she was a new DON at this facility and was not familiar with all of the Residents histories yet. At approximately 2:00 PM the DON came back and stated she did see the order and would contact the prescribing doctor about it. She stated

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F 758	Continued From page 36 Remeron is an antidepressant and should be prescribed for depression, there are drugs marketed specifically for appetite stimulation and she stated she would suggest the MD prescribe one of those. On 8/4/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 758		
F 801 SS=F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e) This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition	F 801	1. The facility will place an advertisement for the recruitment of a qualified Dietary Manager with requisite certification. In the interim, the Dietitian's contact hours at the facility will be increased to forty (40) hours per week to enable the Dietitian to provide oversight over the dietary services at the facility. 2. All residents are at risk. 3. The Administrator will be in-serviced by the Regional Director of Clinical Services on the regulation relating to the required qualification/certification of a Dietary Manager 4. Human Resource office will complete a monthly audit of the dietary management personnel files to ascertain that all their qualifications/certifications meet the state/federal requirements for the positions they occupied. The monthly audit findings of the Human Resource office will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of compliance: 9/12/2022	9/12/22

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F 801	Continued From page 37 professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who- (i) For designations prior to November 28, 2016, meets the following requirements no later than 5 years after November 28, 2016, or no later than 1 year after November 28, 2016 for designations after November 28, 2016, is: (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; and (ii) In States that have established standards for food service managers or dietary managers,	F 801		

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F 801	Continued From page 38 meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to employ a dietary manager with the appropriate credentials. The findings included: On 08/03/2022 at approximately 12:25 P.M., the Director of Nursing provided the credentials for the dietary manager as requested. The Director of Nursing stated that the dietary manager does not have "the right credentials" because he did not complete the full course for certification. The credentials document provided was an identification (ID) card entitled, "Northern Virginia Food Manager ID." On 08/03/2022 at 3:30 P.M., the dietary manager was interviewed. The dietary manager confirmed he was not a certified dietary manager. When asked about the ID entitled "Food Manager", the dietary manager stated that he received that ID as a result of obtaining ServSafe certification. The dietary manager then provided a copy of his ServSafe certification dated 11/11/2019. On 08/04/2022 at approximately 3:45 P.M., the Administrator and Director of Nursing were notified of findings.	F 801		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		

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F 812	Continued From page 39 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility documentation review, the facility staff failed to maintain safe holding temperatures for 3 out of 3 cold beverages tested on 08/03/2022. The findings included: On 08/03/2022 at 11:45 A.M., this surveyor observed the facility staff on the tray line in preparation to distribute lunch to the Residents. There were trays lined up with cold beverages on them in preparation to be delivered to Residents. This surveyor observed the dietary manager check the temperature of the milk on one tray. The temperature was 57.2 degrees Fahrenheit. The dietary manager disposed of that milk. The dietary manager checked the temperature of	F 812	1. The kitchen staff will place the cold beverages in a stainless-steel bowl filled with ice when taking them to the point of service. 2. All residents are at risk. 3. The Dietitian/appropriate designee will provide an in-service to the kitchen staff on the temperature management of cold beverages and the plan instituted to deliver them at required temperature to the point of service. 4. The Dietitian/Appropriate designee will complete a monthly auditing of the tray line to ascertain that cold beverages are kept at appropriate safe serving temperature of below 41 degrees Fahrenheit. Any noted anomaly will be corrected accordingly and as appropriate. The monthly audit findings of the Dietitian/Appropriate designee will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of compliance: 9/12/2022	9/12/22

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F 812	Continued From page 40 another milk from a different tray. It was 55.4 degrees Fahrenheit and the dietary manager disposed of that milk as well. The dietary manager checked the temperature of a cup of apple juice from another tray and the temperature was 65.3 degrees. When asked about the expectation for holding temperatures for cold beverages, the dietary manager stated, "40 degrees." When asked about the process for distributing cold beverages, the dietary manager opened the walk-in refrigerator to show milk and juices in a container on ice. The dietary manager explained that "a few minutes" before tray lines begins, all the cold beverages are distributed to the trays. The facility staff continued with tray line. The cold beverages on the remaining trays were not checked or removed in light of discovering 3 out of the 3 beverages were holding at unsafe temperatures. On 08/03/2022 at 12:05 P.M., the Director of Nursing was notified of findings. On 08/03/2022, the facility staff provided a copy of their policy entitled, "Record of Food Temperatures." In Section 4, it was documented, "Potentially hazardous cold food temperatures will be kept at or below 41 degrees Fahrenheit."	F 812		
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. (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	F 842	1. An elopement/wandering risk assessment will be completed on Resident #52 and his care plan updated accordingly by the DON/a nurse. 2. All residents are at risk. 3. The DON will in-service the nurses on the completion of wandering/elopement risk assessment on residents.	9/12/22

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F 842	Continued From page 41 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. §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-	F 842	4. The DON/appropriate designee will complete a weekly audit on all newly admitted/readmitted patients after completing one on all current residents to ascertain that wandering/elopement risk assessment have been completed on them. Anyone noted with a missing elopement/wandering risk assessment will have one completed on them by a nurse. The weekly audit findings of the DON/appropriate designee will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of compliance: 9/12/2022	

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	NH2656	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 42 (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 observation, interview, clinical record review and facility documentation the facility staff failed to maintain an accurate clinical record for 1 Resident (#52) in a survey sample of 16 Residents. The findings included: For Resident # 52 the facility staff failed to accurately assess Resident #52 for elopement risk. Resident #52 was admitted to the facility on 7/8/22 a review of the care plan revealed the following excerpt: FOCUS: The resident is an elopement risk. Date Initiated: 07/08/2021	F 842		

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F 842	Continued From page 43 Revision on: 08/18/2021 GOAL: The resident's safety will be maintained through the review date. Date Initiated: 07/08/2021 Target Date: 08/10/2021 INTERVENTIONS: Distract resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. Resident prefers: (space left blank) Date Initiated: 07/08/2021 Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes. Date Initiated: 07/08/2021 On 8/3/22 an interview was conducted with the DON who was asked about Resident # 52 being an elopement risk. The DON stated she was not aware of Resident #52 being and elopement risk. She stated she would review his documents and his clinical records . On the morning of 8/4/22 the DON stated that she could not find an elopement assessment for Resident #52 and she could not find any documentation of elopement attempts, or exit seeking behaviors since admission. She stated she also looked into his admission record and could not find any elopement attempts prior to admission. When asked if the care plan was accurate she stated that it was not. On 8/4/22 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 842		

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	F880 as cross reference to 12VAC5-371-180 1. CNA B is no longer working at the facility. CNA D will be given an individualized in-service by the DON on the appropriate donning and doffing of PPEs. Residents #3/# 53 have fully recovered from the Covid infection without complications and the facility is no longer in an outbreak. 2. All residents are at risk. 3. The DON/Appropriate designee will in-service the facility staff on the following: a) Proper donning and doffing of PPEs b) Handwashing standard of practice 4. The DON/appropriate designee will complete a weekly audit of one Unit per week to ascertain that they are adhering to the appropriate use of PPEs and proper handwashing consistently. Any noted deficient practice will be corrected immediately as appropriate. The weekly audit findings of the DON/designee will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of compliance: 9/12/2022	9/12/22

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F 880	Continued From page 45 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and facility documentation review, the facility staff failed to adhere to The Centers for Disease Control and Prevention (CDC) guidance for the proper wearing/removing personal protective equipment (PPE) for 2 Residents (Resident #3, Resident #53) in a sample size of 16 Residents. 1. For Resident #3, a known COVID-19 positive Resident on isolation precautions, the facility staff failed to do the following: a) doff (remove) their	F 880		

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F 880	Continued From page 46 PPE before exiting the room on 08/03/2022 and b) properly wear their PPE while giving care on 08/04/2022. 2. For Resident #53, a known COVID Positive Resident who is on isolation precautions, the facility staff failed to properly wear PPE in the Residents room and failed to perform proper hand washing prior to exiting the room. The findings included: 1. For Resident #3, a known COVID-19 positive Resident on isolation precautions, the facility staff failed to do the following: a) doff (remove) their PPE before exiting the room on 08/03/2022 and b) properly wear their PPE while giving care on 08/04/2022. On 08/03/2022 at approximately 12:50 P.M., this surveyor observed the signage on Resident #3's room door which included but were not limited to the following signs: a) The CDC guidance on how to safely remove PPE. An excerpt of the sign documented, "Remove all PPE before exiting the patient room ..." b) CDC sign for Contact Precautions. An excerpt of the sign document, "Everyone must ...Put on gown before room entry. Discard gown before room exit." On 08/03/2022 at 12:55 P.M., this surveyor, Surveyor E, and the Director of Nursing (DON) observed Certified Nursing Assistant B (CNA B) exit Resident #3's room with an isolation gown on (not tied in the back), no gloves, and carrying a	F 880		

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F 880	Continued From page 47 disposable food tray toward the tray cart down the hall. The DON told CNA B to return to the room to remove the isolation gown and dispose of the lunch tray in the room. At approximately 1:00 P.M., CNA B exited the room. When asked why they left the room with the isolation gown on and the disposable tray, CNA B stated, "I forgot I was supposed to leave it in the room." On 08/04/2022 at 9:15 A.M., this surveyor observed CNA D giving care to Resident #3. CNA D's gown was untied, off the shoulders and hanging down around the wrists. CNA D then looked up and saw this surveyor making the observation from the hall. CNA D then reached for the gown and pulled it up over their shoulders and tied the top and bottom ties in the back of the gown. CNA D then approached the trash can in the room, removed the PPE, washed their hands, and exited the room. When asked what happened with the gown, CNA D stated that the ties were loose and when they bent over the bed to straighten the sheets for Resident #16, the gown fell off. On 08/03/2022, the facility staff provided a copy of their policy entitled, "Novel Corona Virus Prevention and Response." In Section 5(f)(g)(i)entitled, "Interventions to prevent the spread of respiratory germs within the facility:" it was documented, "Educate staff on proper use of personal protective equipment and application of standard, contact, droplet, and airborne precautions, including eye protection. Promote easy and correct use of personal protective equipment (PPE) by: posting signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE."	F 880		

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F 880	Continued From page 48	F 880		

2. For Resident #53, a known COVID Positive Resident who is on isolation precautions, the facility staff failed to properly wear PPE in the Residents room and failed to perform proper hand washing prior to exiting the room.

On 8/3/22 at 12:10 PM, CNA B was observed coming out of Resident # 53's room with N-95 mask below his nose. Resident #53 is known to be COVID positive. This surveyor, and LPN B were preparing to enter the room of Resident #53. This surveyor asked LPN B (charge nurse) if she saw any problems with the way CNA B was wearing his mask. LPN B stated he needs to cover his nose. CNA B adjusted his mask. LPN B asked him to assist her in the room with Resident #53. The Surveyor, LPN B and CNA B all donned PPE and entered the Resident's room.

LPN B gave Resident #53 his medication in ice cream, and some spilled down his chin. LPN B asked CNA B to get her a napkin or paper towel. CNA B doffed his PPE by reaching behind him to unfasten the gown at the top and bottom removing the gown then the gloves. He kept his and face shield on and started to leave the room. LPN B told him not to leave the room but to get the paper towel from the bathroom. CNA B, who is only wearing a mask and face shield, got the paper towel, dampened it, gave it to LPN B and then leaned on the top rails of Resident #53's bed. He stood there a few more minutes to see if the nurse would need him and then left the room without washing his hands.
Note: CDC Signs for proper donning and doffing

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F 880	Continued From page 49 PPE were posted on the Resident's door. The Surveyor and LPN B doffed PPE in the correct order and washed hands prior to leaving the room. On 8/3/22 at approximately 12:25 PM an interview was conducted with CNA B, who when asked about hand washing prior to leaving the Resident's room, stated that he forgot. Per the CDC Guidance found online at: https://www.cdc.gov/handhygiene/providers/guideline.html "Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:" "Immediately before touching a patient Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices Before moving from work on a soiled body site to a clean body site on the same patient After touching a patient or the patient ' s immediate environment After contact with blood, body fluids, or contaminated surfaces Immediately after glove removal" "Healthcare facilities should:" "Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations" On 8/4/22 during the end of day meeting the Administrator was made aware of the concerns	F 880		

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F 880	Continued From page 50 and no further information was provided	F 880		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. §483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents: (i) Facility employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement. §483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and (ii) Staff who provide support services for the facility that are performed exclusively outside of	F 888		9/12/22

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F 888	Continued From page 51 the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section. §483.80(i)(3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility	F 888	1. Facility staff #8 has consistently maintained the use of N95 when in the facility since 8/4/2022. Staff #8 will receive an individualized in-service from the DON on CMS/CDC guidelines for unvaccinated health care workers 2. All residents and facility staff are at risk. 3. The DON/Appropriate designee will in-service the facility staff on CMS/CDC requirement for unvaccinated health care workers 4. The DON/appropriate designee will complete a weekly audit of all newly hired staff personnel files to ascertain that none of them are unvaccinated. The DON/appropriate designee will also complete a weekly observational round on the Units to ensure that mask wearing standard are maintained. Any noted deficient practice will be corrected immediately as appropriate. The weekly audit findings of the DON/designee will be forwarded to the QAPI committee for further review and guidance until it is determined by the committee that the problem no longer exists. 5. Date of compliance: 9/12/2022	

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F 888	Continued From page 52	F 888		

has granted, an exemption from the staff COVID-19 vaccination requirements;
(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;
(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and
(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Effective 60 Days After Publication:
§483.80(i)(3)(ii) A process for ensuring that all

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F 888	Continued From page 53 staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility documentation review, one facility unvaccinated staff member (staff 8), in a sample of 8 staff failed to wear a source control N-95 or higher respirator during the course of an active COVID-91 facility outbreak. The findings included; Staff #8 failed to comply with CDC (Centers for Disease Control) and CMS (Centers for Medicare/Medicaid Services) guidelines for the prevention of COVID-19 infections. On 8-2-22 upon initial entrance the survey team was greeted by the Staff #8. Staff #8 was wearing a paper procedure mask. The survey team was told that the building was experiencing an active outbreak of COVID-19, and all other staff were wearing source control N-95 respirators. During the course of the survey it was determined that Staff #8 was not vaccinated against COVID-19, however, was being tested twice weekly. Staff #8 was seen in close contact with the Social Worker, Director of Nursing, Regional Corporate Registered Nurse, Maintenance Director, Surveyors, and other staff who work	F 888		

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 _____	08/04/2022

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) COMPLETION DATE
F 888	Continued From page 54 with, and were in close proximity to, the resident population and other staff members who provide direct care. At no time was an N-95 respirator worn by Staff #8. On 8-4-22 at the exit conference Staff #8 had donned an N-95 respirator after being told by surveyors that this was a concern. No further information was presented by facility staff.	F 888		