STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495432	A. BUILDING _____ B. WING _____	C 09/07/2023

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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 09/06/23 through 09/08/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey (VA00058553 substantiated with deficiency and VA00000059612 substantiated with deficiency). The census in this 160 certified bed facility was 79 at the time of the survey. The survey sample consisted of 8 resident reviews and 6 employee reviews.	F 000	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 set 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 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies,	F 573	1. Resident #3 expired on 3/25/2023. The last medical record request on 9/7/2023 from Resident #3's family was fulfilled on 09/12/2023. Medical Records policy will be revised to reflect the timeframe in which record requests are to be processed (within 2-5 business days). 2. All residents are at risk. 3. The Administrator/appropriate designee will in-service the Heads of Departments for the Medical Records, Social Services, and Nursing Departments on the facility's revised policies and procedures on medical records requests. 4. The Medical Records Department or appropriate designee will audit weekly x3 weeks and then monthly x3 months to ascertain that all medical records requests have been fulfilled in accordance with facility's medical records requests policy and procedures. Any noted inadequacy will be rectified immediately as appropriate. The result of the audits will also be forwarded to the QAPI committee for review and recommendation until it is determined by the committee that the problem no longer exists.	10/13/2023

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

Colin Gammon | Administrator | 11/27/2023

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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provided that the fee includes only the cost of:
(A) Labor for copying the records requested by the individual, whether in paper or electronic form;
(B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and
(C)Postage, when the individual has requested the copy be mailed.

§483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law.
This REQUIREMENT is not met as evidenced by:
Based on clinical record and facility documentation reviews, the facility staff failed to provide copies of the clinical record as per written request for one resident (Resident #3) in a survey sample of eight (8) residents.

The findings included:

For Resident #3, the facility staff failed to complete a request for medical records timely and failed to provide all the requested records.

On 09/06/2023 and 09/07/2023, a closed clinical record review of Resident #3's chart was conducted. This review revealed no documentation regarding a request from the

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family of Resident #3 for copies of the clinical record.

On 9/6/23 at 11:21 a.m., an interview was conducted with the Medical Records Employee. The medical records employee provided Surveyor C with a paper chart of Resident #3's documents. There was a second folder of documents that read, "[facility name redacted] Copies of requested med rec by family 3/27/23 not completed as of yet" and had Resident #3's name. Enclosed in this folder was a form entitled, "Consent to Release Medical Information," which had been completed by Resident #3's family member on 03/27/2023 requesting, "...from 3/5/23 through 3/25/23. The specific information requested shall include the following items: MAR-specific clinical details related to every medication administered (exact day and time), all charting, progress notes, etc..."

In the aforementioned folder with records, the family requested it contained the following items, a face sheet [demographic page], labs done 3/16/23, diagnosis list, physician orders but the way they were printed appeared to be a screen shot and you couldn't read the order details, an order recap report, progress notes, a care plan which was 17 pages, vital signs, a screen shot of the immunization tab, and a screen shot of the allergy tab of the clinical record. There was also a document titled, "Documentation Survey Report," that had activities of daily living but there was a handwritten note on the top of these pages that read, "not sent per clinical department head."

The medical records employee stated, "They [referring to Resident #3's family] weren't happy because they had to go to an attorney to get

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executor done." Surveyor asked about the family's request for the medication administration record (MAR) and explained that the folder contained no copy of the MAR in the documents provided to the family. The medical records employee said when she went to pull the MAR, she did not have access, so she went to Employee C, the regional director of clinical services.

On 09/07/2023 at 11:48 a.m., an interview was conducted with Employee C, the Regional Director of Clinical Services. Employee C was asked about the request from the family of Resident #3 for records. Employee C said the Administrator and social services were working on this request. When asked about the MAR, that medical records had said she did not have access, he said he printed that document but gave it to the Administrator.

On 09/07/2023 at 1:33 p.m., a telephone interview was conducted with the family member of Resident #3. During this interview, the family member stated they still had not received the requested information for the details of medications administered to Resident #3 from 03/05/2023-03/15/2023.

On 09/07/2023 at approximately 5:00 p.m., an end of day meeting was held with the facility Administrator, Director of Nursing and Regional Director of Clinical Services. They were made aware the family of Resident #3 reports, despite multiple phone calls and emails, they still have not received the requested records. The facility Administrator placed a call to the family during this meeting and said he would be happy to meet with them to review what documents they have

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not received and facilitate getting them any requested records. The family agreed to reach out later to arrange a meeting.

The facility administration provided Surveyor C with a "Medical Records Receipt Form" indicating that Resident #3's family was given records on 05/15/2023. It listed 13 items that were provided, which listed "... 3. Medical Administration Record (MAR)..." However, there was no indication the family received the details of the medication dates and times administered as requested, as the MAR doesn't have that information. Employee C then showed Surveyor C on his computer where he ran those reports and saved them on 05/17/2023.

During the above interview with Employee C and when questioned that the documents requested were generated 2 days after the family picked up the records, Employee C said after they received the records and reviewed them, they requested the details of the date and time medications were administered and this report was generated and provided then. However, they had no documentation that the family had been given those copies. Employee C reported the family tore up the "Medical Records Receipt Form." When asked if they would normally make a note regarding this information, Employee C said he would normally make a note or email but in this case he had not.

Review of the facility policy titled, "Medical Records Request" was conducted. This policy did not address the time frame in which record requests are to be processed.

No further information was provided.

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580	1. Resident #3 expired on 3/25/2023. Unit Manager will identify the nurse that failed to notify Resident #3's family of his change of condition on 3/25/2023 and provide individualized in-service to the identified staff on family notification requirements. 2. All residents are at risk. 3. The DON/UMs/Appropriate Designee will re-educate the nurses on family notification with every residents' change of condition, including when they expired. 4. The DON/UMs/appropriate designee will perform a 10% audit weekly x1 month and then monthly x3 months of all patients who have experienced any change of condition to ensure that their families were notified timely. Any noted deficient practice will be corrected immediately as deemed appropriate. The findings of the audit will also be forwarded to the QAPI committee for review and recommendation.	10/13/2023

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§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on interview, clinical record review, and facility documentation review, the facility staff failed to notify the family of a resident's change in condition in a timely manner for one resident (Resident #3) in a survey sample of eight (8) residents.

The findings included:

For Resident #3, the facility staff failed to notify the family of the resident's expiration, the family came in to visit and found that the resident was deceased.

On 09/06/2023 and 09/07/2023, a closed clinical record review of Resident #3's chart was conducted. This review revealed the following:

A progress note dated 03/25/2023 at 7:25 a.m. read, "Around 07:15 am, Patient was found unresponsive to all stimuli, pupils fixed and dilated, no BP, Pulse, Respirations, Patient was pronounced dead at 07:20 am by Supervisor on duty. And family and Hospice will be contacted soon to notified them about patient passing [sic]."
There was no indication that a call was made to the family until a note at 11:59 a.m. that read,

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"Mortician picked up the body at 11:30 am. [funeral home name redacted] is the funeral home. Family (daughter and son) was at bed side and took his personal belongings."

There was a progress note from hospice scanned into the clinical record that read, "3/25/23 HRN [hospice registered nurse] visit to pronounce death. TOD [time of death] 7:20 AM per facility. Family present at bedside and distraught that they found pt in bed this morning and passed away. Family called hospice to report death. HRN called FH [funeral home] and offered condolences."

On 09/07/2023 during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings. When asked what the expectation is on family notification when a resident expires, the Director of Nursing said, "Immediately."

Employee C, the Regional Director of Clinical Services (RDCS) stated they had implemented a 5-point plan in response to this. They were asked to provide any evidence to the survey team. The RDCS returned to the conference room and presented Surveyor C with a 3-page document titled, "Hospice Management Framework." When asked to describe what this was, the RDCS said it was a protocol for hospice that they implemented following the incident with Resident #3. There was also an in-service sign-in sheet that was dated 04/07/2023 that indicated, "Reason for in-service/education: Hospice procedures in house." Only 17 employees had attended the education, which included 7 licensed practical nurses (LPN), 8 certified nursing assistants (CNA), and 2 registered nurses (RN), one of

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F 580	Continued From page 8 which was the Director of Nursing. When asked about the training of other staff, since only RNs can pronounce death in Virginia, they indicated this was the staff working the day of the training and was all they had to present. No further information was provided.	F 580		
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 staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care based on standards of nursing practice for two residents (Residents #3 and #5) in a survey sample of eight (8)residents. The findings included: 1. For Resident #3, the facility staff failed to administer morphine and prednisone within accordance with physician orders. On 09/06/2023-09/07/2023, a closed clinical record review was conducted of Resident #3's clinical chart. It was noted that the resident went on hospice care on 03/16/2023. Resident #3 had several changes to his orders for morphine that increased the dosage and frequency. The medication administration records (MAR) and the "Controlled Drug Receipt/Record/Disposition Form" were reviewed regarding the morphine. It	F 658	1. Resident #3 expired on 3/25/2023 and Resident #5 expired on 9/10/2023. Unit Managers will identify and provide individualized in-service on standard for safe medication administration practices (right patient, right drug, right dose, right time, right route, and right documentation) to all nurses that worked on 3/13/2023 and 3/14/2023 (late administration of prednisone), 3/25/2023 (inadequate dose administration of morphine solution), and 9/3/2023 (inadequate dose administration of hydromorphone solution). 2. All residents are at risk. 3. The DON/UMs/appropriate designee will in-service all nurses on standard for safe medication administration practices (right patient, right drug, right dose, right time, right route, and right documentation) 4. The DON/UMs/Appropriate designee will perform a 10% audit on all current patients' MARs weekly x1 month and then monthly x3 months to ascertain that standard for safe medication practices are followed consistently. Any noted deficient practice will be corrected immediately as deemed appropriate. The findings of the audit will also be forwarded to the QAPI committee for review and recommendation.	10/13/2023

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was noted on several occasions the morphine was not given timely, in a few instances it was greater than 4 hours after the scheduled time being administered. On several occasions it was documented that the wrong dosage was administered. Specifically, on 03/25/2023, Resident #3's order for morphine was changed to "give 0.75 ml by mouth 4 times a day." On 03/25/2023, according to the controlled drug receipt/record/disposition form, both doses of morphine given were at 0.5 ml.

Review of the MARs and physician orders revealed that the prednisone was to be given at 8:00 a.m. On multiple occasions it was not administered timely. Specifically on 03/13/2023, it was administered at 10:55 a.m. On 03/14/2023 it was not administered until 10:57 a.m. There were several other instances of medications being administered significantly after the ordered/scheduled time.

On 09/07/2023 at 2:20 p.m., an interview was conducted with LPN B. When asked about the administration times of medications, LPN B stated, "we can give it an hour before and an hour after." When asked why the timing of medication administration was important, LPN B said, "for some meds you have to give in a timeframe for it to be effective."

A review of the facility's medication administration policy was conducted. Excerpts from this policy read, "... 1. Medications can generally be administered by a licensed nurse withing [sic] one hour before or after the scheduled time, unless for some medications requiring a specified administration time consistently, such as seizure medications, or the physician ordered it to be

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given at a specified timeframe/time..."

On 09/07/2023 during an end of day meeting with the facility Administrator, Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) the above concerns were shared. The DON identified that the facility nursing staff follows Lippincott standards of nursing practice. When asked about the timing of medication administration, the DON said they are to be given within the hour prior or hour following being scheduled. When asked why the RDCS said to "maintain therapeutic levels."

Review of "Lippincott Manual of Nursing Practice Eighth Edition" on page 17 read, "Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders..."

No further information was provided.

2. For Resident #5, the facility staff failed to administer the correct dose of morphine as ordered by the physician.

On 09/06/2023, Resident #5 was visited in his room. Resident #5 was not able to answer questions about the timing and administration of his medication. Resident #5 did verbalize that he was having pain.

On 09/07/2023, a clinical record review was conducted of Resident #5's chart. This review revealed the resident had orders for morphine that read, "Hydromorphone Solution 1 MG/ML,

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F 658	Continued From page 11 give 0.5 ML (0.5 MG) by mouth or sublingually every hour hours as needed for pain and shortness of breath." According to the "Controlled Drug Receipt/Record/Disposition Form" on 09/03/2023, two administrations were given at 0.25 and again on 09/06/2023, which equaled 0.25 mg. On 09/07/2023, during an end of day meeting with the facility Administrator, Director of Nursing (DON) and Regional Director of Clinical Services (RDCS) the above concerns were shared. The DON identified that the facility nursing staff follows Lippincott standards of nursing practice. The DON stated that such errors should have been avoided by using the 5 rights of medication administration. Review of "Lippincott Manual of Nursing Practice Eighth Edition" on page 17 read, "Common Departures from the Standards of Nursing Care. Claims most frequently made against professional nurses include failure to make appropriate assessments, follow physician orders..." No further information was provided.	F 658		
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 except to the extent the facility itself is permitted	F 842	1. Resident #3 expired on 3/25/2023 and Resident #4 discharged on 8/23/2023. Unit Managers will identify and provide individualized in-service on standard for safe medication administration practices (right patient, right drug, right dose, right time, right route, and right documentation) to all nurses that worked on 3/23/2023 (incomplete documentation of morphine solution administered).	10/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495432	A. BUILDING _____ B. WING _____	C 09/07/2023

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 842	Continued From page 12 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- (i) The period of time required by State law; or	F 842	2. All current residents on insulin with sliding scale order are at risk. All current insulin sliding scale orders will be reviewed and updated with supplemental provision to document unit dose of insulin administered by nurses. Also, all current Morphine orders will be reviewed for appropriate documentation on both the controlled count Form and the eMAR. Any noted inadequate documentation will be rectified as applicable and appropriate. 3. The DON/UMs/appropriate designee will in-service all nurses on standard for safe medication administration practices (right patient, right drug, right dose, right time, right route, and right documentation), standard administration documentation of Morphine orders (controlled drug), and administration documentation requirement for insulin orders with sliding scale. 4. The DON/UMs/Appropriate designee will perform a 10% audit on all current patients' MARs weekly x1 month and then monthly x3 months to ascertain that standard for safe medication practices and required documentation on insulin orders with sliding scale are followed consistently. Any noted deficient practice will be corrected immediately as deemed appropriate. The findings of the audit will also be forwarded to the QAPI committee for review and recommendation.	

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F 842	Continued From page 13	F 842		

(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 interviews, clinical record review, and facility documentation review, the facility staff failed to ensure a complete clinical record was maintained for two residents (Residents #3 and #5) in a survey sample of eight (8) residents.

The findings included:

1. For Resident #3, the facility staff failed to ensure the clinical record was complete and accurate regarding the times and quantity of morphine administered.

On 08/06/2023 and 08/07/2023, a closed clinical record review of Resident #3's chart was conducted. Review of the medication administration record (MAR), medication audit report and controlled drug receipt/record/disposition forms were conducted. Special attention was paid to the administration of

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F 842	Continued From page 14	F 842		

morphine. There were three instances on 03/23/2023, that morphine was signed out on the controlled drug receipt/record/disposition form and not documented on the MAR as having been administered.

A review was conducted of the facility's Medication Administration policy. This policy read, "... 15. Administer medication as ordered in accordance with manufacturer specifications. 16. Observe resident consumption of medication... 18. Sign MAR after administered. 19. If medication is a controlled substance, sign narcotic book...".

On 08/07/2023 during an end of day meeting, the above findings were reviewed with the facility Administrator, Director of Nursing and Regional Director of Clinical Services.

No further information was provided.

2. For Resident #4, the facility staff failed to maintain a complete clinical record to include the amount of insulin administered.

On 08/07/2023, a clinical record review was conducted of Resident #4's chart. This included the medication administration record (MAR) and physician orders. Special attention to the administration of insulin was given. There were orders on 08/21/2023, for Humalog insulin to be administered as per a sliding scale before meals and at bedtime. The sliding scale orders for insulin was changed on 08/23/2023. Review of the MAR revealed no record of the amount/number of units administered to Resident #4.

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F 842	Continued From page 15 On 08/07/2023 during an end of day meeting, the Regional Director of Clinical Services (RDCS) and Director of Nursing (DON) were asked about this. The RDCS stated the order did not have the option for nursing staff to record the number of units administered. When asked if he would consider this a complete clinical record without this information, he said, "Ideally they should be documenting that." No further information was provided.	F 842		