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	495432	A. BUILDING _____ B. WING _____	C 11/29/2023

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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 11/28/23 through 11/29/23. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey (VA00059997-substantiated with deficiency). The census in this 160 certified bed facility was 88 at the time of the survey. The survey sample consisted of 3 current resident reviews and 1 closed record review.	F 000		
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, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of four residents in the survey sample; Resident #1. The facility provided an acceptable plan of correction, having already identified the concern on 10/27/23. This is cited at past non-compliance. The findings include: The facility staff failed to implement the physician's order to provide orthopedic follow up aftercare for staple removal for Resident #1.	F 658	Past noncompliance: no plan of correction required.	

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

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Resident #1 was admitted to the facility on 10/2/23 and discharged on 10/20/23 and had the diagnosis of but not limited to osteoporosis with current pathological fracture status post surgery with staples to the right hip.

A review of the clinical record revealed the hospital discharge instructions dated 10/2/23 (from the hospital to the facility). These instructions included, "Date of most recent surgery 9/21/23...ORIF (Open reduction internal fixation)....Please contact the office as soon as possible to schedule a follow-up appointment with (name of orthopedic surgeon). You will need to be seen approximately 2 weeks after your discharge from the hospital..."

A review of the physician's orders revealed one dated 10/3/23 for "COMMUNICATION ORDER: ORTHOPEDIC FOLLOW-UP needs to be scheduled for patient postop surgical visit and staple removal."

A nurse's note dated 10/3/23 documented, " Observed on admission 4 surgical sites to right hip area with 24 staples all together....NP (Nurse Practitioner) notified orders received."

A wound care nurse practitioner note dated 10/5/23 documented, " The patient has a surgical wound....Needs surgical follow up ASAP (as soon as possible), due today (2 weeks post op). Notified facility via post rounds report."

A medical nurse practitioner note dated 10/5/23 documented, "right hip fracture s/p (status post) ORIF/ortho after care....f/u (follow up) ortho."

A wound care nurse practitioner note dated

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F 658	Continued From page 2	F 658		

10/10/23 documented, "The patient has a surgical wound. Recommend f/u with surgeon asap....Notified facility via post rounds report."

A nurse's note dated 10/13/23 documented, "Called her geriatric case worker/(name) for (Resident #1) to find out when is (Resident #1's) surgeon f/u appointment but no answer (according to unit manager, POA (Power of Attorney) will make appointment- called her son/ (name) But he said (name of geriatric case worker) will take care of this matter). Left message on (phone number)/(geriatric case worker) to call use back regarding surgeon f/u appointment- made unit manager aware of this matter & (and) e-mailed to (agency) case manager too."

A medical nurse practitioner note dated 10/16/23 documented, "...right hip fracture s/p ORIF/ortho after care....f/u ortho..."

A wound care nurse practitioner note dated 10/17/23 documented, "The patient has a surgical wound. Recommend f/u with surgeon asap....Notified facility via post rounds report."

The resident was discharged on 10/20/23 to home with 24 staples still intact. No further documentation was noted regarding the status of any follow up with orthopedic surgeon and staple removal.

On 11/28/23 at 2:07 PM an interview was conducted with RN #1 (Registered Nurse) the unit manager. She stated that the care manager from the community came to the facility and was told that the resident needed to see the orthopedic doctor. She stated that the care manager said

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she would schedule the appointment. She stated that the care manager never got back with the facility on when the appointment would be. She stated that the care manager spoke to the nurse practitioner regarding the staples. She stated that the facility called the care manager and left a message to return call regarding the orthopedic appointment. She stated that she was not aware of her ever returning the call. She stated that this was right after the resident was admitted. When asked if she followed up any further regarding the appointment, she stated that she "did not follow up a second time which I should have done."

On 11/28/23 at 2:24 PM an interview was conducted with LPN #2 (Licensed Practical Nurse) the wound care nurse. She stated that the care manager in the community asked if the facility could remove the staples. She stated that she said yes but the surgeon needed to send an order to do so, because sometimes they want to do an x-ray first. She stated that the care manager said "ok I am gonna make an appointment" and left. She stated that she was not aware if anyone followed up. She stated that she did not recall if she followed up with anyone about the staples because they only see residents for wound care once a week. She stated that the facility had not received anything from the surgeon about removing them. She stated that she saw the care manager twice and both times she said she was making the appointment. She stated that she told the care manager both times the facility needed the order. She stated "We never received the order."

On 11/29/23 at 9:00 AM an interview was conducted with ASM #4 (Administrative Staff Member) the Nurse Practitioner. She stated that

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typically sutures and staples are removed after 14 days post surgery. She stated that it was a bit excessive that the resident had staples for approximately one month, given that surgery was on 9/21/23 and was discharged to home on 10/20/23. She stated that the need for orthopedic follow up and staple removal was relayed to the facility staff multiple times and that she did not know why it was not done. She stated that if an outside individual (family member, case manager, etc.) had stated they were going to make the follow up appointment and then did not follow through, she would expect the facility to follow through with ensuring the appointment was made and the resident was seen.

The facility policy, "Verbal Orders" documented, "6. Follow through with orders by making appropriate contact or notification (e.g.., "lab" or "pharmacy")."

On 11/29/23 at 3:30 PM, ASM #1 the Administrator, was made aware of the findings.

A plan of correction was provided and documented as follows:
Initiated on 10/27/23.
5-Steps Action Plan
Surgical Wound/Voiding Trial/Pressure Injuries Management

The Situation:
On 10/27/23, the Administrator received an allegation of neglect call from the Care Manager of (Resident #1), a post-surgical skilled patient that was at the facility from 10/2/23 -10/20/23. The complaint entails three allegations; viz: failure of the facility to remove or facilitate removal of patient's surgical staples, failure to

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discontinue the patient's foley catheter for voiding trial, and failure to notify the family of the presence of wounds on the patient.

The quality assurance questions, therefore, explored by the facility included the following: What may have led to the possible alleged inadequacies in the management of the above-stated patient's surgical staples, voiding trial, and notification of the family about the patient's pressure injuries? What framework does the facility have in place to holistically manage surgical wounds, voiding trial, and family notification of patients' pressure injuries at the facility? What additional resources could have been put in place to mitigate the incidence of the alleged inadequacies in care provision at the facility?

It is against the above quality assurance questions that the facility will implement the following action plan below:
The 5-Steps Action Plan:
1. (Resident #1) was discharged from the facility on 10/20/23. Facility attempted to coordinate an appointment with the surgeon on 10/13/23 but was unsuccessful - no order received to discontinue (Resident #1's) staples up to the date of her discharge on 10/20/23. Facility received an order for a voiding trial on 10/19/23 from her urologist and discontinued the foley catheter on 10/20/23 for a trial - patient voided before discharge. (Resident #1) was admitted with SDTI (suspected deep tissue injury) to bilateral heels from the hospital - her comprehensive care plan that included all active wounds and foley catheter were discussed with the family and resident during her CP (care plan) conference. (Resident #1) son was also notified about the admitted-with

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bilateral pressure injuries to her heels on 10/5/23 and again on 10/12/23.

2. All residents are at risk. DON/UMs (Director of Nursing/Unit Managers) will review all current surgical/pressure injury wounds and foley catheter to ensure that those requiring follow-up with the surgeon has been completed, staples removed as ordered, family notifications for pressure injuries completed, and foley catheter with potential for voiding trial undertaken accordingly. Any inadequacies/deficient practices noted will be corrected accordingly and as appropriate. Facility will also develop a post-surgical wound protocol to guide the nurses in the management of all surgical wounds.

3. The DON/Unit Mangers/Appropriate Designee will complete the following education with the nurses:
i. Post-surgical wound management protocol and wound policies/procedures.
ii. Management of admitted with and inhouse acquired pressure injuries.
iii. Foley catheter and voiding trial management.
iv. Completing documented family notification.

4. The DON/Ums/appropriate designee will audit 10% of all current patients with surgical wounds, pressure ulcers, and foley catheters weekly x4 weeks and then monthly to ascertain that the post-surgical protocol is being followed by the nurses, foley catheter with voiding trial request/order completed timely, and the notification of family about active pressure ulcers. Any noted deficient practice will be corrected immediately as appropriate. Result of the audit outcome will also be forwarded to the Weekly Risk Meeting and/or the QAPI Committee for

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further review/guidance until the meeting determines that it is no longer needed.
5. Date of Compliance: 11/27/23.
(End of POC)

The POC documented that a policy was developed for Post-Surgical Wound Management Protocol. This policy documented, in full:

The admission and management of post-surgical patients is an integral part of the skilled services provided by all (facility company name). To help the facility to adequately manage all post-surgical patients, particularly their surgical wounds, the below protocol in addition to the policies and procedures of the company related to the subject matter will be followed by the staff accordingly:

1. All post-surgical patients admitted at the facility will immediately have a follow-up appointment scheduled with their surgeon within 24-72 hours of their admission.
2. All post-surgical patients' incision sites will be assessed on admission for staples and/or sutures to determine their discontinuation pathway in consultation with the facility attending physician/practitioner and the residents' surgeons.
3. All surgical wounds must be evaluated daily even when no treatment was ordered by the surgeon at the time of discharge from the hospital or post admission follow-up with the surgeon.
4. Where directed by the attending facility physician/practitioner for an order from the patient surgeon to remove staple/suture, the nurse should ensure to have such an order from the surgeon within 24 hours of receiving such an instruction from the attending physician/practitioner.

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F 658	Continued From page 8 5. Definitive determination to remove surgical staples/sutures from a post-surgical patient's incision site must be made within 24-72 hours of the patient admission to the facility. 6. Responsible party (RP), where applicable, will be updated on the progress of healing of the patient's post-surgical incision sites. 7. All surgical sites must be evaluated by the discharging nurse to determine their status at time of discharge and document the evaluation outcome in the patient's clinical record accordingly. 8. Collaborate closely with the wound specialist in coordinating post-surgical patients' incision site management. (End of policy) This policy was signed by the Director of Nursing on 11/15/23. The facility's plan of correction and credible evidence was reviewed, including identification of the issue, audits of all other residents, education of staff, policy development, and ongoing audits of the implemented plan of correction, on 11/29/23. There were no identified concerns with current residents reviewed. This deficiency is cited at past non-compliance.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	F 684		

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F 684	Continued From page 9	F 684	Past noncompliance: no plan of correction required.	

practice, the comprehensive person-centered care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to arrange for the provision of follow up care for one of four residents in the survey sample; Resident #1. The facility provided an acceptable plan of correction, having already identified the concern on 10/27/23, therefore, this is cited at past non-compliance.

The findings include:

The facility staff failed to arrange follow up aftercare with the orthopedic surgeon per the physician's order. The resident was admitted on 10/2/23 with 24 staples in a right hip surgical incision. Multiple orders and notes documented the need to follow up with the orthopedic surgeon. The follow up was never obtained and the resident was discharged to home on 10/20/23 with 24 staples still intact. This was approximately one month after the surgery, which was 9/21/23.

The facility policy, "Special Needs" documented, "3. If necessary, the facility will assist residents in making appropriate appointments with a qualified person or facility and arranging for transportation to and from such appointments."

The facility policy, "Provision of Physician Ordered Services" documented, "2. Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to the appropriate entity....5. In instances where diagnostic testing or

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F 684	Continued From page 10	F 684		

consultations are not available to be performed on-site OR the Physician has requested that services be performed at an off-site facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments."

Resident #1 was admitted to the facility on 10/2/23 and discharged on 10/20/23 and had the diagnosis of but not limited to osteoporosis with current pathological fracture status post surgery with staples to the right hip.

A review of the clinical record revealed the hospital discharge instructions dated 10/2/23 (from the hospital to the facility). These instructions included, "Date of most recent surgery 9/21/23...ORIF (Open reduction internal fixation)....Please contact the office as soon as possible to schedule a follow-up appointment with (name of orthopedic surgeon). You will need to be seen approximately 2 weeks after your discharge from the hospital..."

A review of the physician's orders revealed one dated 10/3/23 for "COMMUNICATION ORDER: ORTHOPEDIC FOLLOW-UP needs to be scheduled for patient postop surgical visit and staple removal."

A nurse's note dated 10/3/23 documented, " Observed on admission 4 surgical sites to right hip area with 24 staples all together....NP (Nurse Practitioner) notified orders received."

A wound care nurse practitioner note dated 10/5/23 documented, " The patient has a surgical wound....Needs surgical follow up ASAP (as soon as possible), due today (2 weeks post op).

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F 684	Continued From page 11	F 684		

Notified facility via post rounds report."

A medical nurse practitioner note dated 10/5/23 documented, "right hip fracture s/p (status post) ORIF/ortho after care....f/u (follow up) ortho."

A wound care nurse practitioner note dated 10/10/23 documented, "The patient has a surgical wound. Recommend f/u with surgeon asap....Notified facility via post rounds report."

A nurse's note dated 10/13/23 documented, "Called her geriatric case worker/(name) for (Resident #1) to find out when is (Resident #1's) surgeon f/u appointment but no answer (according to unit manager, POA (Power of Attorney) will make appointment- called her son/ (name) But he said (name of geriatric case worker) will take care of this matter). Left message on (phone number)/(geriatric case worker) to call use back regarding surgeon f/u appointment- made unit manager aware of this matter & (and) e-mailed to (agency) case manager too."

A medical nurse practitioner note dated 10/16/23 documented, "...right hip fracture s/p ORIF/ortho after care....f/u ortho..."

A wound care nurse practitioner note dated 10/17/23 documented, "The patient has a surgical wound. Recommend f/u with surgeon asap....Notified facility via post rounds report."

The resident was discharged on 10/20/23 to home with 24 staples still intact. No further documentation was noted regarding the status of any follow up with orthopedic surgeon and staple removal prior to discharge.

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On 11/28/23 at 2:07 PM an interview was conducted with RN #1 (Registered Nurse) the unit manager. She stated that the care manager from the community came to the facility and was told that the resident needed to see the orthopedic doctor. She stated that the care manager said she would schedule the appointment. She stated that the care manager never got back with the facility on when the appointment would be. She stated that the care manager spoke to the nurse practitioner regarding the staples. She stated that the facility called the care manager and left a message to return call regarding the orthopedic appointment. She stated that she was not aware of her ever returning the call. She stated that this was right after the resident was admitted. When asked if she followed up any further regarding the appointment, she stated that she "did not follow up a second time which I should have done."

On 11/28/23 at 2:24 PM an interview was conducted with LPN #2 (Licensed Practical Nurse) the wound care nurse. She stated that the care manager in the community asked if the facility could remove the staples. She stated that she said yes but the surgeon needed to send an order to do so, because sometimes they want to do an x-ray first. She stated that the care manager said "ok I am gonna make an appointment" and left. She stated that she was not aware if anyone followed up. She stated that she did not recall if she followed up with anyone about the staples because they only see residents for wound care once a week. She stated that the facility had not received anything from the surgeon about removing them. She stated that she saw the care manager twice and both times she said she was making the

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(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
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appointment. She stated that she told the care manager both times the facility needed the order. She stated "We never received the order."

On 11/29/23 at 9:00 AM an interview was conducted with ASM #4 (Administrative Staff Member) the Nurse Practitioner. She stated that typically sutures and staples are removed after 14 days post surgery. She stated that it was a bit excessive that the resident had staples for approximately one month, given that surgery was on 9/21/23 and was discharged to home on 10/20/23. She stated that the need for orthopedic follow up and staple removal was relayed to the facility staff multiple times and that she did not know why it was not done. She stated that if an outside individual (family member, case manager, etc.) had stated they were going to make the follow up appointment and then did not follow through, she would expect the facility to follow through with ensuring the appointment was made and the resident was seen.

On 11/29/23 at 3:30 PM, ASM #1 the Administrator, was made aware of the findings.

A plan of correction was provided and documented as follows:
Initiated on 10/27/23.
5-Steps Action Plan
Surgical Wound/Voiding Trial/Pressure Injuries Management

The Situation:
On 10/27/23, the Administrator received an allegation of neglect call from the Care Manager of (Resident #1), a post-surgical skilled patient that was at the facility from 10/2/23 -10/20/23. The complaint entails three allegations; viz:

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	495432	A. BUILDING _____ B. WING _____	C 11/29/2023

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failure of the facility to remove or facilitate removal of patient's surgical staples, failure to discontinue the patient's foley catheter for voiding trial, and failure to notify the family of the presence of wounds on the patient.

The quality assurance questions, therefore, explored by the facility included the following: What may have led to the possible alleged inadequacies in the management of the above-stated patient's surgical staples, voiding trial, and notification of the family about the patient's pressure injuries? What framework does the facility have in place to holistically manage surgical wounds, voiding trial, and family notification of patients' pressure injuries at the facility? What additional resources could have been put in place to mitigate the incidence of the alleged inadequacies in care provision at the facility?

It is against the above quality assurance questions that the facility will implement the following action plan below:
The 5-Steps Action Plan:
1. (Resident #1) was discharged from the facility on 10/20/23. Facility attempted to coordinate an appointment with the surgeon on 10/13/23 but was unsuccessful - no order received to discontinue (Resident #1's) staples up to the date of her discharge on 10/20/23. Facility received an order for a voiding trial on 10/19/23 from her urologist and discontinued the foley catheter on 10/20/23 for a trial - patient voided before discharge. (Resident #1) was admitted with SDTI (suspected deep tissue injury) to bilateral heels from the hospital - her comprehensive care plan that included all active wounds and foley catheter were discussed with the family and resident

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during her CP (care plan) conference. (Resident #1) son was also notified about the admitted-with bilateral pressure injuries to her heels on 10/5/23 and again on 10/12/23.

2. All residents are at risk. DON/UMs (Director of Nursing/Unit Managers) will review all current surgical/pressure injury wounds and foley catheter to ensure that those requiring follow-up with the surgeon has been completed, staples removed as ordered, family notifications for pressure injuries completed, and foley catheter with potential for voiding trial undertaken accordingly. Any inadequacies/deficient practices noted will be corrected accordingly and as appropriate. Facility will also develop a post-surgical wound protocol to guide the nurses in the management of all surgical wounds.

3. The DON/Unit Mangers/Appropriate Designee will complete the following education with the nurses:
i. Post-surgical wound management protocol and wound policies/procedures.
ii. Management of admitted with and inhouse acquired pressure injuries.
iii. Foley catheter and voiding trial management.
iv. Completing documented family notification.

4. The DON/Ums/appropriate designee will audit 10% of all current patients with surgical wounds, pressure ulcers, and foley catheters weekly x4 weeks and then monthly to ascertain that the post-surgical protocol is being followed by the nurses, foley catheter with voiding trial request/order completed timely, and the notification of family about active pressure ulcers. Any noted deficient practice will be corrected immediately as appropriate. Result of the audit

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outcome will also be forwarded to the Weekly Risk Meeting and/or the QAPI Committee for further review/guidance until the meeting determines that it is no longer needed.
5. Date of Compliance: 11/27/23.
(End of POC)

The POC documented that a policy was developed for Post-Surgical Wound Management Protocol. This policy documented, in full:

The admission and management of post-surgical patients is an integral part of the skilled services provided by all (facility company name). To help the facility to adequately manage all post-surgical patients, particularly their surgical wounds, the below protocol in addition to the policies and procedures of the company related to the subject matter will be followed by the staff accordingly:

1. All post-surgical patients admitted at the facility will immediately have a follow-up appointment scheduled with their surgeon within 24-72 hours of their admission.
2. All post-surgical patients' incision sites will be assessed on admission for staples and/or sutures to determine their discontinuation pathway in consultation with the facility attending physician/practitioner and the residents' surgeons.
3. All surgical wounds must be evaluated daily even when no treatment was ordered by the surgeon at the time of discharge from the hospital or post admission follow-up with the surgeon.
4. Where directed by the attending facility physician/practitioner for an order from the patient surgeon to remove staple/suture, the nurse should ensure to have such an order from the surgeon within 24 hours of receiving such an

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instruction from the attending physician/practitioner.
5. Definitive determination to remove surgical staples/sutures from a post-surgical patient's incision site must be made within 24-72 hours of the patient admission to the facility.
6. Responsible party (RP), where applicable, will be updated on the progress of healing of the patient's post-surgical incision sites.
7. All surgical sites must be evaluated by the discharging nurse to determine their status at time of discharge and document the evaluation outcome in the patient's clinical record accordingly.
8. Collaborate closely with the wound specialist in coordinating post-surgical patients' incision site management.
(End of policy)

This policy was signed by the Director of Nursing on 11/15/23.

The facility's plan of correction and credible evidence was reviewed, including identification of the issue, audits of all other residents, education of staff, policy development, and ongoing audits of the implemented plan of correction, on 11/29/23. There were no identified concerns with current residents reviewed. This deficiency is cited at past non-compliance.