

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 08/28/2024  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                 |
| F 0578<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21875</p> <p>Based on staff interview, clinical record review, and state code, the facility staff failed to document a valid do not resuscitate order form for one of twenty-three residents in the survey sample (Resident 59).</p> <p>The findings include:</p> <p>Resident #59's durable do not resuscitate order form (DDNR), a portable, state-issued form communicating the resident's DNR status when transported outside of the nursing facility, was incomplete and included no required signatures of the physician or the resident's authorized representative.</p> <p>Resident #59 (R59) was admitted to the facility with diagnoses that included diabetes, neuropathy, dysphagia, cerebral infarction with hemiparesis, dementia, psychotic disturbance, mood disturbance, anxiety, chronic kidney disease and insomnia. The minimum data set (MDS) dated [DATE] assessed R59's with moderately impaired cognitive skills.</p> <p>A nursing note dated 3/2/22 documented, Care plan meeting conducted today. Resident was present and [authorized family member] was present via phone. Reviewed code status and resident and [authorized family member] decided that resident would go from a full code to a DNR [do not resuscitate]</p> <p>R59's clinical record documented a physician's order dated 3/3/22 stating, Do Not Resuscitate.</p> <p>R59's clinical record documented a Virginia Department of Health Durable Do Not Resuscitate Order (DDNR) form that included R59's name and date of 3/2/22. The form indicated R59 was incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment and documented, .the patient has executed a written advanced directive which appoints a 'Person Authorized to Consent on the Patient's Behalf' with authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of 'Person Authorized to Consent on the Patient's Behalf is required.).</p> <p>(continued on next page)</p> |                                                                                                         |                                                 |

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.

|                                                                          |                         |                                                                         |
|--------------------------------------------------------------------------|-------------------------|-------------------------------------------------------------------------|
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER<br>REPRESENTATIVE'S SIGNATURE | TITLE                   | (X6) DATE                                                               |
| FORM CMS-2567 (02/99)<br>Previous Versions Obsolete                      | Event ID:<br><br>495221 | Facility ID:<br><br>495221<br><br>If continuation sheet<br>Page 1 of 18 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                 |
| <p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>R59's DDNR form included no signature of a physician or nurse practitioner and no signature of the person authorized to consent on the resident's behalf. In the space for patient's signature was written, verbal consent [name of authorized family member]. In the form space for signature of person authorized to consent on the patient's behalf, were signatures of two registered nurses. The form included no signature from the person authorized in the resident's advance directive to make health care decisions.</p> <p>On 1/23/24 at 1:00 p.m., the licensed practical nurse unit manager (LPN #2) caring for R59 was interviewed about the resident's resuscitation status. LPN #2 stated R59 had a DNR order. LPN #2 stated the DDNR forms were kept in a book and a copy of the DDNR form was sent with the resident if transferred to the hospital or out of the facility for medical appointments. LPN #2 reviewed R59's DDNR form in the book and stated the form did not have signatures. LPN #2 stated that verbal consent was written in the space for the patient's signature and was signed by two registered nurses who no longer worked at the facility. LPN #2 stated that she did not know why the physician/provider had not signed the form.</p> <p>On 1/23/24 at 1:11 p.m., the director of nursing (DON) was interviewed about R59's incomplete DDNR form. The DON stated R59's resuscitation status was reviewed routinely during care plan meetings. The DON stated verbal consent was provided by R59's authorized family member during a care plan meeting in March 2022. The DON stated after the form was signed by the resident or authorized representative, it was supposed to be sent to the physician/provider for signature. On 1/23/24 at 1:50 p.m., the DON stated that she did not know why the provider had not signed the DNR form. When questioned further, the DON stated she did not have a facility policy specifically about completing the DDNR form.</p> <p>On 1/23/24 at 2:25 p.m., the facility's social worker (other staff #1) was interviewed about R59's incomplete DDNR form. The social worker stated she was not working in the facility when R59's DNR order was entered or the DDNR form was completed. The social worker stated the DDNR forms were supposed to be signed by the resident's physician/provider in addition to the resident, if capable, or their authorized representative.</p> <p>The Code of Virginia 12VAC5-66-40 regarding the Durable Do Not Resuscitate Order form documents,</p> <p>The following requirement and provisions shall apply to the approved Durable DNR Order form .A Durable DNR Order Form shall contain, from a physician with whom the patient has a [NAME] fide physician/patient relationship, a do not resuscitate determination, signature and the date of issue, the signature of the patient or, if applicable, the person authorized to consent on the patient's behalf .A Durable DNR Order .shall be valid for the purposes of withholding or withdrawing cardiopulmonary resuscitation by qualified health care personnel in the event of cardiac or respiratory arrest .A patient who is traveling outside his home or between health care facilities should have an original or photocopied Durable DNR Order .accompany him (1)</p> <p>On 1/23/24 at 4:20 p.m., these findings were reviewed during a meeting with the administrator and director of nursing.</p> <p>(1) Durable Do Not Resuscitate Program. Office of Emergency Medical Services. Virginia Department of Health. 1/25/24. <a href="https://www.vdh.virginia.gov/emergency-medical-services/other-ems-programs-and-links/durable-do-not-resuscitate-program">https://www.vdh.virginia.gov/emergency-medical-services/other-ems-programs-and-links/durable-do-not-resuscitate-program</a>.</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                 |
| F 0655<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41449</p> <p>Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop and implement a baseline care plan for one Resident (Resident #234) in a survey sample of 23 Residents, which should to direct the patient centered care of the resident.</p> <p>The findings included:</p> <p>On 1/23/24, a clinical record review was conducted of Resident #234's chart. This revealed that Resident #234 was admitted to the facility on [DATE], but the baseline care plan was not developed until 1/22/24.</p> <p>On 1/23/24, the unit manager/LPN #4, was asked about the baseline care plan for Resident #234. LPN #4 provided the surveyor with a 3-ring binder that was kept at the nursing station that contained baseline care plans. Resident #234's baseline care plan was noted to be a 6-page document. Across the top, Resident #234's name, admitted , allergies, and code status were noted. All the other boxes which would direct the patient centered care were blank and incomplete.</p> <p>On 1/23/24, LPN #4 was asked when the base line care plan is developed and the purpose. LPN #4 stated that the admitting nurse is to complete the base line care plan upon the Resident's admission, and it is used to direct the staff to care for the resident until the comprehensive care plan is developed. LPN #4 reviewed the base line care plan for resident #234 and confirmed that it was blank and had not been completed.</p> <p>On the afternoon of 1/23/24, an interview was conducted with RN #3, the MDS (minimum data set/a comprehensive assessment) nurse. RN #3 stated that the nurses on the floor complete the base line care plan and it is used to guide the staff in caring for the resident until the comprehensive care plan is developed.</p> <p>On 1/23/24, during an end of day meeting, the facility Administrator and Director of Nursing (DON) were made aware of the above findings and the facility's policy was requested.</p> <p>The facility policy titled Care Plans was reviewed. The policy stated, . 17. An interim care plan [known as a baseline care plan] will be developed within 24 hours which is based on the initial assessment of each resident.</p> <p>No further information was provided.</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                 |
| F 0656<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49456</p> <p>Based on staff interview, clinical record review, and facility document review the facility failed to develop a care plan for one of 23 residents. Resident #1 (R1) had an admitting diagnosis of PTSD (Post Traumatic Stress Disorder), and a care plan was not developed.</p> <p>The Findings Include:</p> <p>Diagnoses for R1 included: PTSD, anxiety, depression, and obsessive-compulsive disorder. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/17/23. R1 was assessed with a cognitive score of 12 indicating cognitively intact.</p> <p>A review of the Trauma Informed Screen assessment dated [DATE] revealed R1 was in Vietnam and did not reveal any other information related to PTSD. No other social service assessments or notes revealed information related to PTSD.</p> <p>A review of the care plan dated 12/19/23 revealed no information related to PTSD interventions and accommodations except for a cognitive impaired care plan indicating to administer and monitor medication and to let R1 make decisions and for nursing staff not to rush with care provided for R1.</p> <p>On 1/23/24 at 1:03 P.M. registered nurse (RN#2, MDS coordinator) was interviewed about the individualized care plan for R1 with diagnosis of PTSD and was handed a policy titled, Trauma Informed Care. RN #2 reviewed the policy and R1's care plan and agreed there was no care plan completed for PTSD.</p> <p>A review of the facility policy titled, Trauma Informed Care read in part .is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.</p> <p>On 1/23/24 at 4:14 P.M. during the end of day meeting the DON and Administrator were made aware of the above findings.</p> <p>No other information was presented prior to exit conference on 1/24/24.</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                         |                                                 |
| F 0657<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Some                        | <p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 21875</p> <p>Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of twenty-three residents in the survey sample (Residents #57 and #61).</p> <p>The findings include:</p> <p>1. Resident #57 did not have a comprehensive care plan review/meeting conducted by the interdisciplinary team, including the resident and/or family member, after each minimum data set (MDS) for over a year.</p> <p>Resident #57 (R57) was admitted to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease), emphysema, gastroesophageal reflux disease, chronic respiratory failure, osteoarthritis, peripheral vascular disease, osteoporosis, depression and protein-calorie malnutrition. The MDS dated [DATE] assessed R57 as cognitively intact.</p> <p>On 1/22/23 at 2:50 p.m., R57 was interviewed about quality of care/life in the facility. R57 stated during this interview that she did not recall any recent care plan meetings or invitations to a meeting.</p> <p>R57's clinical record documented quarterly MDS assessments on 11/21/23 and 8/26/23 and a re-admission assessment on 5/29/23. There was no documentation indicating a care plan review after these assessments.</p> <p>On 1/22/23 at 2:51 p.m., the registered nurse (RN #3) MDS coordinator was interviewed about R57's care plan review/meetings. RN #3 stated the social worker was responsible for coordinating the care plan meetings. RN #3 reviewed the clinical record and stated she was not sure when R57's last care plan meeting was held.</p> <p>On 1/23/24 at 2:20 p.m., the social worker (other staff #1) was interviewed about review and resident/family involvement with R57's care plan. The social worker stated that meetings were supposed to be conducted at least quarterly. The social worker stated a written invitation letter was sent to the resident's representative and a verbal invitation made to the resident. Information on R57's care plan meetings/reviews was requested.</p> <p>On 1/23/24 at 3:00 p.m., the social worker stated that an invitation letter was sent to R57's representative in November 2023 but the care plan meeting never happened. The social worker stated R57's last care plan meeting was held in January 2023. The social worker stated the November 2023 care plan review did not get scheduled.</p> <p>(continued on next page)</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                         |                                                 |
| <p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On 1/23/14 at 3:16 p.m., the social worker stated she reviewed R57's clinical record. The social worker stated again the last formal care plan meeting was held in January 2023. The social worker stated there should have been a care plan review/meeting conducted in May 2023, August 2023 and in November 2023 in coordination with MDS assessments. The social worker stated invitation letters were sent for the August and November care plan reviews, but the meetings were never conducted. The social worker stated there was no invitation letter sent for a May 2023 care plan review meeting.</p> <p>The facility's policy titled Care Plans (undated) documented, .A comprehensive care plan is developed and reviewed as follows .completed within 7 days of MDS completion, Q [every] 90 days thereafter .</p> <p>This finding was reviewed with the administrator and director of nursing during a meeting on 1/23/24 at 4:20 p.m.</p> <p>2. Resident #61's plan of care was not revised to included problems, goals and interventions regarding significant weight loss.</p> <p>Resident #61 (R61) was admitted to the facility with diagnoses that included diabetes, pressure ulcer, protein-calorie malnutrition, hypertension, anemia, chronic kidney disease, depression, peripheral vascular disease, and chronic osteomyelitis. The MDS dated [DATE] assessed R61 with severely impaired cognitive skills.</p> <p>R61's clinical record documented weight monitoring with the resident recognized with significant weight loss on 11/27/23. A nursing note dated 11/27/23 documented, .RD [registered dietitian] reviewed resident d/t [due to] weight loss .Add prostat .encourage increased food and fluid intake and assist as needed . A nursing note dated 1/2/24 documented R61 was evaluated by therapy due to weight loss. The nurse practitioner (NP) progress note dated 1/4/24 documented, .on rounds today at the request of the facility as her weight continues to trend down . New orders were entered on 1/4/24 to liberalize the resident's reduced concentrated sweets diet. A NP note dated 1/18/24 documented, .rounds today at the request of the facility for weight loss. RD and ST [speech therapy] aware .No Tube Feed. Currently on regular level 7 diet, recently liberalized diet .Refuses dining room and doesn't like supplements .</p> <p>R61's plan of care (revised 5/9/23) documented the resident had a potential for impaired nutritional status related to: malnutrition .diabetes, weakness, unhealed pressure areas/wound infection, occasional nausea/vomiting . The plan of care made no mention of the resident's recent weight loss and had not been revised to include problems, goals and/or interventions regarding weight loss. Interventions listed were generalized statements to provide food, medications and supplements as ordered but included no individualized interventions that had been implemented in response to actual weight loss. The clinical record also documented R61 was assessed by psychiatry due to mood changes with increases made to her antidepressant medication in December 2023.</p> <p>(continued on next page)</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                         |                                                 |
| F 0657<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Some                        | <p>On 1/23/24 at 1:09 p.m., the licensed practical nurse unit manager (LPN #2) was interviewed about R61's care plan. LPN #2 stated R61 had recently been assessed with significant weight loss. LPN #2 stated R61 had been down due to some family issues, assessed by psychiatry with an increase made to her antidepressant. LPN #2 stated the resident was evaluated by therapy, had supplements added, had her diet liberalized and orders entered for encouragement/increased assistance with meals. LPN #2 stated she did not know why the care plan had not been updated with weight loss interventions. LPN #2 stated that the MDS coordinators were responsible for updating care plans.</p> <p>On 1/23/24 at 1:24 p.m., the registered nurse MDS coordinators (RN #2 and RN #3) were interviewed about R61's plan of care. RN #2 reviewed the care plan and stated there were interventions listed to provide diet and supplements as ordered. RN #2 stated the care plan was last reviewed on 12/14/23 but had not been updated with individualized interventions in response to actual weight loss. RN #2 stated, I don't think it [care plan] is individualized for her about weight loss.</p> <p>This finding was reviewed with the administrator and director of nursing during a meeting on 1/23/24 at 4:20 p.m.</p> |                                                                                                         |                                                 |



|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                         |                                                 |
| <p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>41449</p> <p>Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to maintain respiratory equipment in accordance with standards of practice affecting four residents (Resident #72, 234, 231, and 232) and the facility staff failed to administer oxygen in accordance with physician orders for one resident (Resident #3), in a survey sample of 23 residents.</p> <p>The findings included:</p> <p>1. For residents #72, 234, 231, and 232, the facility staff failed to store nebulizer equipment in a manner to prevent contamination when not in use.</p> <p>On 1/22/24 at approximately 11:30 am, during a facility tour of the 400 and 500 units, it was noted that Resident #234, 231 and 232's nebulizer masks and handheld mouth pieces were on the bedside tables open to air, not stored in a bag.</p> <p>On 1/22/24 at approximately 2 pm, an interview was conducted with RN #4, who was the nurse assigned to the unit. When asked about nebulizers, she stated, the tubing is changed weekly on Wednesdays by the evening shift. when asked to explain how they are to be stored when not in use, RN #4 stated, they are to be stored in bags. When asked why this is done, RN #4 said, for infection control. RN #4 was made aware of the earlier observations involving resident #234, 231 and 232. She stated that she had not noticed the nebulizers at first when she was in the rooms but said, we have gone down now and put them all in bags.</p> <p>On 1/23/24 at 3:39 pm, observations were conducted of resident #72's handheld nebulizer at the bedside open to air.</p> <p>On 1/23/24 at approximately 4:05 pm, an interview was conducted with LPN #4, the unit manager. When asked to explain the storage of nebulizers, she stated they used to have the respiratory bags but now use zip lock bags to store them in when not being used. LPN #4 was asked why they are stored in a bag, she stated, for infection control, so they don't touch a dirty surface.</p> <p>Following the above interview, LPN #4 accompanied the surveyor to resident #72's room and confirmed the nebulizer was open to air and not stored in a manner to prevent contamination.</p> <p>A review was conducted of the facility policy titled; Nebulizer Therapy. Excerpts from the policy stated, Care of the Resident . 16. Disassemble and rinse the nebulizer with sterile or distilled water and store in patient setup bag .Care of the Equipment: . 6. Store the nebulizer cup and mouthpiece or mask in a plastic setup bag .</p> <p>On 1/23/24, during an end of day meeting, the facility Administrator and Director of Nursing were made aware of the above findings.</p> <p>No further information was provided.</p> <p>(continued on next page)</p> |                                                                                                         |                                                 |



|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                         |                                                 |
| F 0695<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | 49456<br><br>2. For resident #3, the facility staff failed to administer oxygen at the rate ordered by the physician.<br><br>Resident #3(R3) had diagnosis of obstructive and reflux uropathy, muscle weakness, cerebral infarction, and atrial fibrillation. The most current MDS (minimum data set) was a significant change in status assessment with an ARD (assessment reference date) of 12/31/23. R3 was assessed with a cognitive score of 8 indicating moderate cognitive impairment.<br><br>On 1/22/24 at 1:20 P.M. R3 was observed in bed with oxygen administered at 1.5 lpm from an oxygen concentrator. R3 was observed again on 1/23/24 at 9:00 A.M. with oxygen administered at 1.5 lpm.<br><br>R3's clinical record documented a physician's order dated 12/25/23 for oxygen administration via nasal cannula at 2 lpm continuously.<br><br>On 1/23/24 at 9:01 A.M., accompanied by registered nurse (RN#5), the resident's oxygen administration rate was observed. RN#5 looked at the concentrator and verbalized the oxygen was not set on 2 lpm. RN#5 was interviewed at this time about the oxygen administration rate. RN#5 stated R3's oxygen was supposed to be at 2 lpm. RN#5 stated nurses are supposed to check for the correct oxygen rate during each shift.<br><br>This finding was reviewed with the administrator and director of nursing during a meeting on 1/23/24 at 4:14 P.M.<br><br>No further information provided regarding the oxygen rate prior to the end of the survey. |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                 |
| F 0699<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Provide care or services that was trauma informed and/or culturally competent.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49456</p> <p>Based on resident interview, staff interview, clinical record review and facility documentation the facility failed to initiate trauma informed care for one of 23 residents. Resident #1 (R1) had an admitting diagnosis of PTSD (Post Traumatic Stress Disorder), and the facility did not identify triggers which may cause re-traumatization.</p> <p>The Findings Include:</p> <p>Diagnoses for R1 included: PTSD, anxiety, depression, and obsessive-compulsive disorder. The most current MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/17/23. R1 was assessed with a cognitive score of 12 indicating cognitively intact.</p> <p>A review of the Trauma Informed Screen assessment dated [DATE] revealed R1 was in Vietnam and did not reveal any other information related to PTSD. No other social service assessments or notes revealed information related to PTSD.</p> <p>A review of the care plan dated 12/19/23 revealed no information related to PTSD interventions and accommodations except for a cognitive impaired care plan indicating to administer and monitor medication and to let R1 make decisions and for nursing staff not to rush with care provided for R1.</p> <p>On 1/22/24 at 12:35 P.M. R1 was interviewed about diagnosis of PTSD. R1 stated, staff are getting frustrated with me if I am moving to slow, and staff moves my things around and do not place my belongings back and seems staff is blaming everything on me because the office staff comes in and offers to help me be placed somewhere else and that upsets me and causes anxiety and my PTSD to go off. [SIC]</p> <p>On 1/23/24 at 1:03 P.M. registered nurse (RN #5, MDS coordinator) was interviewed regarding identifying triggers to individualize care for PTSD. RN #5 voiced unawareness to having to have triggers in the pan of care.</p> <p>A review of the facility policy titled, Trauma Informed Care [read in part] .is an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization.</p> <p>On 1/23/24 during the end of day meeting the DON and Administrator were made aware of the above findings.</p> <p>No other information was presented prior to exit conference on 1/24/24.</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                 |
| F 0761<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>21875</p> <p>Based on observation, staff interview and facility document review, the facility staff failed to provide accurate and/or timely medication labeling on two of five units (100 hall, 200 hall).</p> <p>During a medication pass on the 200 hall, Resident #61's medication sertraline was labeled with an inaccurate dosage. On the 100 hall, a bottle of aspirin was observed in the medication cart without labeling indicating when the bottle was opened.</p> <p>The findings include:</p> <p>1. Resident #61's medication sertraline was labeled with a discontinued dosage, not matching the current medication order.</p> <p>On 1/23/24 at 8:16 a.m., a medication pass observation was conducted on the 200 hall, with registered nurse (RN #1) administering medications to Resident #61 (R61). Among the medications administered were four tablets of sertraline 25 mg (milligrams) to equal a 100 mg dose. The pharmacy label on R61's sertraline documented sertraline 25 mg with instructions to give 3 tablets (75 mg) by mouth once time per day related to major depressive disorder.</p> <p>R61's clinical record documented a current physician's order dated 12/11/23 for sertraline 100 mg one time per day for treatment of major depressive disorder. A previous order for sertraline 75 mg once daily was discontinued on 12/11/23.</p> <p>On 1/23/24 at 8:43 a.m., RN #1 was interviewed about R61's sertraline pharmacy label not matching the current order. RN #1 stated pharmacy was supposed to send a new card/supply of medication when orders were changed. RN #1 stated the pharmacy labels were supposed to match and discontinued medications were supposed to be returned to the pharmacy. RN #1 stated R61's sertraline dose was increased in December 2023 from 75 mg to 100 mg daily.</p> <p>On 1/23/24 at 8:46 a.m., the licensed practical nurse (LPN #3) assistant director of nursing was interviewed. LPN #3 stated the medication labels were supposed to accurately reflect the current dosage/order. On 1/23/24 at 9:20 a.m., LPN #3 stated she checked with pharmacy about R61's inaccurate label. LPN #3 stated pharmacy stated they had previously sent a 30-day supply on a new card with the updated dose. LPN #3 stated the previous supply cards with the discontinued dose were not sent back to the pharmacy. LPN #3 stated she checked the medication cart and did not find a current supply of sertraline for R61 labeled for the 100 mg dose. LPN #3 stated, Only the old cards [75 mg dose] were in the cart.</p> <p>(continued on next page)</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                 |
| F 0761<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>The facility's policy titled Labeling of Medications (undated) documented, The purpose of this procedure is to insure that all medications maintained in the facility are properly labeled in accordance with current state and federal regulations .Labels for individual drug containers must include .The name, strength, and quantity of the drug .Only the issuing pharmacy may place a drug label on a medication container . The facility's policy titled Discontinued Medications (undated) documented, .The staff/charge nurse receiving the order to discontinue a medication is responsible for charting such information and must also notify the issuing pharmacy of such order .Discontinued medications are destroyed or returned to the issuing pharmacy in accordance with established procedures . (Sic)</p> <p>This finding was reviewed with the administrator and director of nursing during a meeting on 1/23/24 at 4:20 p.m.</p> <p>28106</p> <p>2. Failed to ensure medications were labeled appropriately in one of two medication carts reviewed.</p> <p>Findings were:</p> <p>During a medication storage review conducted on 1/24/24 at 9:06 AM, the medication cart on the 100 unit was reviewed with license practical nurse (LPN #1). An over the counter (OTC) bulk bottle of Vitamin C 500 Mg was opened and did not show an opened date. Also a bottle of Geri-Tussin cough syrup was opened and did not show an opened date. LPN #1 also reviewed the medications and verbalized there should be a date on all opened medications. LPN #1 then removed the medications from the cart.</p> <p>A facility policy titled Labeling of Medications read in part 6. Labels of over the counter (OTC) drugs must contain: a) Date opened b) The expiration date.</p> <p>On 1/24/24 at 10:32 AM the above information was presented to the director of nursing and and administrator.</p> <p>No further information was obtained prior to the exit conference on 1/24/2024.</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                 |
| F 0812<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>28106</p> <p>Based on observation, and staff interview, the facility staff failed to store food properly in the main kitchen. Dried food was not labeled.</p> <p>The Findings Include:</p> <p>On 1/22/24 at 11:35 AM an initial kitchen tour was conducted with the dietary manager (other staff, OS #2). The dry storage room yielded an opened bulk bag of sugar without dates indicating when the item was opened or when the item was to be used by. when asked about the opened bag of sugar. OS #2 said the staff should have dated the bag with an open date and used by date.</p> <p>On 1/23/24 at 4:18 PM the administrator and director of nursing was notified of the above finding.</p> <p>No other information was provided prior to exit conference on 1/24/24.</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Allegheny                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Allegheny Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                         |                                                 |
| F 0880<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Some                        | <p>Provide and implement an infection prevention and control program.</p> <p>41449</p> <p>Based on observation, staff interview, clinical record review and facility documentation review, the facility staff failed to implement infection control practices to prevent the transmission of communicable diseases and infections on 2 of 5 units, which had the potential of affect multiple residents.</p> <p>The findings included:</p> <p>1. For Resident #18, who was on transmission-based precautions, the facility staff failed to wear proper PPE (personal protective equipment) while providing care, to prevent the transmission of infection(s) within the facility.</p> <p>On 1/22/24 at 11 am, resident #18 was observed from the hallway. It was noted that on the room door frame there was a sign that indicated Stop: Contact precautions. The sign indicated that prior to entering the room to don (put on) an isolation gown and gloves and prior to exiting the room to perform handwashing. It was also noted that a bin was positioned in the hall outside of the room that contained isolation gowns and gloves.</p> <p>On 1/22/24 at 11:27 am, CNA #1 was observed to enter the room to respond to the resident's call light. The CNA did not put on any PPE prior to entering the room. CNA #1 then returned to the hallway to retrieve incontinence supplies from a supply cart and returned into the resident's bathroom, again without donning any PPE. CNA #1 was observed when she exited the bathroom to remove gloves and used hand sanitizer.</p> <p>Upon CNA #1's exit from the room an interview was conducted. CNA #1 confirmed that she had assisted the resident with toileting. When asked about the sign for contact precautions, she said, she [Resident #18] has something in her urine, I don't know exactly what it is. When asked if she was helping the resident with toileting, she confirmed she was. When the surveyor pointed to the sign, CNA #1 said she was only told to wear gloves. When asked about the gown as noted on the sign and why she didn't put a gown on, CNA #1 said, I don't know.</p> <p>On 1/22/24, a clinical record review was conducted of Resident #18's chart. This review revealed that the resident had a physician order dated 1/14/24, that remained an active order, that read, Contact Isolation Precautions d/t [due to] ESBL [Extended-spectrum beta-lactamases] in urine. Review of Resident #18's care plan revealed a focus area that read, [resident's name redacted] requires contact isolation related to ESBL in urine, which was initiated 1/24/24. Interventions for this focus area included but were not limited to: . maintain isolation precautions per infection control policy, PPE supplies available outside room .</p> <p>(continued on next page)</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                         |                                                 |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>The facility policy titled; Isolation was reviewed. Excerpts from the policy read as follows: 1. Should there be reason to believe that a resident has an infectious or communicable disease, the charge nurse shall notify the resident's attending physician for appropriate isolation instructions. 2. The charge nurse shall enter the physician's order on the Physician's Order Sheet. The physician's orders must be carried out as quickly as practical . 5. Isolation precautions shall remain in effect until discontinued by the attending physician or criteria are met . Contact Isolation: Contact Isolation is designed to prevent transmission of highly transmissible or epidemiologically important infections (or colonization) that do not warrant Strict Isolation. All diseases or conditions included in this category are spread primarily by close or direct contact. Thus, masks, gowns and gloves are recommended for anyone in direct contact with any resident who has an infection that is included in this category .</p> <p>On 1/23/24, during an end of day meeting, the facility administrator and director of nursing, who is also the infection preventionist were made aware of the above findings.</p> <p>No further information was provided.</p> <p>2. The facility staff failed to conduct COVID-19 testing in accordance with CDC guidance following a COVID-19 outbreak and having conducted contact tracing to identify persons with exposure, affecting residents and staff on 2 of 5 nursing units.</p> <p>On 1/23/24, a review of the facility's infection control program was conducted with the facility's director of nursing (DON), who is also the infection preventionist (IP). During the review it was noted that the facility experienced a COVID-19 outbreak on 12/29/23, due to a Resident on their rehab unit testing positive for COVID-19 following being symptomatic.</p> <p>The facility performed contact tracing and identified those with exposure. The IP stated that following a known exposure and in accordance with their policy and CDC guidance they conduct testing on days 1, 3 and 5. Review of the testing logs revealed that the testing performed on 12/29/23, 12/21/23 and 1/2/24, did not include occurrences of each person being exposed having been tested .</p> <p>Review of the testing documents revealed that on 12/29/23, testing was performed on 17 staff members who had been exposed. All of which, tested negative. Then on 12/31/23, only 2 staff were tested , both of which were negative. On 1/2/24, ten staff were tested and one of those was positive. The DON was asked to explain why all the staff who had been exposed were not tested on day 1, 3 and 5 following an exposure as recommended when contact tracing is performed. The DON said that they struggle with staff who are off that day having them to come in and test.</p> <p>(continued on next page)</p> |                                                                                                         |                                                 |



|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                         |                                                 |
| F 0880<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Some                        | <p>The facility policy titled, COVID-19 Prevention, Response and Reporting with a revision date of 8/10/23, was reviewed. Excerpts from the policy read as follows: . 12. Testing: The facility will report viral testing for SARS-CoV-2 as per national standards such as CDC recommendations . c. Asymptomatic residents with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1, day 3, and day 5 13. Outbreak: Responding to a newly identified SARS-CoV-2 infected HCP [healthcare personnel] or resident: . b. A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. c. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach .; d. Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status .</p> <p>The CDC (Centers for Disease Prevention and Control) gives guidance to nursing facilities in their document titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, which was updated May 8, 2023. This document read, . Responding to a newly identified SARS-CoV-2-infected HCP or resident . Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 .</p> <p>During a pre-exit meeting with the facility administrator and director of nursing they were made aware of the above findings.</p> <p>No additional information was provided.</p> |                                                                                                         |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                         |                                                 |
| <p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>41449</p> <p>Based on staff interview, clinical record review and facility documentation review, the facility staff failed to provide evidence that one resident (Resident #46) was offered the COVID-19 vaccine in a survey sample of 5 residents reviewed for immunizations.</p> <p>The findings included:</p> <p>For resident #46, the facility staff failed to have evidence that the resident had been offered the updated COVID-19 vaccine.</p> <p>On 1/23/24, a clinical record review was conducted of Resident #46's chart. There was no evidence that the resident had been offered the current 2023-2024 COVID-19 vaccine, his last dose was documented as having been received on 7/7/22.</p> <p>On 01/24/24 at 10:17 am, an interview was conducted with the facility's director of nursing (DON), who is also the infection preventionist (IP). The DON was made aware that the surveyor had been unable to locate any evidence in resident #46's chart to indicate the current COVID-19 vaccine had been offered. The flu and pneumonia consent forms were noted but nothing for COVID. The DON reviewed the clinical chart and was unable to locate it and wanted to check into it.</p> <p>On 1/24/24 at approximately 11:30 am, the DON returned and told the surveyor that they had no evidence the resident had been offered the vaccine. The DON also went on to say that because the resident was currently out of the facility at an appointment she had called and spoke with the resident. The resident didn't recall if it was offered or not but was interested in receiving the immunization and the DON stated she had ordered it.</p> <p>Review of the facility's COVID-19 Vaccination was conducted. Excerpts from this document read, . 2. COVID-19 vaccinations currently in use include the updated (2023-2024 Formula) mRNA COVID-19 vaccines such as the Pfizer-BioNTech or Moderna brands, and the protein subunit monovalent vaccine known as Novavax as per current FDA and CDC guidance . 11. COVID-19 vaccinations will be offered to residents when supplies are available, as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. 12. Following assessment for potential medical contraindications, COVID-19 vaccinations for residents may be administered in accordance with physician-approved standing orders . 14. The facility will educate and offer the COVID-19 vaccine to residents and staff and maintain documentation of such. Residents/staff may self-report vaccination status with signed attestation .</p> <p>The CDC (Centers for Disease Control and Prevention) gives the following recommendations with regards to COVID-19 immunizations in their document titled; Stay Up to Date with COVID-19 Vaccines, which was updated Jan. 18, 2024. Recommendations for Everyone Aged 5 Years and Older: Everyone aged 5 years and older should get 1 dose of an updated COVID-19 vaccine to protect against serious illness from COVID-19. None of the updated 2023-2024 COVID-19 vaccines is preferred over another . Accessed online at: <a href="https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html">https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html</a></p> <p>(continued on next page)</p> |                                                                                                         |                                                 |

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 08/28/2024  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                        |                                                                                                         |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>495221                                                                                                                    | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                                | (X3) DATE SURVEY<br>COMPLETED<br><br>01/24/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Brian Center of Alleghany                                                                      |                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Alleghany Regional Hospital Lane<br>Low Moor, VA 24457 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                        |                                                                                                         |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                              |                                                                                                         |                                                 |
| F 0887<br><br>Level of Harm - Minimal harm or<br>potential for actual harm<br><br>Residents Affected - Few                         | On 1/24/24, during a group meeting with the facility administrator and director of nursing, they were made<br>aware of the above findings.<br><br>No further information was provided. |                                                                                                         |                                                 |