STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Loudoun Rehabilitation and Nursing Center	235 Old Waterford Road, Northwest Leesburg, VA 20176

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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on observation, resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to maintain dignity for three of 41 residents in the survey sample, Residents #246, #42, and #24. The findings include: 1. For Resident #246 (R246), the facility staff failed to cover the resident's lower body on 11/28/23. On 11/28/23 at 9:50 a.m., R246 was observed from the hallway lying in bed. The resident's lower body was completely uncovered. The resident was not wearing any clothing on his legs. The resident's incontinence brief was partially unfastened, and visible to anyone who looked in from hallway. Over the next 15 minutes, three staff members walked by or into the room. None of these staff members attempted to cover R246's exposed lower body. On 11/30/23 at 9:53 a.m., LPN (licensed practical nurse) #4 was interviewed. She stated walking by a resident who is exposed due to lack of covers is a no-no. She stated R246 should have been covered by staff when they walked into or by the resident's room. She stated this is not a dignified manner for the resident to be treated. On 11/30/23 at 10:09 a.m., CNA (certified nursing assistant) #13 was interviewed. She stated if she saw a resident with the lower body and unfastened brief exposed, she would go in and cover the resident. She stated it is not dignified for a resident to appear uncovered that way. She stated: I would not want to be that way myself. On 11/30/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. A review of the facility policy, Dignity, revealed, in part: Each resident shall be cared for in a manner that promotes his or her sense of wellbeing, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents will be treated with dignity and respect at all times. No further information was provided prior to exit. (continued on next page)

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 REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2023

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	42183 2. For Resident #42, the facility staff failed to promote and enhance the resident's right to a dignified existence and being respected. The facility staff failed to wear a name/ID badge. Observations on 11/28/23 and 11/29/23 revealed that no staff on the [NAME] Wing were wearing name tags, with the exception of two CNA (certified nursing assistant) students. Resident #42 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: hearing loss. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/6/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the comprehensive care plan dated 8/18/23 revealed, FOCUS: Resident has a communication problem related to Hearing deficit. INTERVENTIONS: COMMUNICATION: Allow adequate time to respond, repeat as necessary, do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. An interview was conducted on 11/28/23 at 9:40 AM with CNA #2. CNA #2 was not wearing a visible name tag. When asked the location of their name tag, CNA #2 stated, It is in my car. I will go get it shortly. An interview was conducted on 11/28/23 at 1:30 PM with LPN (licensed practical nurse) #1. LPN #1 was not wearing a visible name tag. When asked the location of her name tag, LPN #1 stated, It is downstairs in my locker. An interview was conducted on 11/29/23 at 9:55 AM with CNA #2. CNA #2 was not wearing a visible name tag. CNA #2 stated My name tag is in my other car. I do not have it. An interview was conducted on 11/29/23 at 10:15 AM with Resident #42. Resident #42 stated, The staff do not wear their name tags. It is difficult to know who is taking care of you. I recognize some faces but without their names, it is difficult to know who is caring for you. When asked if she feels treated with dignity and respect, Resident #42 stated, No, when you do not know who is caring for you. An interview was conducted on 11/29/23 at 3:55 PM with LPN (licensed practical nurse) #2. When asked if staff do not wear their name tags are they being treated with dignity and respect, LPN #2 stated, No, the residents are not being treated with dignity if the staff are not wearing their name tag. On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's policy Resident Rights which reveals, The facility will ensure that facility operations and systems are implemented in a manner that facilitates the resident / resident representative can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The facility will implement and maintain systems to ensure all facility staff understand and foster the rights of every nursing home resident. A review of the facility's policy Identification Name Badges which reveals, All personnel are required to wear identification name tags or badges during their work shift. No further information was provided prior to exit. 3. For Resident #24, the facility staff failed to promote and enhance the resident's right to a dignified existence and being respected. The facility staff failed to wear a name/ID badge. Observations on 11/28/23 and 11/29/23 revealed that no staff on the [NAME] Wing were wearing name tags, with the exception of two CNA (certified nursing assistant) students. Resident #24 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: diabetes, CVA (cerebrovascular accident), hemiplegia, hemiparesis, and epilepsy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/6/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the comprehensive care plan dated 6/16/23 revealed, FOCUS: Resident has a communication problem related to Aphasia following nontraumatic intracerebral hemorrhage. INTERVENTIONS: All staff to converse with resident while providing care. COMMUNICATION: Allow adequate time to respond, repeat as necessary, do not rush, Request clarification from the resident to ensure understanding, Face when speaking, make eye contact, turn off TV/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed. An interview was conducted on 11/28/23 at 9:40 AM with CNA #2. CNA #2 was not wearing a visible name tag. When asked the location of their name tag, CNA #2 stated, It is in my car. I will go get it shortly. An interview was conducted on 11/28/23 at 1:30 PM with LPN (licensed practical nurse) #1. LPN #1 was not wearing a visible name tag. When asked the location of her name tag, LPN #1 stated, It is downstairs in my locker. An interview was conducted on 11/29/23 at 9:55 AM with CNA #2. CNA #2 was not wearing a visible name tag. CNA #2 stated, My name tag is in my other car. I do not have it. An interview was conducted on 11/29/23 at 10:30 AM with Resident #24. Resident #24 stated, The staff do not wear their name tags. I do not know who is taking care of me and when I ask their name, they sometimes do not tell me. I wish they would wear their name tags. It does not make me feel respected. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 11/29/23 at 3:55 PM with LPN (licensed practical nurse) #2. When asked if staff do not wear their name tags are they being treated with dignity and respect, LPN #2 stated, No, the residents are not being treated with dignity if the staff are not wearing their name tag. On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. According to the facility's policy Resident Rights which reveals, The facility will ensure that facility operations and systems are implemented in a manner that facilitates the resident / resident representative can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. The facility will implement and maintain systems to ensure all facility staff understand and foster the rights of every nursing home resident. A review of the facility's policy Identification Name Badges which reveals, All personnel are required to wear identification name tags or badges during their work shift. No further information was provided prior to exit.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 27660 Based on observation, resident interview, staff interview and facility document review, it was determined the facility staff failed to assess a resident for the self-administration of a medicated mouthwash for one of 41 residents in the survey sample, Resident #45. The findings include: For Resident #45 (R45), the facility staff failed to assess the resident for the self-administration of a medicated mouthwash. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/6/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Observation was made of R45 on 11/28/2023 at approximately 9:00 a.m. There was a bottle of Dexamethasone oral solution was noted on the bedside table. R45 stated her oncologist ordered this for her. She stated she takes it with her when she leaves the facility to go on outings. R45 stated she goes out almost daily with friends or goes to the senior center. The physician order dated, 11/10/2023 documented, Dexamethasone oral liquid (1) 0.5 mg/5 ml (milligrams per milliliters) solution four times a day; Give 10 ml orally 4 times day. Swish for 2 minutes then spit. Do not eat or drink for 1 hr. after. Do not swallow. Use for 8 weeks. Review of the clinical record failed to evidence documentation of an assessment for the self-administration of the medicated mouth wash. Review of the comprehensive care plan failed to address the use and self-administration of the medicated mouthwash. An interview was conducted with LPN (licensed practical nurse) #6 on 11/29/2023 at 11:59 a.m. When asked the process for a resident to keep medications at the bedside, LPN #6 stated the doctor must give an order for the resident to administer medications. LPN #6 was asked even if it was a medicated mouthwash, LPN #6 stated, R45 goes out to the senior center all the time and takes it with her. When asked if R45 was assessed for the self-administration of the medicated mouthwash, LPN #6 stated, I don't know. An interview was conducted with RN (registered nurse) #2 on 11/29/2023 with LPN #6 present. When asked if R45 was assessed for self-administration of her medicated mouthwash, RN #2 stated the resident has her medicated mouthwash, but we give her, her other medications. When asked if the resident had been assessed for the self-administration of the medicated mouthwash, RN #2 instructed LPN #6 to look in the chart. LPN #6 reviewed the clinical record and stated she didn't see an assessment for that. A request was made for the self-administration of medication assessment for R45 on 11/29/23 at 5:00 p.m. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/30/2023 at 9:09 a.m. ASM (administrative staff member) #2, the director of nursing, stated they did not have the assessment and decided to not let the resident have it at the bedside. The facility policy, Self - Administration of Medications, Treatments, documented in part, POLICY: : Residents have the right to self-administer medications / treatments if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. SPECIFIC PROCEDURES / REQUIREMENTS: 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities and choice to determine whether self-administering medications and/or treatments is clinically appropriate for the resident. 2. The staff and practitioner may ask residents who are identified as being able to self-administer medications/treatments whether they wish to do so. 3. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, which may include (but not limited to) the resident's: a. Ability to read and understand medication labels / treatment instructions; b. Comprehension of the purpose and proper administration for his or her medications/treatments. c. Ability to remove medications and/or treatment supplies from a container. d. Ability to recognize risks and major adverse consequences of his or her medications/treatments. ASM #1, the administrator, ASM #2, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit. (1) Dexamethasone is a steroid used to treat inflammation and certain cancers. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682792.html.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on staff interview, facility document review and clinical record review, the facility staff failed to implement Advance Directive requirements for one of 41 residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff failed to maintain the resident's advance medical directive on the clinical record. Review of R6's clinical record revealed a social services assessment dated [DATE] that documented R6 had advance directives and R6 assigned the resident's daughter as POA (power of attorney). Further review of R6's clinical record (including the electronic record and paper record) failed to reveal the advance directive and POA documents were on file. On 11/29/23 at 3:44 p.m., an interview was conducted with OSM (other staff member) #5 (the director of social services). OSM #5 stated the facility staff obtains advance directive and POA documents upon admission and uploads the documents into the electronic clinical record or gives the documents to the medical records clerk. R6's advance directive and POA documents were requested. On 11/29/23 at 4:42 p.m., OSM #5 presented a copy of R6's advance medical directive and POA documents dated 3/8/21. OSM #5 stated she obtained the documents from the admissions office. On 11/30/23 at 3:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Advance Directives) documented, 7. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 31753 Based on staff interview, facility document review and clinical record review, the facility staff failed to issue a beneficiary notice of non-coverage for one of three beneficiary notice reviews, Resident #75. The findings include: For Resident #75 (R75), the facility staff failed to provide an advance beneficiary notice of non-coverage in a timely manner. A review of a list of residents discharged from a Medicare covered Part A stay with benefit days remaining revealed R75 was discharged from services on 9/23/23. A Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage documented, Medicare doesn't pay for everything, even some care that you or your health care provider think you need. The Skilled Nursing Facility (SNF) or its Utilization Review Committee believes that the care listed below does not meet Medicare coverage requirements. Beginning on 09/23/2023, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs . The notice was signed by R75 on 11/29/23. On 12/1/23 at 8:44 a.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated the advance beneficiary notice of non-coverage should be provided to a resident within 48 hours of the date of discharge from services. ASM #2 stated R75's notice was not given in a timely manner. ASM #2 was made aware this was a concern.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 32642 Based on observation, staff interview, and facility document review, the facility staff failed to protect clinical information privacy for one of 41 residents in the survey sample, Resident #246. The findings include: For Resident #246 (R246), the facility staff failed to protect the resident's clinical information privacy by posting information related to the resident's medical diagnosis and feeding protocol on signs above his bed, visible to all visitors. On the following dates and times, R246 was observed in his room: 11/28/23 at 9:50 a.m. and 3:53 p.m.; 11/30/23 at 10:04 a.m. At each observation, two signs were posted on the wall above the head of the resident's bed. Each sign contained information about the resident's medical diagnosis of difficulty swallowing, and instructions regarding the altered texture of his food and liquids, and instructions regarding the resident's need for feeding assistance. On 11/30/23 at 9:53 a.m., LPN (licensed practical nurse) #4 was interviewed. When asked about the signs at the head of R246's bed, she stated the resident is unable to speak for himself. She stated R246 has a roommate, and his roommate has visitors all the time. She stated the instructions regarding altered textures of food and liquids, as well as feeding instructions, are usually placed on the inside of a resident's closet door. She stated the resident's medical privacy is not protected when instructions are placed at the head of the bed, visible for all to see. On 11/30/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. A review of the facility policy, Resident Rights, revealed, in part: The resident has a right to secure and confidential personal and medical records. No further information was provided prior to exit. Based on observation, staff interview, and facility document review, the facility staff failed to protect clinical information privacy for one of 41 residents in the survey sample, Resident #246. No further information was provided prior to exit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32642 Based on observation, staff interview, and facility document review, the facility staff failed to provide a clean, homelike environment for one of 41 residents in the survey sample, Resident #247. The findings include: For Resident #247 (R247), the facility staff failed to change the resident's soiled sheet and underpad. On 11/28/23 at 10:15 a.m. (first shift staff on duty) and 3:54 p.m. (second shift staff on duty), R247 was observed lying in his bed. On the left side, between his left shoulder to just below his left hand, dried red/black spots were visible on the sheet and the exposed underpad. On 11/28/23 at 3:54 p.m., LPN (licensed practical nurse) #2 observed R247's bed linens. She stated the linens looked to have blood stains on them. She stated: These need to be changed. I need to assess him because he is a bleeder. She stated the soiled linens did not create a clean, homelike environment for the resident. On 11/28/23 at 3:58 p.m., CNA (certified nursing assistant) #12 was interviewed. She stated if a resident has blood on the sheets, the sheets should be changed, and the nurse should be notified. She stated the soiled linens were neither sanitary nor homelike. On 11/30/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. A review of the facility policy, Homelike Environment, revealed, in part: The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .a clean, sanitary and orderly environment .clean bed and bath linens that are in good condition. No further information was provided prior to exit.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 27660 Based on staff interview and facility document review, it was determined the facility staff failed to report a potential crime in a timely manner to the state agency. The findings include: There was threat to blow up this place up made by a resident's family member on 8/13/2023 and it was not reported to the state agency until 8/22/2023. The facility synopsis of the event was not dated where is stated, report date. At the bottom of the document it was dated, 8/13/2023, where the responsible party and law enforcement was notified. This form documented in part, The facility is reporting a bomb threat made by son of (resident's name). (Name of son) came into the facility intoxicated and when it was discovered his father's shirts were missing he made the comment, 'I should blow this place up. The family member was escorted from the facility and police called at which time the son was arrested. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 11/30/2023 at 9:24 a.m. When asked if the facility had a bomb threat made against the facility, ASM #1 stated there was an incident where the son of a resident came into the facility, drunk, accompanied by his mother. The son started saying crude things to the staff and stated he should blow this place up. ASM #1 stated he called 911 and the son left the facility. When asked if he reported this crime to the state agency, ASM #1 stated, I thought it was sent but when I looked at it a few days later, I noticed it hadn't gone through the fax so I resent it. When asked how many days do you have to report a crime to the state agency, ASM #1 stated he has two hours to report an allegation of abuse and 24 hours for any allegation of neglect, crime, exploitation or misappropriation. The facility policy, Abuse documented in part, Reporting: 2. The organization will maintain systems to ensure that all [alleged] violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, and crime, are reported in accordance with federal and state guidance. The facility will use the state designated form and protocol for reporting. a. Initial Report: i. For alleged violations of abuse or if there is resulting serious bodily injury, the facility must report the allegation immediately, but no later than 2 hours after the allegation is made. ii. For alleged violations of neglect, exploitation, misappropriation of resident property, or mistreatment that do not result in serious bodily injury, the facility must report the allegation no later than 24 hours. ASM #1, ASM #2, the director of nursing, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was obtained prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide evidence that required clinical information was provided to the receiving facility at the time of discharge for two of 41 residents in the survey sample, Residents #73 and #24. The findings include: 1. For Resident #73 (R73), the facility staff failed to provide evidence of sending clinical documents for the continuity of care (including care plan goals, advance directives, and current orders) to the receiving hospital when the resident was discharged on [DATE]. A review of R73's clinical record revealed she was emergently transferred to a local hospital on 10/19/23. Further review of her record failed to reveal evidence that any clinical information was sent to the receiving hospital when she was transferred. On 11/30/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. On 11/30/23 at 4:33 p.m., RN (registered nurse) #2, a unit manager, was interviewed. She stated when a resident is discharged to the hospital, the assigned nurse makes a copy of the face sheet, recent progress notes, advance directives, and other clinical information and places it in a manilla folder. This manilla folder is given to emergency medical personnel, who, in turn, give the manilla folder to the hospital staff. When asked if the facility retains any evidence that this clinical information was sent to the hospital, she stated: Not unless the nurse writes a progress note. A review of the facility policy, Facility Initiated Transfer, revealed, in part: The medical record will .Identify Information provided to the receiving provider which at a minimum will include .Contact information of the practitioner who was responsible for the care of the resident . Resident representative information, including contact information .Advance directive information .Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to treatments and devices .Precautions such as isolation or contact .Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions .The resident's comprehensive care plan goals .All information necessary to meet the resident's needs. No further information was provided prior to exit. 42183 2. For Resident #24, the facility staff failed to evidence provision of required resident information to the receiving facility at the time of discharge. Resident #24 was transferred to the hospital on 8/14/23. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the progress note dated 8/14/23 at 8:54 AM, revealed, Resident observed with stroke like symptoms, decreased cognition, slow to respond to verbal stimuli, aphasic, with right sided facial droop. The MD (physician) was notified, she was sent to ER (emergency room) for evaluation & treatment. There was no evidence of clinical documents sent with the resident to the hospital on 8/14/23. A review of the eINTERACT (interventions to reduce acute care transfers) dated 8/14/23, revealed the Acute Care Document Transfer Checklist as blank. An interview was conducted on 11/30/23 at 8:57 AM with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, We do not have evidence of the clinical documents sent with this resident to the hospital. On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. A review of the facilities Facility Initiated Transfer and Discharge policy revealed, The facility will consistently deploy systems to identify resident needs and preferences. When it is determined that the resident needs to be discharged to another location, the facility will provide notice to the resident, resident representative, attending physician and discharge location in an effort to support the resident's right for appeal and a successful discharge. No further information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 31753 Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for three of 41 residents in the survey sample, Residents #72, #78 and #80. The findings include: 1. For Resident #72 (R72), the facility staff failed to attempt the BIMS (Brief Interview for Mental Status) and mood interviews for the quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 11/1/23. Section B of R72's quarterly MDS with an ARD of 11/1/23 coded the resident as understood and as able to understand verbal content. A review of sections C and D revealed the BIMS and mood interviews were not attempted with the resident. On 11/29/23 at 4:02 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator) and ASM (administrative staff member) #4 (the regional MDS coordinator). ASM #4 stated the BIMS and mood interviews are completed by the social services department and the interviews should be attempted with every resident because in that moment, the resident may be able to answer. ASM #4 stated there was a time when the facility staff was having trouble with keeping up with the MDS assessments and she guessed the interviews for R72 were not done since they were coded as not assessed. ASM #4 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) when completing MDS assessments. On 11/29/23 at 4:51 p.m., an interview was conducted with OSM (other staff member) #5 (the director of social services). OSM #5 stated the BIMS and mood interviews are supposed to be completed within the seven-day ARD period and attempted with all residents. OSM #5 stated that if R72's BIMS and mood interviews were coded as not assessed then it's because the social services staff did not see the patient within the seven-day ARD period. OSM #5 stated that sometimes the MDS nurses put the assessment in the computer system to be completed after the ARD date. OSM #5 stated the interviews can't be done after the ARD date and have to be coded as not assessed. On 11/30/23 at 3:13 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The CMS RAI manual documented, C0100: Should Brief Interview for Mental Status Be Conducted? Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date .D0100: Should Resident Mood Interview Be Conducted? Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date . 2. For Resident #78 (R78), the facility staff inaccurately coded the resident as having a restraint on the admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/6/23. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R78's clinical record revealed a physician's order dated 9/29/23 that documented, MAY USE SIDERAILS OR MOBILITY BAR FOR BED MOBILITY IF NEEDED. Section P of R78's admission MDS assessment with an ARD of 10/6/23 documented, Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Section P further documented a bed rail was used daily as a physical restraint. On 11/29/23 at 7:41 a.m., R78 was observed lying in bed with bilateral one-half bed rails in the upright position. On 11/29/23 at 4:02 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator) and ASM (administrative staff member) #4 (the regional MDS coordinator). ASM #4 stated that when the nurses complete daily skilled evaluations and check off bed rail use in the computer system, the evaluations automatically trigger the bed rails to be coded as restraints on the MDS assessments. ASM #4 stated the nurses were not aware of this and the MDS staff should be checking the MDS for accuracy. ASM #4 stated R78 was inaccurately coded as having a restraint and she was currently working on a solution for this problem. ASM #4 stated she references the CMS (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) manual when completing MDS assessments. On 11/30/23 at 3:13 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The CMS RAI manual documented, SECTION P: RESTRAINTS AND ALARMS Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices, or an alarm was used, at any time during the day or night, during the 7-day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories. 3. For Resident #80 (R80), the facility staff inaccurately coded the resident as having a restraint on the admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/18/23. A review of R80's clinical record revealed a physician's order dated 9/14/23 that documented, MAY USE SIDERAILS OR MOBILITY BAR FOR BED MOBILITY IF NEEDED. Section P of R80's admission MDS assessment with an ARD of 0/18/23 documented, Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Section P further documented a bed rail was used daily as a physical restraint. On 11/28/23 at 9:29 a.m., R80 was observed lying in bed with bilateral one-half bed rails in the upright position. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/29/23 at 4:02 p.m., an interview was conducted with RN (registered nurse) #1 (the MDS coordinator) and ASM (administrative staff member) #4 (the regional MDS coordinator). ASM stated #4 that when the nurses complete daily skilled evaluations and check off bed rail use in the computer system, the evaluations automatically trigger the bed rails to be coded as restraints on the MDS assessments. ASM #4 stated the nurses were not aware of this and the MDS staff should be checking the MDS for accuracy. ASM #4 stated R80 was inaccurately coded as having a restraint and she was currently working on a solution for this problem. On 11/30/23 at 3:13 p.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 32642 Based on observation, facility document review, clinical record review, and facility document review, the facility staff failed to develop a complete baseline care plan for one of 41 residents in the survey sample, Resident # 246. The findings include: For Resident #246 (R246), the facility staff failed to develop a baseline care plan for the resident's neck stabilizing collar. On the following dates and times, R246 was observed in his room wearing a neck stabilizing collar: 11/28/23 at 9:50 a.m. and 3:53 p.m. and 11/30/23 at 10:04 a.m. A review of R246's clinical record revealed the following order dated 11/8/23: Aspen (neck stabilizing) collar at all times every shift for support. Further review of R246's orders failed to reveal evidence of orders to check R246's skin or to clean the collar. A review of R246's baseline care plan dated 11/8/23 revealed no information at all related to R246's neck stabilizing collar. On 11/30/23 at 9:40 a.m., ASM (administrative staff member) #4, the regional MDS (minimum data set) coordinator, was interviewed. When asked if a resident's neck stabilizing collar should be included on the baseline care plan, she stated: Yes, it should be included on the baseline care plan. She stated the baseline care plan should include interventions related to skin integrity, pain, and positioning. After reviewing R246's baseline care plan, she stated she did not see any information related to the neck stabilizing collar. On 11/30/23 at 9:53 a.m., LPN (licensed practical nurse) #4 was interviewed. She stated if a resident is wearing a neck stabilizing collar, the facility staff should take it off at least twice a day to clean the collar and to check the resident's skin underneath the collar. She stated the collar can rub the skin causing skin breakdown. She stated if the collar is dirty, bacteria can get inside the wound and cause infection. She stated the provider should give orders for both cleaning and assessing the skin. On 11/30/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. A review of the facility policy, Person Centered Care Planning, revealed, in part: To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within 48 hours of the resident's admission .The Interdisciplinary Team will review the following to assist in developing the baseline care plan .Orders obtained at the time of admission .The instructions are needed to provide effective and person-centered care that meets professional standards of quality care .The residents' immediate health and safety needs .Physician and dietary orders. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on observations, staff interview, resident interview, and facility document review, it was determined the facility staff failed to develop/implement the care plan for three of 41 residents in the survey sample; Resident #8, Resident #5 and Resident #63. The findings include: 1. For Resident #8, the facility staff failed to implement the comprehensive care plan for diet as ordered. Resident #8 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: dysphagia, oropharyngeal phase, and Parkinson's disease. The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 11/6/23, coded the resident as scoring a 08 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating. MDS Section K0520. Nutritional Approaches: C. Mechanically altered diet - require change in texture of food or liquids (e.g. , pureed food, thickened liquids)-yes. D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)-yes. A review of the comprehensive care plan dated 7/12/23, which revealed, FOCUS: The resident has nutritional problem or potential nutritional problem related to altered diet texture; Parkinson's, diabetes, dysphagia, long term care resident. INTERVENTIONS: Provide, serve diet as ordered. Monitor intake and record every meal. Gluten Free diet, Dysphagia Puree texture, Regular/Thin consistency. A review of the physician's orders dated 7/10/23, revealed, Consistent Carbohydrate Diet, Dysphagia Puree texture, Regular/Thin consistency. An interview was conducted on 11/28/23 at 5:45 PM with Resident #8. The supper tray was observed to include textured rotisserie chicken and lima beans, bread, cheesy mashed potatoes, and vanilla ice cream. When asked if the supper was the same smooth consistency, Resident #8 stated, No, but I am not choking on it. An interview was conducted on 11/28/23 at 5:45 PM with CNA (certified nursing assistant) #5. When shown Resident #8's tray and asked if it was pureed, CNA #5 stated, No, this is not the smooth consistency and texture that pureed food should be. An interview was conducted on 11/29/23 at 3:55 PM with LPN (licensed practical nurse) #2. When asked the purpose of the care plan, LPN #2 stated, the care plan's purpose is for us to figure out the kind of care the patient needs, interventions and goals. When asked if a pureed diet is ordered by the physician and on the care plan, but the resident is not receiving a pureed diet, is the care plan being implemented, LPN #2 stated, no, the care plan is not implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. A review of the facility's Resident Centered Care Plan policy revealed, The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process. The resident will receive the services and/or items included in the plan of care. No further information was provided prior to exit. 49369 2.a. For Resident #5 (R5), the facility staff failed to develop and/or implement the comprehensive care plan for PTSD trauma related care, and incontinence. On the most recent MDS (minimum data set) an annual assessment with an ARD (assessment reference date) of 9/28/23, R5 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status). He was admitted to the facility with diagnoses including anxiety disorder, depression and PTSD (post traumatic stress disorder)(1). A review of a progress note dated 9/16/23 revealed: Pt (Patient) noted to be screaming out, cursing, stating that the Housekeeper shouldn't be in his room when he is in there. Stated that he doesn't like the dust. Cursing at the Housekeeper, stating that he would 'cuss her out but she doesn't know English.' Removed patient from room and tried to explain that she was only attempting to help, by cleaning his room. Pt very upset and difficult to console. This note was from a registered nurse who is no longer employed at the facility. A further review of the progress notes revealed no information regarding PTSD prior to survey entrance. A review of the social service assessments dated 5/1/23 and 5/11/23 revealed no information related to PTSD. A review of the Trauma Screen assessments dated 7/24/23 and 7/25/23 revealed no information related to PTSD and were not fully completed. A review of the care plan dated 5/11/23 revealed no information related to PTSD interventions and accommodations. On 11/29/23 at 3:45 p.m., OSM (Other Staff Member) #5, the director of social services, was interviewed. She stated that their process for admitting someone with PTSD includes them looking for any behaviors and symptoms that indicate PTSD. She states that they would then care plan for any mood or behaviors that were exhibited. She also added that she had been employed at the facility for only 5 months. She could not explain why there was no documentation prior to survey entrance. She stated that since R5 has PTSD the facility should have developed a care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/29/23 at 3:44 PM., LPN (licensed practical nurse) #2 was interviewed. She stated that she is not sure who would report behaviors and that it should be in the progress notes if they were any. She was unsure if R5 had a psych visit. She stated that if residents did have any behaviors, they would notify the physician and nurse as well as place their name in the psych grid and make sure they were MDS coded. She also stated that nurses usually communicate during morning clinical meetings. That is when they would discuss behaviors if any. She stated that she was not informed on the info, but they would usually send an email out if they were. She stated that it is everybody's responsibility to take care of the resident's needs. She also stated that she does not see any orders, but it on the care plan. On 11/29/23 at 2:50 p.m , ASM (administrative staff member) #1, the administrator; ASM#2, the director of nursing; and ASM#3 the regional director of operations were informed of these concerns. No further information was provided prior to exit. References: 1.Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event. This information was taken from the website https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd. 2.b. For Resident #5 (R5), the facility staff failed to develop and/or implement the comprehensive care plan for incontinence related care. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) 9/28/23, R5 was coded as being moderately impaired for making daily decisions, having scored 10 out 15 on the BIMS (brief interview for mental status. He was coded as requiring the supervision of one person for toileting. He was coded as being occasionally incontinent for urinary and frequently incontinent for bowel. R5 has an indwelling catheter. A review of the care plan dated 5/1/23 revealed no information related to any incontinence care or treatment. Further review of R5's clinical record revealed no evidence of order or that R5 had received any care or treatment regarding incontinence. On 11/29/23 at 3:44 PM., LPN (licensed practical nurse) #2 was interviewed. She stated that R5 has indwelling catheter and that it is on care plan. She stated that it is everybody's responsibility to take care of the resident's needs. She then said that the incontinence is not on the care plan, but it should have been taken care of. On 11/29/23 at 2:50 p.m , ASM (administrative staff member) #1, the administrator; ASM#2, the director of nursing; and ASM#3 the regional director of operations were informed of these concerns. No further information was provided prior to exit. 27660 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For Resident #63, the facility staff failed to develop a care plan for the use of side rails. On the most recent MDS (minimum data set) assessment, a quarterly assessment with an assessment reference date of 9/5/2023, the resident scored a six out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions. Observation was made of Resident #63 on 11/28/2023 at approximately 9:00 a.m. Resident #63 was in bed with the bilateral side rails up in place. The physician order dated, 7/18/2023, documented, May use siderails or mobility bar for bed mobility if needed. Review of the comprehensive care plan failed to address the use of side rails. An interview was conducted with ASM (administrative staff member) #4, the regional MDS consultant, on 11/30/2023 at 10:59 a.m. When asked if she would expect to see side rails on the care plan, ASM #4 stated, if the resident has them, then yes, it should be on the care plan. ASM #1, the administrator, ASM #2, the director of nursing, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit.

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NAME OF PROVIDER OR SUPPLIER Loudoun Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 235 Old Waterford Road, Northwest Leesburg, VA 20176	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to review and revise the care plan for one of 41 residents in the survey sample, Resident #45. The findings include: For Resident #45, the facility staff failed to review and revise the care plan for the use and self-administration of a medicated mouthwash. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 10/6/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. Observation was made of R45 on 11/28/2023 at approximately 9:00 a.m. There was a bottle of Dexamethasone oral solution was noted on the bedside table. R45 stated her oncologist ordered this for her. She stated she takes it with her when she leaves the facility to go on outings. R45 stated she goes out almost daily with friends or goes to the senior center. The physician order dated, 11/10/2023 documented, Dexamethasone oral liquid (1) 0.5 mg/5 ml (milligrams per milliliters) solution four times a day; Give 10 ml orally 4 times day. Swish for 2 minutes then spit. Do not eat or drink for 1 hr. after. Do not swallow. Use for 8 weeks. Review of the comprehensive care plan failed to address the use and self-administration of the medicated mouthwash. Review of the clinical record failed to evidence documentation of an assessment for the self-administration of the medicated mouth wash. An interview was conducted with LPN (licensed practical nurse) #6 on 11/29/2023 at 12:05 p.m. When asked if a resident is allowed to use and self-administer a medicated mouthwash, should that be addressed on the resident's care plan, LPN #6 stated, yes. What's the purpose of the care plan, LPN #6 stated, it's the plan on how to take care of the resident. The facility policy, Resident Centered Care Plan documented in part, 1) The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a) When requested by the resident / resident representative. b) When there has been a significant change in the residents' condition. c) When the desired outcome is not met. d) When the resident has been readmitted to the facility from a hospital stay; and e) At least quarterly and after each OBRA MDS assessment. ASM #1, the administrator, ASM #2, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Dexamethasone is a steroid used to treat inflammation and certain cancers. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682792.html.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow professional standards of practice for the administration of medications and treatments for two of 41 residents in the survey sample, Residents #147 and #63. The findings include: 1. For Resident #147, the facility staff failed to administer a medication when it was available in the emergency medication supply. The physician order dated, 11/23/2023, documented, Pravastatin Sodium (1) Oral Tablet 40 MG (milligrams); Give 40 mg by mouth one time a day for hyperlipidemia. The MAR (medication administration record) documented the above order. On 11/24/2023, 11/25/2023, 11/26/2023 and 11/27/2023 a 13 was documented in the block for administration. A 13 indicated, Medication Not Available. Review of the nurse's notes for the dates above failed to evidence documentation for the reason the medication was not administered. Review of the Inventory On Hand list of medications available in the emergency box (CUBEX), documented, Pravastatin Sod (sodium) 10 MG tablet. On hand in UDI (name of system) - 30. An interview was conducted with LPN (licensed practical nurse) #6 on 11/29/2023 at 11:50 a.m. When asked if she runs out of medications, does the facility have any back up stock, LPN #6 stated they have extras in the bottom of the medication cart. She further stated there used to be a STAT box but since the new company, they only have a few things, mostly antibiotics. LPN #6 was asked where it was located, LPN #6 stated she didn't know, but only the supervisor and director of nursing had access to it. An interview was conducted with RN (registered nurse) #4, on 11/29/2023 at 3:44 p.m. When asked if the facility has a STAT box of medications, RN #4 stated they have a CUBEX in the first-floor supply room. She explained the nurse must log in to get in the system. All nurses have a log in. Observation was made of the CUBEX in the supply room on the first floor. When asked what type of medications are in the system, RN #4 stated it has most medications. She stated there are also stock medications on the medication carts too. When asked the process if a nurse is administering medications and doesn't have the medication in the cart, RN #4 stated they should first go to the CUBEX, call the pharmacy to deliver the mediation stat. Notify the nursing supervisor, doctor and resident and/or responsible party. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Medications Not Available documented in part, 3. In the event, that a prescribed medication is not available, staff will follow the steps below as necessary: a. Search the medication cart - look in all drawers; look to see if medication has mistakenly been taken out of the package. b. Look in all possible medication storage areas [i.e., med room]; look on all nursing units if resident has had recent medication change. c. Review medication list for meds available in on-site medication dispensing machine [i. e., Cubex, Omnicell, etc.]. If missing med is in medication dispensing machine, then obtain medication from dispenser- contact pharmacy for verification code if medication is a narcotic. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit. (1) Pravastatin works by slowing the production of cholesterol in the body to decrease the amount of cholesterol that may build up on the walls of the arteries and block blood flow to the heart, brain, and other parts of the body. This information was obtained from the following website: https://medlineplus. gov/druginfo/meds/a692025.html. 2. For Resident #63, the facility staff failed obtain blood sugars per the physician orders. The physician order dated, 6/15/2023, documented, BS AC/HS (blood sugar before meals and at bedtime) before meals and at bedtime for diabetes mellitus. The September MAR (medication administration record) documented the above order. Documented on 9/14/2023 at 7:30 a.m. was a 9. A 9 indicated Other/See Progress note. On 9/14/2023 at 11:30 a.m., it was blank, no documentation of the blood sugar. Review of the nurse's notes for 9/14/2023 at 9:44 a.m. documented, Resident ate already. There was no documentation related to the 11:30 a.m. physician ordered blood sugar. The November 2023 MAR documented the above order. The MAR documented the following: 11/6/2023 at 5:30 p.m. - a 9 was documented. 11/10/2023 at 11:30 a.m. - blank. 11/12/2023 at 7:30 a.m. - a 9 was documented. 11/16/2023 at 11:30 a.m. - blank 11/23/2023 at 11:30 a.m. - blank Review of the nurse's notes revealed: 11/6/2023 at 2:09 a.m. documented, Didn't check the blood sugar. 11/10/2023 at 11:30 a.m. there was no nurse's note documented. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/12/2023 at 7:30 a.m. the nurse documented, Resident ate already. 11/16/2023 at 11:30 a.m. and 11/23/2023 at 11:30 a.m., there was no nurse's note documented. On 11/30/23 at 8:59 a.m. ASM (administrative staff member) #2, the director of nursing stated blanks in the MAR (medication administration record), TAR (treatment administration record) and ADL (activities of daily living) documentation indicates it was either not given or completed. The facility policy, Medication Administration documented in part, 18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and document in the MAR the reason that the medication was not administered. ASM #1, the administrator, ASM #2, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was obtained prior to exit.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 42183 Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence of providing ADLs (activities of daily living) for two of 41 residents, Resident #42 and Resident #8. The findings include: 1. The facility staff failed to provide evidence of bathing and showers for Resident #42. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 11/6/23, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring supervision for bed, mobility, transfer, bathing, dressing, hygiene, eating and locomotion. A review of the comprehensive care plan dated 5/18/23 revealed, FOCUS: Resident has an ADL self-care performance deficit related to multiple health issues and difficulty in walking. INTERVENTIONS: BATHING /SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. A review of the October ADL form reveals three out of 31 missing day shift documentation on 10/5/23, 10/7/23 and 10/19/23. A review of the November ADL form reveals two out of 30 missing day shift documentation 11/11/23 and 11/13/23. An interview was conducted on 11/29/23 at 7:40 AM with CNA (certified nursing assistant) #6. When asked where bathing and showers are documented, CNA #6 stated they document the showers in PCC (Point Click Care-electronic charting system) there is no book. When asked what it indicates if there are blanks in the documentation, CNA #6 stated, the bathing and showers were not done. An interview was conducted on 11/30/23 at 10:00 AM with RN (registered nurse) #2. When asked where bathing and showers are documented, RN #2 stated, everything should be in PCC, they used to have a shower sheet but everything goes into PCC. The CNAs are responsible for putting it into system. Each resident is schedule for twice a week showers and Sundays are shower make up days. Each resident should be getting a bed bath every single day. If the documentation is missing, then the care was not provided. On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Activities of Daily Living policy revealed, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). No further information was provided prior to exit. 2. The facility staff failed to provide evidence of bathing and showers for Resident #8. The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 11/6/23, coded the resident as scoring a 08 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating. MDS Section K0520. Nutritional Approaches: C. Mechanically altered diet - require change in texture of food or liquids (e.g. , pureed food, thickened liquids)-yes. D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)-yes. A review of the comprehensive care plan dated 10/31/23, which revealed, FOCUS: Resident requires assistance with self-care and mobility related to Parkinson's disease with fluctuations in ADLs. INTERVENTIONS: Shower/Bathing; Dependent. A review of the October ADL form reveals four out of 31 missing day shift documentation on 10/5/23, 10/7/23, 10/29/23 and 10/31/23. A review of the November ADL form reveals two out of 30 missing day shift documentation 11/11/23 and 11/13/23. An interview was conducted on 11/29/23 at 7:40 AM with CNA (certified nursing assistant) #6. When asked where bathing and showers are documented, CNA #6 stated they document showers in PCC (Point Click Care-electronic charting system) there is no book. When asked what it indicates if there are blanks in the documentation, CNA #6 stated, the bathing and showers were not done. An interview was conducted on 11/30/23 at 10:00 AM with RN (registered nurse) #2. When asked where bathing and showers are documented, RN #2 stated everything should be in PCC, they used to have a shower sheet but everything goes into PCC. The CNAs are responsible for putting it into system. Each resident is schedule for twice a week showers and Sundays are shower make up days. Each resident should be getting a bed bath every single day. If the documentation is missing, then the care was not provided. On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. A review of the facility's Activities of Daily Living policy revealed, Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). No further information was provided prior to exit.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 42183 Based on staff interview, clinical record review and facility document review, the facility staff failed to provide evidence of providing ADL (activities of daily living) care for one of 41 dependent residents, Resident #146. The findings include: For Resident #146, the facility staff failed to provide evidence of showers, bathing, and incontinence care. The most recent MDS (minimum data set) assessment, a significant change assessment, with an ARD (assessment reference date) of 6/25/23, coded the resident as scoring a 00 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as being dependent for bed mobility, transfers, locomotion, dressing, eating, personal hygiene, toileting and bathing. A review of the comprehensive care plan dated 6/23/23 included: FOCUS: The resident has an ADL self-care performance deficit related to immobility and Advanced Dementia. Resident is incontinent of bowel and bladder related to immobility and advanced Dementia. INTERVENTIONS: BATHING /SHOWERING: The resident is totally dependent on staff to provide bath/shower and as necessary. All staff to be informed of resident's special dietary and safety needs. Clean peri-area with each incontinence episode. A review of Resident #146's July 2023 ADL documentation revealed, bladder elimination care missing eight of 31 evening shifts (7/1/23, 7/3/23, 7/4/23, 7/6/23, 7/7/23, 7/8/23, 7/9/23 and 7/11/23) and eight of 31-night shifts (7/1/23, 7/2/23, 7/7/23, 7/13/23, 7/16/23, 7/20/23, 7/23/23 and 7/26/23). A review of Resident #146's August 2023 ADL documentation revealed, bladder elimination care missing 17 of 31 evening shifts (8/3/23, 8/8/23, 8/10/23, 8/12/23, 8/14/23, 8/15/23, 8/17/23, 8/18/23, 8/19/23. 8/20/23, 8/22/23, 8/23/23, 8/24/23, 8/25/23, 8/28/23, 8/30/23 and 8/31/23) and 5 of 31 night shifts (8/7/23, 8/13/23, 8/14/23, 8/25/23 and 8/26/23). Bathing/shower documentation was missing for 5 of 31 day shifts (8/25/23, 8/27/23, 8/28/23, 8/29/23 and 8/31/23). A review of Resident #146's September 2023 ADL documentation revealed, bladder elimination care missing 15 of 20 evening shifts (9/1/23, 9/2/23, 9/5/23, 9/6/23, 9/7/23, 9/8/23, 9/11/23, 9/12/23, 9/13/23, 9/14/23, 9/15/23, 9/16/23, 9/17/23, 9/19/23 and 9/20/23) and 5 of 20 night shifts (9/3/23, 9/7/23, 9/9/23, 9/13/23 and 9/19/23). An interview was conducted on 11/29/23 at 7:40 AM with CNA (certified nursing assistant) #6. When asked where bathing and showers are documented, CNA #6 stated, they document the showers in PCC (Point Click Care-electronic charting system) there is no book. When asked what it indicates if there are blanks in the documentation, CNA #6 stated, the bathing and showers were not done. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 11/30/23 at 10:00 AM with RN (registered nurse) #2. When asked where bathing and showers are documented, RN #2 stated, everything should be in PCC, we used to have a shower sheet but everything goes into PCC. The CNAs are responsible for putting it into system. Each resident is schedule for twice a week showers and Sundays are shower make up days. Each resident should be getting a bed bath every single day. If the documentation is missing, then the care was not provided. On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. A review of the facility's Activities of Daily Living policy revealed, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. No further information was provided prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 27660 Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure two of 41 residents in the survey received care and services in accordance with professional standards of practice and the comprehensive care plan, Residents #48 and #246. The findings include: 1. For Resident #48. the facility staff failed to administer a treatment for a wound on the resident's shoulder. On the most recent MDS (minimum dataset) assessment, a significant change assessment, with an assessment reference date of 10/13/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired for making daily decisions. The physician order dated, 11/2/2023, documented, Cleanser left shoulder with normal saline, pat dry, apply hydrocolloid and leave open to air three times a week and PRN (as needed). The TAR (treatment administration record) documented the above order. On 11/7/2023, the block to sign off that the treatment was performed was blank. On 11/30/23 at 8:59 a.m. ASM (administrative staff member) #2, the director of nursing stated blanks in the MAR (medication administration record), TAR (treatment administration record) and ADL (activities of daily living) documentation indicates it was either not given or completed. ASM #1, the administrator, ASM #2, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit. 32642 2. For Resident #246 (R246), the facility staff failed to provide evidence of skin checks and device cleaning for the resident's use of a neck stabilizing collar. On the following dates and times, R246 was observed in his room wearing a neck stabilizing collar: 11/28/23 at 9:50 a.m. and 3:53 p.m., and 11/30/23 at 10:04 a.m. A review of R246's clinical record revealed the following order dated 11/8/23: Aspen (neck stabilizing) collar at all times every shift for support. Further review of R246's orders failed to reveal evidence of orders to check R246's skin or to clean the collar. A review of R246's baseline care plan dated 11/8/23 revealed no information at all related to R246's neck stabilizing collar. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/30/23 at 9:53 a.m., LPN (licensed practical nurse) #4 was interviewed. She stated if a resident is wearing a neck stabilizing collar, the facility staff should take it off at least twice a day to clean the collar and to check the resident's skin underneath the collar. She stated the collar can rub the skin causing skin breakdown. She stated if the collar is dirty, bacteria can get inside the wound and cause infection. She stated the provider should give orders for both cleaning and assessing the skin. On 11/30/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. No further information was provided prior to exit.

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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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on resident interview, staff interview, facility document review and clinical record review, the facility staff failed to implement a complete pain management program for one of 41 residents in the survey sample, Resident #197. The findings include: For Resident #197 (R197), the facility staff failed to administer the physician prescribed medication gabapentin (1) on 11/22/23. R197 was admitted to the facility on [DATE] with a fractured left upper leg. The MDS (minimum data set) assessment was not complete. A review of R197's clinical record revealed a BIMS (Brief Interview for Mental Status) assessment dated [DATE] that documented a score of 15 on a scale from 0 to 15, indicating the resident was cognitively intact. On 11/28/23 at 9:50 a.m., an interview was conducted with R197. The resident voiced concern about not getting pain medication in a timely manner during the first couple of days after admission to the facility. Further review of R197's clinical record revealed a physician's order dated 11/21/23 for gabapentin 100 mg (milligrams) three times a day for neuropathy. A review of R197's November 2023 MAR (medication administration record) revealed the same physician's order. On 11/22/23 at 9:00 p.m., the MAR documented the code, 9= Other/ See Progress Notes. A nurse's note dated 11/22/23 at 8:52 p.m. documented, Awaiting delivery from pharmacy. A review of the facility backup medication supply list revealed gabapentin 100 mg was available in the supply. A review of the inventory for the backup medication supply revealed gabapentin 100 mg was only pulled from the supply for R197 twice on 11/22/23. On 11/30/23 at 9:36 a.m., an interview was conducted with LPN (licensed practical nurse) #3. LPN #3 stated that when a resident is admitted to the facility, the admitting nurse should put the orders into the computer system. LPN #3 stated the orders are transmitted to the pharmacy then the pharmacy sends the medications. LPN #3 stated that if a medication is due and has not arrived from the pharmacy, then nurses should obtain the medication from the facility backup medication supply. On 12/1/23 at 10:08 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Pain Management documented, The organization will ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Reference: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Gabapentin is used to treat seizures and nerve pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a694007.html

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 49369 Based on staff interview, facility document review, and clinical record review, the staff failed to provide trauma informed care for one of 41 resident in the survey sample, Resident #5. The findings include: For Resident #5, the facility staff failed to provide informed care for a resident with PTSD (post traumatic disorder) (1). On the most recent MDS (minimum data set) an annual assessment with an ARD (assessment reference date) of 9/28/23, R5 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status). He was admitted to the facility with diagnoses including anxiety disorder, depression and PTSD. A review of the social service assessments dated 5/1/23 and 5/11/23 revealed no information related to PTSD. A review of the Trauma Screen assessments dated 7/24/23 and 7/25/23 revealed no information related to PTSD and were not fully completed. A review of care plan dated 5/11/23 revealed no information related to PTSD interventions and accommodations. On 11/29/23 at 3:45 p.m., OSM (Other Staff Member) #5, the director of social services, was interviewed. She stated that their process for admitting someone with PTSD includes the facility staff looking for any behaviors and symptoms that indicate PTSD. She states that they would then care plan for any mood or behaviors that were exhibited. She also added that she had been employed at the facility for only 5 months. She could not explain why there was no documentation prior to survey entrance. She stated that since R5 has PTSD and the facility should have provided services and trauma informed care. A review of the facility policy, Trauma Informed Care revealed in part, The interdisciplinary team will be trained on screening tools, assessments that collect data regarding potential of the resident's having experienced trauma, and hot to identify triggers associated with re-traumatization. Such information may be obtained from interview with the resident/ resident representative or review of medical record: a. as part of the comprehensive assessment, b. as part of the resident's social history . Staff are guided in evidence-based organizational and interpersonal strategies that support trauma informed care .The interdisciplinary team will make referrals to the attending practitioner as needed for mental health services. On 11/29/23 at 2:50 p.m , ASM (administrative staff member) #1, the administrator; ASM#2, the director of nursing; and ASM#3 the regional director of operations were informed of these concerns. No further information was provided prior to exit. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event. This information was taken from the website https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 49369 Based on, staff interview and facility document review, and clinical record review, the facility staff failed to provide medically related social services for one of 41 residents in the survey sample, Resident #5. The findings include: For Resident#5 (R5), who had a diagnosis of PTSD (post traumatic stress disorder) (1), the facility social worker failed to follow up on a recommendation for counseling services. There was no evidence of any kind of recommendation for counseling services. On the most recent MDS (minimum data set) an annual assessment with an ARD (assessment reference date) of 9/28/23, R5 was coded as being moderately impaired for making daily decisions, having scored 10 out of 15 on the BIMS (brief interview for mental status). He was admitted to the facility with diagnoses including anxiety disorder, depression and PTSD. A review of the social service assessments dated 5/1/23 and 5/11/23 revealed no information related to PTSD. A review of the Trauma Screen assessments dated 7/24/23 and 7/25/23 revealed no information related to PTSD and was not fully completed. A review of care plan dated 5/11/23 revealed no information related to PTSD interventions and accommodations. On 11/29/23 at 3:45 p.m., OSM (Other Staff Member) #5, the director of social services, was interviewed. She stated that their process for admitting someone with PTSD includes them looking for any behaviors and symptoms that indicate PTSD. She stated that they would then care plan for any mood or behaviors that were exhibited. She also added that she had been employed at the facility for only 5 months. She could not explain why there was no documentation prior to survey entrance. She stated that since R5 has PTSD the facility should have provided services. On 11/29/23 at 2:50 p.m , ASM (administrative staff member) #1, the administrator; ASM#2, the director of nursing; and ASM#3 the regional director of operations were informed of these concerns. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's job description for the social services director revealed, in part: Works with the resident, family, and other members of the health care team to formulate a discharge plan that provides the resident services in the appropriate post-acute setting. Gathers and assesses information regarding the resident's physical needs, mental status, family support system, financial resources, and available community and governmental resources. Employs assessment to develop comprehensive case management plan that will address the needs identified .Determines specific objectives, goals, and measures that are designed to meet the client's needs that have been identified through assessment. The plan will be action-oriented and time-specific including collaboration with utilization management to manage length of stay .Performs a variety of services for meeting the psychosocial needs of residents and their families such as assisting with initial adjustment and subsequent changes, crisis management, providing financial counseling and assistance and coordinating in house room transfers. A review of the facility policy, Trauma Informed Care revealed in part, The interdisciplinary team will be trained on screening tools, assessments that collect data regarding potential of the resident's having experienced trauma, and hot to identify triggers associated with re-traumatization. Such information may be obtained from interview with the resident/ resident representative or review of medical record: a. as part of the comprehensive assessment, b. as part of the resident's social history . Staff are guided in evidence-based organizational and interpersonal strategies that support trauma informed care .The interdisciplinary team will make referrals to the attending practitioner as needed for mental health services. No further information was provided prior to exit. References: 1. Post-traumatic stress disorder (PTSD) is a disorder that develops in some people who have experienced a shocking, scary, or dangerous event. This information was taken from the website https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32642 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure medications were available for administration for one of seven residents in the medication administration observation, Resident #198. The findings include: For Resident #198 (R198), the facility staff failed to reorder Aspirin and Multivitamins from the pharmacy in a timely manner, resulting in the resident missing a dose of both medications on 11/28/23. On 11/28/23 at 9:10 a.m., LPN (licensed practical nurse) #5 was observed preparing medications for administration to R198. LPN #5 handed two medication cards to the surveyor, and stated: These are not available. I will have to request a refill from the pharmacy. They will be here tomorrow. The two cards were for Aspirin 81 mgs (milligrams) and a Multivitamin. Neither card had any remaining medications. LPN #5 did not check for the availability of these two medications anywhere in the building, and did not administer Aspirin or a Multivitamin to R198. A review of R198's orders revealed an order for Aspirin 81 mgs and a Multivitamin to be given daily. A review of R198's December 2023 MAR (medication administration record) revealed a 13 in the box for the Aspirin and Multivitamin on 11/28/23. According to the MAR code key, a 13 means the medication was not administered because it was not available from the pharmacy. A review of the medications available in the facility's always-available (back up) supply did not reveal evidence that Aspirin or Multivitamins were available from that supply. On 11/30/23 at 9:53 a.m., LPN #4 was interviewed. She stated medications provided by the pharmacy should always be available for administration to residents. She stated the medications should be reordered from the pharmacy when there are only three or four left on a medication card. She stated neither Aspirin nor Multivitamins are available in the facility's back up medication supply or in facility stock medication bottles. On 11/30/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. ASM #2 stated both Aspirin and Multivitamins are both available in stock bottles on each medication cart. On 11/30/23 at 4:04 p.m., LPN #7 was asked to show all of the stock bottles in the medication cart for R198. There were no Aspirin or Multivitamins available in a stock bottle. LPN #7 stated both Aspirin and Multivitamins come on a card from the pharmacy, and are not available in the back up medication supply or in the med carts in stock bottles. She stated pharmacy-supplied medications should be reordered when there are five remaining medications on the card. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Medications Not Available, revealed, in part: Search the medication cart - look in all drawers; look to see if medication has mistakenly been taken out of the package .b. Look in all possible medication storage areas [i.e., med room]; look on all nursing units if resident has had recent medication change .Review medication list for meds available in on-site medication dispensing machine .Call the pharmacy for a refill - do not assume that someone else has done it. Ask the pharmacy if the medication or supply had been sent to the facility. No further information was provided prior to exit.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 32642 Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to administer medications at an error rate of less than five percent for one of seven residents in the medication administration observation, Resident #198. The findings include: For Resident #198 (R198), the facility failed to administer Aspirin and a Multivitamin as ordered by the physician during the medication administration observation on 11/28/23, resulting in two errors out of 34 total opportunities. The medication administration error rate was 5.88%. On 11/28/23 at 9:10 a.m., LPN (licensed practical nurse) #5 was observed preparing medications for administration to R198. LPN #5 handed two medication cards to the surveyor, and stated: These are not available. I will have to request a refill from the pharmacy. They will be here tomorrow. The two cards were for Aspirin 81 mgs (milligrams) and a Multivitamin. Neither card had any remaining medications. LPN #5 did not check for the availability of these two medications anywhere in the building, and did not administer Aspirin or a Multivitamin to R198. A review of R198's orders revealed an order for Aspirin 81 mgs and a Multivitamin to be given daily. A review of R198's December 2023 MAR (medication administration record) revealed a 13 in the box for the Aspirin and Multivitamin on 11/28/23. According to the MAR code key, a 13 means the medication was not administered because it was not available from the pharmacy. On 11/30/23 at 9:53 a.m., LPN #4 was interviewed. She stated medications provided by the pharmacy should always be available for administration to residents. She stated the medications should be reordered from the pharmacy when there are only three or four left on a medication card. She stated neither Aspirin nor Multivitamins are available in the facility's back up medication supply or in facility stock medication bottles. On 11/30/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. ASM #2 stated both Aspirin and Multivitamins are both available in stock bottles on each medication cart. On 11/30/23 at 4:04 p.m., LPN #7 was asked to show all of the stock bottles in the medication cart for R198. There were no Aspirin or Multivitamins available in a stock bottle. LPN #7 stated both Aspirin and Multivitamins come on a card from the pharmacy, and are not available in the back up medication supply or in the med carts in stock bottles. She stated pharmacy-supplied medications should be reordered when there are five remaining medications on the card. No further information was provided prior to exit.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31753 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to prepare and serve food and liquids to residents with orders for modified consistency diets for two of 41 residents in the survey sample, Residents #80 and #8. For Resident #8, the facility staff failed to serve pureed foods as ordered by the physician. For Resident #80, the facility staff served the incorrect food and fluid consistency which resulted in Resident #80 coughing and a nosebleed. The facility's deficient practice placed the resident at risk of infection, lack of oxygen to the brain, or death. This resulted in a determination of Immediate Jeopardy (IJ). After Immediate Jeopardy was removed, the scope and severity was lowered to a level 2 isolated. The findings include: 1. For Resident #80 (R80), the facility staff failed to serve food and liquid to the resident per the physician prescribed orders. R80 who had physician orders for pureed food and honey thick liquids was served a regular meal with thin liquids. The resident presented with coughing and a nosebleed after eating bites of regular oatmeal and thin milk. R80 was admitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty swallowing food or liquid). A review of R80's clinical record revealed a physician's order dated 9/14/23 for a regular diet with a dysphagia pureed texture, honey/moderately thickened liquids, and pleasure feeds as tolerated. R80's comprehensive care plan created on 9/18/23 documented, Regular diet, Dysphagia Puree texture, Honey/Moderately Thick consistency, for Nutrition PLEASURE FEEDS AS TOLERATED . A speech therapy evaluation dated 10/12/23 documented, Patient presents with severe aphasia (a comprehension and communication disorder) and dysphagia, following a stroke which necessitates skilled SLP (speech language pathology) services for dysphagia to reduce signs and symptoms of aspiration .What modified liquid is recommended for the patient to swallow safely? = Moderately thick. What modified diet is recommended for the patient to swallow solids safely? = Pureed . On 11/29/23 at 8:24 a.m., CNA (certified nursing assistant) #7 served R80 the resident's roommate's meal tray. The meal ticket on the tray contained the roommate's name and documented a regular diet. The meal tray contained a regular biscuit with sausage gravy, shredded hash browns, oatmeal, and a carton of thin consistency milk. CNA #7 opened the milk carton and poured some of the milk on the oatmeal, lifted the lid off the plate, and left the room. R80 fed herself one bite of the oatmeal mixture and began to cough. R80 fed herself a second bite of oatmeal mixture, coughed and tried to clear her throat. She took a sip of honey thick water, which was on her over bed table. Her nose began to bleed. CNA #8 and OSM (other staff member) #4 (the speech therapist) entered the room. CNA #8 and OSM #4 recognized R80 had been served her roommate's meal tray. OSM #4 removed the meal tray. On 11/29/23 at 10:00 a.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing), and ASM #4 (the regional minimum data set coordinator) were notified of Immediate Jeopardy (IJ). (continued on next page)

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F 0805

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

On 11/29/23 at 1:15 p.m., an interview was conducted with CNA #7. CNA #7 stated she identifies residents by looking at their wristbands but if they don't have a wristband then she looks at the names on the door. CNA #7 stated that this was her first day working at the facility, so she was paired with CNA #8. CNA #7 stated she has served meal trays a million times so when the trays arrived on the unit, she asked CNA #8 if she wanted her to start serving trays. CNA #7 stated she thought someone was going to assist her, but CNA #8 told her to go ahead and begin. CNA #7 stated that while she was serving trays, CNA #8 came to her and told her she accidentally gave the wrong tray to R80. CNA #7 stated she was unaware that the top name on the room name plate was the resident by the window and the bottom number on the room name plate was the resident by the door. CNA #7 stated that after she served the wrong tray to R80, CNA #8 told her the room numbers are posted on the light fixtures above the residents' beds so she should always look at that.

On 11/29/23 at 1:25 p.m., an interview was conducted with CNA #8. CNA #8 stated that when serving meal trays, CNAs should compare the room numbers on the meal tray tickets with the room numbers that are posted on the light fixtures above residents' beds. CNA #8 stated CNA #7 wanted to pass meal trays by herself, so she told her twice that she had to compare the meal tray tickets to the room numbers on the light fixtures. CNA #8 stated that earlier this morning, she and OSM #4 noticed R80 had a nosebleed, so they entered the room and OSM #4 realized R80 had been served the roommate's meal tray. CNA #8 stated OSM #4 removed the meal tray, and she (CNA #8) notified the nursing management team.

On 11/30/23 at 9:21 a.m., an interview was conducted with OSM #4. OSM #4 stated R80 came to the facility from Florida with a feeding tube and has orders for pleasure feeds with pureed food and honey thick liquids. OSM #4 stated the potential risks of R80 eating regular food and thin liquids includes aspiration with food and drink going into the lungs instead of the stomach. OSM #4 stated that 11/29/23 was CNA #7's first day so staff told her to look at the room numbers on the light fixtures in the rooms to identify the appropriate patients. OSM #4 stated that on 11/29/23, she was in a room across the hall from R80 and she saw R80 eating so she went over to R80 and saw the resident had received the wrong tray. OSM #4 stated she removed the tray and educated CNA #7.

The facility policy titled, Food and Fluid Tray Identification and Service documented, POLICY: Appropriate identification/coding shall be used to identify and appropriate serve various diets and fluids. SPECIFIC PROCEDURES/ REQUIREMENTS:

1. To assist in setting up and serving the correct food trays/diets to residents, the Food Services Department will use appropriate computer generated identification diet cards to specify the resident specific ordered diets/fluids, name and room number.

2. The Food Services staff will check trays and/ or prepared meals for correct diets before they are provided to the resident.

3. Nursing staff or person assisting to deliver the meal to the resident, will check foods/fluids, name, room number for the correct diet and resident before serving the resident.

4. If there is an error, dietary Department and nursing supervisor will be immediately notified so that the appropriate food/fluid items can be served to the appropriate resident.

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility document titled, Bed Identification System documented, Each semi-private room has two numbers outside the room door. The room number on top is the resident bed by the window. The room number on the bottom is the resident bed by the door. For example, room [ROOM NUMBER] is the bed by the window. room [ROOM NUMBER] is the bed by the door. The facility presented the following IJ removal plan which was accepted on 11/29/23 at 5:30 p.m. Date: 11/29/23 ISSUE/CONCERN: F805- The facility staff failed to prepare and serve food and liquids to a resident prescribed a pureed diet and honey thick liquids. The wrong texture of diet and consistency of liquids was served to Resident #80. This resulted in a choking incident for this resident. Goals/Objectives/Expected Outcome: It is the policy of the facility to ensure that residents are protected from the likelihood of choking or aspirating from receiving the incorrect consistency of food or liquid. Action(s) Planned. 1. Correction for identified resident/system (if applicable) 2. How you will identify other potential residents and correct for them if needed? 3. System changes; what are you going to do differently to minimize recurrence? 4. Monitoring- explain how you will monitor that the plan and system changes are successful; include QA Committee oversight. 5. Add/modify tasks and plan as needed. CORRECTION: The resident's tray was immediately removed. The Nurse Practitioner and Speech Therapist were onsite and addressed the resident. Care was provided to address the resident's nose bleed until it was resolved. The resident will continue to be monitored by licensed nurses and the provider and responsible party will be notified of any changes in the resident's condition. OTHER POTENTIAL: Other residents with practitioner's ordered altered textured diets and thickened liquids are at risk for the deficient practice. Residents who had orders for altered textured diets and liquids were observed during tray pass. There were no discrepancies noted. SYSTEM CHANGES: List each action separately. -Dietary staff currently on duty have been trained on the proper preparation of pureed diets. Staff members will validate receiving and understanding the training. Dietary staff not present for this training will be trained at their next scheduled day of work, they will not prepare or fill trays until training has been completed. Dietary staff will audit each tray for proper diet order prior to leaving kitchen. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Loudoun Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 235 Old Waterford Road, Northwest Leesburg, VA 20176	

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Clinical staff on duty have been training on proper tray identification and resident identification to ensure residents are served the appropriate diet and fluids. Staff members will validate receiving and understanding the training. Clinical staff not present for this training will be training at their next scheduled shift/day of work, they will not deliver or provide food or fluids to residents until training has been completed. -Current staff on duty have been trained on resident bed/room identification. Staff members will validate receiving and understanding the training. Other staff not present for this training will be trained at their next scheduled shift/day of work, they will not deliver or provide food or fluids to residents until training has been completed. -The Food Service Department will continue to use computer generated tray cards to specify the resident's prescribed diet and fluid orders. -The Food Service Department will continue to validate that the proper diet/fluid are provided on the tray according to the meal ticket during the preparation of the tray in the kitchen. -Nursing staff or persons assisting to deliver the meals to the residents, will check foods/fluids, resident name, room number for the correct diet and fluids before serving the resident. -The resident room/bed number has been placed above each bed to indicate the correct resident with the corresponding number. MONITORING/QA OVERSIGHT: -The Dietary Manager/designee will monitor 10% of resident meal trays for each meal x 1 week and then 10% for one meal each day x 3 weeks for meal consistency and fluid accuracy. Any discrepancies noted will be corrected immediately and staff re-educated and/or disciplined as necessary. -The Speech Therapist, licensed nurse, or facility leadership will monitor 100% of pureed and/or thickened liquid meal trays for each meal x 1 week then 10% for one meal each day x 3 weeks for meal consistency and fluid accuracy. Any discrepancies noted will be corrected immediately and staff re-educated and/or disciplined as necessary. All the above audits will be provided weekly to the administrator for review and oversight. An analysis of the audits will be presented to the QAPI committee for additional oversite and input. Compliance Date: 11/30/23 11:50 a.m. On 11/30/23 at 3:30 p.m., the survey team, through observations, interviews, and documentation review, verified the removal plan had been fully implemented by the facility. On 11/30/23 at 3:33 p.m., ASM #1, ASM #2, ASM #3 (the regional director of operations) were informed the removal plan had been verified and the IJ had been abated. 42183 (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. For Resident #8 , the facility staff failed to serve pureed foods as ordered by the physician. The supper tray was observed to include textured rotisserie chicken and lima beans, bread, cheesy mashed potatoes, and vanilla ice cream. Resident #8 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: dysphagia, oropharyngeal phase, Parkinson's disease and diabetes. The most recent MDS (minimum data set) assessment, a quarterly Medicare assessment, with an ARD (assessment reference date) of 11/6/23, coded the resident as scoring a 08 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was moderately cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring supervision for eating. MDS Section K0520. Nutritional Approaches: C. Mechanically altered diet - require change in texture of food or liquids (e.g. , pureed food, thickened liquids)-yes. D. Therapeutic diet (e.g., low salt, diabetic, low cholesterol)-yes. A review of the comprehensive care plan dated 7/12/23, which revealed, FOCUS: The resident has nutritional problem or potential nutritional problem related to altered diet texture; Parkinson's, diabetes, dysphagia, long term care resident. INTERVENTIONS: Provide, serve diet as ordered. Monitor intake and record every meal. Gluten Free diet, Dysphagia Puree texture, Regular/Thin consistency. A review of the physician's orders dated 7/10/23, revealed, Consistent Carbohydrate Diet, Dysphagia Puree texture, Regular/Thin consistency. On 11/28/23 at 12:52 p.m., the food on a test tray was sampled by two surveyors. OSM (other staff member) #1, the dining services district manager, was present for the sampling. The pureed meat did not have a smooth appearance; it contained identifiable pieces/chunks of hamburger OSM #1 stated the pureed meat looked a little like pudding, but with small chunks of meat present. He stated: When you bite into it, it has small chunks of meat. He added: I don't have the equipment in this building to puree food to the consistency it needs to be. I have requested a [commercial grade food processor]. On 11/28/23 at 1:05 p.m., OSM #4, a speech therapist, observed and tasted the pureed meat on the test tray. She stated: It's more of a mechanical soft consistency. Some of it is pureed, but it has chunks of meat. She stated this pureed meat was not safe to serve to residents with orders for a pureed diet. She stated if those at risk residents ate this meat, they were at risk for aspirating and choking. She stated this meat could also leave residue in their mouths and the residents could choke later. She stated: It is a safety hazard. It is not appropriate for someone on a pureed diet. On 11/28/23 at 4:45 p.m., OSM #1 stated: The [commercial grade food processor] has been ordered and will be here tomorrow. I haven't had the right equipment since I started this job. A review of a purchase order dated 11/27/23 at 6:00 p.m. revealed a commercial grade food processor was on order for the facility. An interview was conducted on 11/28/23 at 4:50 PM with Resident #8. When asked if he receives a pureed diet, Resident #8 stated, they do. When asked if the food was of a smooth consistency, Resident #8 stated it was not. When asked if he had choked or coughed while eating any of his pureed meals, Resident #8 stated they had not. (continued on next page)

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	An interview was conducted on 11/28/23 at 5:45 PM with CNA (certified nursing assistant) #5, after Resident #8 was served their supper tray which was observed not to be pureed. When shown Resident #8's tray and when asked if it was pureed, CNA #5 stated, No, this is not the smooth consistency and texture that pureed food should be. An interview was conducted on 11/30/23 at 9:30 AM with OSM (other staff member) #4, the speech language pathologist. When asked the purpose of a pureed diet, OSM #4 stated, the purpose is to help residents with dysphagia to not aspirate. When asked the signs of aspiration, OSM #4 stated, throat clearing, coughing, double swallows and a wet vocal quality. When asked the texture of a pureed diet, OSM #4 stated, pureed diet is smooth and with no chunks. On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. A review of the facility's policy Therapeutic Diet revealed, Mechanically Altered Diet: means one in which the texture of a diet is altered. When the texture is modified, the type of texture modification must be specific and part of the physicians' or delegated registered or licensed dietitian order. A review of the facility's policy Specialized Diets revealed, Dietary precautions, including use of therapeutic and mechanically altered diets will be communicated to the interdisciplinary team. Diet orders will be communicated to the dietary department. Dietary orders, including restrictions and precautions will be documented in the resident's medical record, examples may include: Medication Administration Record, Special Instructions, Tasks for CNAs, Kardex, Dietary restrictions, precautions will be included in the resident's comprehensive plan of care. Meals will be prepared and served according to the prescribed diet. A menu card or tool that includes the diet order, any restrictions, precautions, and resident preferences/dislikes will be used by staff preparing and delivering the food to the resident. No further information was provided prior to exit.

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F 0812

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.

32642

Based on observation, staff interview, and facility document review, the facility staff failed to prepare, store, and serve food in a sanitary manner in one of one facility kitchens.

The findings include:

The initial kitchen tour and follow up observation on 11/28/23 revealed concerns with food storage, preparation, and service in a sanitary manner.

On 11/28/23 at 7:52 a.m., initial observation of the kitchen occurred. All three compartments of the three compartment sink contained a moderate amount of loose debris and a small amount of grease residue. OSM (other staff member) #7, the dietary manger, stated: I agree. The sink could be cleaner.

The plate warmer contained loose debris and a large amount of crumbs around the plate. Additionally, a buildup of grease/dirt was observed in the ledge surrounding the plate. OSM #7 stated the plate warmer needed to be cleaned.

The standing food warmer contained a moderate amount of crumbs and loose black debris, as well as patches of grease build up. The handles were sticky. OSM #7 stated: It's not so great with cleanliness.

The stove contained a large amount of crumbs and loose black debris, as well as patches of grease build up.

The walk in freezer contained a three pound bag of frozen broccoli and a bag of cookies. Both bags were opened, but not labeled.

The floor of the walk in refrigerator was littered with food peelings and trash.

The dry storage area contained a large bag of cereal that was split lengthwise, and flakes of the cereal littered the shelves underneath and the floor. The bag was unlabeled.

On 11/28/23 at 11:39 a.m., the floor of the walk in refrigerator remained unchanged from the earlier observation.

On 11/28/23 at 1:18 p.m., OSM #13, a dietary aide, was observed loading the dishwasher. The observed wash temperature was 140 degrees Fahrenheit. The maximum wash temperature of the next load of dishes was 159. The final rinse temperature ranged between 116 and 140 for both loads of dishes. OSM #13 was asked what temperatures the machine needed to reach during the wash and rinse cycles to effectively wash and sanitize the dishes. He stated: I don't know who has that knowledge. Maybe other people. Not me. OSM #1, the regional dining services director stated: I will put out a service call. It is not functioning like it should be. When asked why the dishwasher was being used when the temperatures were not sufficiently high enough to be effective, he stated: I will need to find out.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/30/23 at 2:50 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. A review of the facility policy, Dishwashing Machine Use, revealed, in part: Food Service staff required to operate the dishwashing machine will be trained in all steps of dishwashing machine use by the supervisor or a designee proficient in all aspects of proper use and sanitation .Dishwashing machines that use hot water to sanitize will maintain the following wash solution temperatures: a. 150 F for stationary rack, dual temperature machines or multi-tank, conveyor, multi-temperature machines. b. 160 F for single tank, conveyor, dual temperature machines. c. 165 F for stationary rack, single temperature machines . 7. The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log. The operator will monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately. A review of the facility policy, Refrigerators and Freezers, revealed, in part: 7. All food will be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. a. Use by dates may be completed with expiration dates on all prepared food in refrigerators. b. Expiration dates on unopened food will be observed and use by dates indicated once food is opened . 10. Refrigerators and freezers will be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary. No further information was provided prior to exit.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 27660 Based on staff interview, resident interview, clinical record review and facility document review, the facility staff failed failed to maintain an effective infection control tracking system; failed to maintain an effective infection control program for five of 41 residents in the survey sample, Residents #49 #24, #15, #86, #76 ; and failed to store linens in a sanitary manner, for one of one linen carts. The findings include: 1. The facility staff failed to maintain complete infection control tracking. The March, May, June 2023 tracking logs documented the number of the following infections: UTI (urinary tract infections) Pneumonia Wound Gastrointestinal Clostridium Difficile Cellulitis Osteomyelitis Surgical Other infections. Attached to this tracking log were the list of antibiotics prescribed. There was no documentation of onset date of the infection, no diagnostic (x-ray or laboratory) results. No tracking of where the infections were in the facility. There was no infection tracking log for April 2023. What was presented was the vaccination status of residents, but no infection tracking. The tracking logs for July and August 2023, failed to evidence documentation of the onset date or diagnostic results. Again, it just listed the antibiotics prescribed. The September and October 2023 infection tracking logs failed to evidence in the designated columns, the onset date, laboratory test results, signs, and symptoms, whether it was healthcare-associated infections. Again, only antibiotics were documented when prescribed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted with ASM #2, the director of nursing, on 12/1/2023 at 10:18 a.m. When asked the process for tracking infections, ASM #2 stated she gets the names of residents with signs and symptoms of infections in morning clinical meeting. The staff talk to the nurse practitioner. ASM #2 stated she tracks the use of antibiotics. She stated she has only worked on the September and October tracking logs. She reviewed the logs for these two months and stated, yes there is a column for symptoms or onset date and a column for diagnostics. She further stated she uses the census sheet to track infection areas, trends and to see if any are the same organism. Then she completes education where needed. The facility policy, Infection Surveillance documented in part, Data collection and recording: Identifying information (resident's name, age, room number, unit and attending physician); diagnosis; admitted , date of onset of infection (may list onset of symptoms, if known, or date of positive diagnostic test); Infection site (be specific as possible); pathogens, invasive procedures or risk factors (surgery indwelling tubes, Foley, fractured hip, malnutrition, altered mental status); Pertinent remarks (additional relevant information, temperature, other symptoms of specific infection, white blood cell count) Also, record if the resident is admitted to the hospital or expires. Treatment measures and precautions. ASM #1, the administrator and ASM #2 were made aware of the above concern on 12/1/2023 at 10:09 a.m. No further information was provided prior to exit. 2. For Resident #49 (R49), the facility staff failed to store an indwelling urinary drainage collection bag in a sanitary manner. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/21/2023, the resident scored a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is not cognitively impaired for making daily decisions. In Section H - Bladder and Bowel, the resident was coded as having an indwelling urinary catheter. Observation was made on 11/28/2023 at 3:54 p.m. R49 was in bed. The urinary drainage collection bag was lying flat on the floor. R49 was asked if she has had any urinary tract infections, she replied that she has only had one and that was quite a while ago. An interview was conducted with CNA (certified nursing assistant) #12 on 11/29/2023 at 3:55 p.m. When asked if a resident has an indwelling catheter, where is the drainage collection bag stores, CNA #12 stated it should be below the resident and she usually hooks it to the bed frame. CNA #12 was asked if it should be lying on the floor, CNA #12 stated, no, it shouldn't be on the floor. An interview was conducted with LPN (licensed practical nurse) #2, on 11/29/2023 at 4:03 p.m. When asked where an indwelling catheter drainage collection bag should be stored, LPN #2 stated, below the resident, on the bedframe. LPN #2 was asked if it should be lying on the floor, LPN #2 stated no. The facility policy, Urinary Catheter Care, documented in part, b. Be sure the catheter tubing and drainage bag are kept off the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit. 42183 3. The facility staff failed to follow infection control practices for Resident #24. The blood glucose (BG) glucometer was not cleaned prior to use on Resident #24's during the medication administration observation. A review of the physician orders dated 6/29/23 revealed, Blood Sugar Check in AM . On 11/28/23 at 7:45 AM during the medication administration, LPN (licensed practical nurse) #1 was observed using the glucometer machine on Resident #24 without first cleaning it. On 11/28/23 at 8:30 AM an interview was conducted with LPN #1. When asked the process to clean the glucometer, LPN #1 stated, It should have been cleaned before the first use and then between the residents. I did not do that and I always clean it. Resident #24 did not have any bloodborne pathogens. On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. According to the facility policy, Cleaning and Use of Resident Point of Care Devices (Blood Glucose Meters) which revealed, The facility will maintain processes to prevent the spread of infection and disease and to ensure that Point of Care Devices are utilized safely when used on multiple residents by properly cleaning the devices between each resident. When point of care devices [such as blood glucose meters or prothrombin time devices] are shared for multiple residents, the device will be cleaned and disinfected before and after each resident use by licensed staff following facility protocol and/or manufacturer's guidelines. No further information was provided prior to exit. 4. The facility staff failed to follow infection control practices for Resident #15. The blood glucose (BG) glucometer was not cleaned prior to use on Resident #15's during the medication administration observation. A review of the physician orders dated 7/27/23 revealed, Finger stick blood sugar ac &hs QID (before meals and at bedtime four times a day) for Diabetes Monitor. On 11/28/23 at 7:45 AM during the medication administration, LPN (licensed practical nurse) #1 was observed using the glucometer machine without first cleaning it on Resident #15. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/28/23 at 8:30 AM an interview was conducted with LPN #1. When asked the process to clean the glucometer, LPN #1 stated, It should have been cleaned before the first use and then between the residents. I did not do that and I always clean it. Resident #15 did not have any bloodborne pathogens. On 11/30/23 at 1:30 PM, ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the Regional Director of Operations and ASM #4, the Regional Director of MDS were made aware of the finding. According to the facility policy, Cleaning and Use of Resident Point of Care Devices (Blood Glucose Meters) which revealed, The facility will maintain processes to prevent the spread of infection and disease and to ensure that Point of Care Devices are utilized safely when used on multiple residents by properly cleaning the devices between each resident. When point of care devices [such as blood glucose meters or prothrombin time devices] are shared for multiple residents, the device will be cleaned and disinfected before and after each resident use by licensed staff following facility protocol and/or manufacturer's guidelines. No further information was provided prior to exit. 32642 5. For Resident #86 (R86), the facility staff failed to follow infection control procedures during the medication administration observation on 11/28/23. On 11/28/23 at 9:24 a.m., LPN (licensed practical nurse) #4 was observed preparing to administer medications to R86. LPN #4 was wearing gloves, and with her gloved hands, she touched the top of the medication cart, the computer, the medication cart handles, and multiple individual cards containing medications. As she punched each of the following medications for R86 from its medication card, the medication landed in her dirty gloved hand. She poured the medications from her hand into the medication cup: Midodrine 5 mg (milligrams) (used to regulate blood pressure), Lexapro 5mg (an antidepressant), and Potassium 20 mEq (milliequivalents) (an electrolyte necessary for heart function). R86 was observed taking each of these medications from the cup. On 11/30/23 at 9:53 a.m., LPN #4 was interviewed. When asked if she remembered punching R86's pills into her gloved hands before putting the pills into the medication cup, she stated she did. She stated: I know I shouldn't have done that. I should have punched the pills directly in the cup. She stated she knew her gloves were not clean, and her actions were a risk for the spread of infection. On 12/1/23 at 10:19 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit. 6. For Resident #76 (R76), the facility staff failed to follow infection control procedures during the medication administration observation on 11/28/23. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 11/28/23 at 9:33 a.m., LPN (licensed practical nurse) #4 was observed preparing to administer medications to R76. LPN #4 was wearing gloves, and with her gloved hands, she touched the top of the medication cart, the computer, the medication cart handles, and multiple individual cards containing medications. She placed her gloved right index finger inside a medication cup, and used this finger and her thumb to place the medication cup on the medication cart. She punched one Claritin D tablet from the medication card into this medication cup. The resident was observed to swallow the pill that was in this cup. On 11/30/23 at 9:53 a.m., LPN #4 was interviewed. When asked if she remembered placing her dirty gloved index finger inside R76's pill cup prior to putting the Claritin D in the cup. She stated she thought she remembered. She stated she knew her gloves were not clean, and her actions were a risk for the spread of infection. On 12/1/23 at 10:19 a.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit. 31753 7. The facility staff failed to store linens in a sanitary manner. On 11/28/23 at 7:52 a.m. and 9:26 a.m., observation of a clean linen cart in the basement hall was conducted. The linen cart contained clean towels, bed linens and gowns. The front cover of the cart was flipped up on top of the cart, exposing the clean linens to dust and contaminates. No staff was observed around the linen cart. On 11/30/23 at 9:52 a.m., an interview was conducted with OSM (other staff member) #8 (the environmental services supervisor). OSM #8 stated she receives clean linens in bins from an outside company then transfers the clean linens from the bins to a metal cart for transportation to the linen closets. OSM #8 stated the metal transportation cart should be completely covered to avoid contamination. OSM #8 stated she was loading the linen cart on 11/28/23 and must have been pulled away to do something else. OSM #8 stated she usually makes sure the linen cart is covered. On 11/30/23 at 3:13 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495275	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/01/2023
NAME OF PROVIDER OR SUPPLIER Loudoun Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 235 Old Waterford Road, Northwest Leesburg, VA 20176	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to offer a influenza vaccination and/or pneumococcal vaccination for two of five residents in the infection control task/review, Residents #48 and #72. The findings include: 1. For Resident #48, the facility staff failed to offer a pneumococcal vaccination. The clinical record was reviewed. Under the tab for immunizations, there was no documentation for a pneumococcal vaccination. Next to the pneumococcal vaccine it was documented, Consent Required. A request was made on 11/30/2023 at 5:00 p.m. for evidence of a pneumococcal vaccination administration or evidence that is was offered and declined. On 12/1/2023 at 8:45 a.m. ASM (administrative staff member) #2, the director of nursing, stated there was no documentation that it was given. The staff is pulling information from the state vaccination website. The staff need to verify if the resident needs it and if so, it will be offered. The facility policy, Pneumococcal Vaccine, documented in part, 1. Prior to or upon admission, resident will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. ASM #1, the administrator and ASM #2 were made aware of the above concern on 12/1/2023 at 10:09 a.m. No further information was provided prior to exit. 2. For Resident #72, the facility staff failed to offer an influenza vaccination for the current influenza season. The clinical record documented under the immunization tab that the last recorded influenza vaccination was dated 6/2/2022. A request was made on 11/30/2023 at 5:00 p.m. for evidence of a influenza vaccination administration or evidence that is was offered and declined. On 12/1/2023 at 8:45 a.m. ASM #2, she stated the resident did not get the influenza vaccine. Apparently, the staff asked her, and she declined, but I don't have any documentation related to it. ASM #2 stated the resident is discharging today and is getting it prior to discharge. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Influenza Vaccination, documented in part, All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccination against influenza . 1. Resident and employees of the long-term care facility will be offered the influenza vaccination upon initial admission to the nursing home in accordance with the guidelines set forth by the Center for Disease Control. ASM #1, the administrator and ASM #2 were made aware of the above concern on 12/1/2023 at 10:09 a.m. No further information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 27660 Based on observation, staff interview, facility document review, it was determined the facility staff failed to conduct regular bed inspections for four of 41 residents in the survey sample, Residents #63, #48, #9 and #7. The findings include: 1. For Resident #63, the facility staff failed to conduct regular bed inspections. Observation was made of Resident #63 on 11/28/2023 at approximately 9:00 a.m. Resident #63 was in bed with the bilateral side rails up in place. A copy of the bed inspections was requesting during the entrance conference on 11/28/2023 at 8:30 a.m. A book was presented on 11/28/2023 of the bed inspections. The last bed inspection was dated April 2022. A document dated 10/1/2022 through 9/30/2023 documented in part On-site repairs and preventative maintenance was performed. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 11/30/2023 at 9:24 a.m. When asked if the bed inspections have been completed since April 2022, ASM #1 stated the facility did not have any bed inspections since April 2022. They had a company come in and do general maintenance but there was no assessment for the risk of entrapment. The facility policy, Bedrail, Risk and Safety, documented in part, POLICY: This organization will take measures to develop and implement a strategy to minimize the possibility of resident entrapment and or injury while using bed rails. This will include an evaluation of residents who have a need for or desire to use bed rails and that may have characteristics that place them at special risk for entrapment. The evaluation will also include inspection of the bed, mattress, and bed rail for risk of entrapment. ASM #1, ASM #2, the director of nursing, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit. 2. For Resident #48, the facility staff failed to conduct regular bed inspections. Observation was made of Resident #48 on 11/28/2023 at approximately 8:50 a.m. Resident #48 was in bed with the bilateral side rails up in place. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A copy of the bed inspections was requesting during the entrance conference on 11/28/2023 at 8:30 a.m. A book was presented on 11/28/2023 of the bed inspections. The last bed inspection was dated April 2022. A document dated 10/1/2022 through 9/30/2023 documented in part On-site repairs and preventative maintenance was performed. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 11/30/2023 at 9:24 a.m. When asked if the bed inspections have been completed since April 2022, ASM #1 stated the facility did not have any bed inspections since April 2022. They had a company come in and do general maintenance but there was no assessment for the risk of entrapment. ASM #1, ASM #2, the director of nursing, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit. 3. For Resident #9, the facility staff failed to conduct regular bed inspections. Observation was made of Resident #9 on 11/28/2023 at approximately 9:20 a.m. Resident #9 was in bed with the bilateral padded side rails up in place. A copy of the bed inspections was requesting during the entrance conference on 11/28/2023 at 8:30 a.m. A book was presented on 11/28/2023 of the bed inspections. The last bed inspection was dated April 2022. A document dated 10/1/2022 through 9/30/2023 documented in part On-site repairs and preventative maintenance was performed. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 11/30/2023 at 9:24 a.m. When asked if the bed inspections have been completed since April 2022, ASM #1 stated the facility did not have any bed inspections since April 2022. They had a company come in and do general maintenance but there was no assessment for the risk of entrapment. ASM #1, ASM #2, the director of nursing, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit. 4. For Resident #7, the facility staff failed to conduct regular bed inspections. Observation was made of Resident #7 on 11/28/2023 at approximately 3:30 p.m. Resident #7 was in bed with the bilateral side rails up in place. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A copy of the bed inspections was requesting during the entrance conference on 11/28/2023 at 8:30 a.m. A book was presented on 11/28/2023 of the bed inspections. The last bed inspection was dated April 2022. A document dated 10/1/2022 through 9/30/2023 documented in part On-site repairs and preventative maintenance was performed. An interview was conducted with ASM (administrative staff member) #1, the administrator, on 11/30/2023 at 9:24 a.m. When asked if the bed inspections have been completed since April 2022, ASM #1 stated the facility did not have any bed inspections since April 2022. They had a company come in and do general maintenance but there was no assessment for the risk of entrapment. ASM #1, ASM #2, the director of nursing, and ASM #3, regional director of operations, were made aware of the above concern on 11/30/2023 at 2:49 p.m. No further information was provided prior to exit.