STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495276	A. Building B. Wing	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Walter Reed Nursing & Rehabilitation Center	7602 Meredith Drive Gloucester, VA 23061

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 49455 Based on observation, resident interview, staff interview, clinical record review, and review of facility documents, the facility's staff failed to assist the resident to obtain vision services for 1 of 45 residents (Resident #85), in the survey sample. The findings included: Resident #85 was originally admitted to the facility 11/16/23 after an acute care hospital stay. The current diagnoses included Macular Degeneration. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/5/2024 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #85 cognitive abilities for daily decision making were intact. In sections B.1000 the resident's vision was coded as two which represented moderately impaired, limited vision, and not able to see newspaper headlines but can identify objects and section B.1200 was coded zero, identified the resident did not utilize corrective lenses. The current care plan dated 8/13/2024 was initiated on 11/16/23 had a problem which read B1000.2 Vision: (name of resident) ability to see in adequate light was moderately impaired. The goal read, will maintain current level of function/activity without injury through the next review. The interventions included schedule eye exam for evaluation/management of vision and use large print for any item (the resident name) must read (signs, labels, menu). This care plan has not been revised since initiation for vision. An interview was conducted with Resident #85 on 08/20/24 at approximately 4:35 PM. The resident stated that she was unable to see my face, but she could see the outline of my body. The resident also stated that she could no longer view the television screen or read books which is a hobby. Resident #85 stated that she had not seen an eye doctor since admission to the facility and staff is aware of her low vision. On 8/20/24 an interview was conducted with Licensed Practical Nurse (LPN) #2 at approximately 4:50 PM. LPN #2 stated that she was aware of Resident #85's visual impairments but not aware of her limitations which included the inability to see faces and view the television. LPN #2 Further stated that she ensures that frequently used items are kept within reach. (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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was held with one of the facility's Social Workers (SW) on 8/21/24 at approximately 5:25 PM. The SW stated that Resident #85 was not on her primary case load, but based on her chart review she does not see where the resident had a vision appointment since admission. The SW confirmed this with the Administrator to be accurate. The SW further stated she would add Resident #85 to the list to be seen next month by SVS. The facility's policy titled person-centered baseline and comprehensive care plan, last reviewed on 11/14/22 indicated, the facility will review and revise residents care plans on a quarterly basis and as needed. The facility was unable to provide a policy on resident's vision care services but did provide an agreement from 2007 with Senior Vision Services (SVS). This agreement indicated SVS will provide primary vision care for the facility residents by request. On 8/22/24 at approximately 10:00 AM, the above findings were shared with the Administrator and Director of Nursing. An opportunity was offered to the facility's staff to present additional information, but no additional information was provided.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40711 Based on observation, staff interview, clinical record review, and review of facility documents, the facility's staff failed to ensure a leg strap was available to secure to a resident's leg to prevent the Foley (brand) catheter from dislodging or being pulled and the facility staff failed to date resident's Foley bag and Foley catheter for 1 of 45 residents (Resident #29), in the survey sample. The findings included: Resident #29 was originally admitted to the facility 02/22/2016 and readmitted [DATE] after an acute care hospital stay. The current diagnoses included; retention of urine. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 6/17/24 coded the resident as not having the ability to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long and short term memory problems as well as severely impaired for daily decision making. In sectionH(Bladder and Bowel) the resident was coded as having an indwelling catheter. The care plan dated 6/26/24 read that Resident #29 requires the use of an indwelling catheter. The goal for the resident was that urine elimination needs will be met through the use of the catheter through the next review. The intervention for the resident was to change catheter and bag per order to maintain patency and minimize infection. A review of the Physicians Order dated 11/26/22 read: ensure catheter is secured to the leg with appropriate device two times daily, days, evenings and as needed. A review of the Physicians Order dated 11/26/22 read: Gravity/leg drainage bag to be changed every two weeks and as needed. On 08/21/24 at approximately 3:01 PM., an observation was made of Resident #29 lying in her [NAME] (recliner) chair in the TV room. The resident's Foley bag was observed with no label affixed. On 8/21/24 at approximately 3:05 PM., an interview was conducted with Licensed Practical Nurse (LPN) #1 concerning the resident's Foley bag. LPN #1 said that she wasn't sure if the resident's Foley bag was dated but will take the resident to her room and check. Upon visual inspection, the foley bag had no label, the foley catheter observed laying on the side of the resident's left upper thigh unsecured. LPN #1 said that there should be a date and a strap to keep the foley in place. On 8/21/24 at approximately 3:30 PM., an interview was conducted with the Director of Nursing (DON) concerning the above issue. The DON said there should have been a strap to hold the catherter tubing in place. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/21/24 at approximately 3:50 PM., an interview was conducted with Certified Nursing Assistant #1. CNA #1 said that while showering the resident this morning, she noticed that the resident's leg strap was missing, but forgot to report it to the nurse. CNA #1 also said that the strap is important because it keeps the Foley cathere tubing from getting pulled. The importance of fixation and securing devices in supporting indwelling catheters: Health-care professionals follow recognized national guidelines to assess clinical reasons for the insertion of urinary catheters. However, the use of fixation and securing devices is an area that is often neglected. Health-care professionals sometimes employ a 'do-it-yourself' approach, using adhesive tape or Velcro strapping devices, neither of which are appropriate. If urinary catheters are not secured appropriately, they can lead to severe trauma of a patient's urethra, potential damage to bladder neck, infection and inflammation, pain and irritation, possible bypassing, accidental dislodging of a catheter and a cleaving (condition whereby the catheter splits the penile or labial tissues). This article identifies reasons for using securing/fixation devices and explains the advantages and disadvantages of the different types of devices in relation to individual patients. https://pubmed.ncbi.nlm.nih.gov/24335791/ On 8/22/24 at approximately 10:00 AM., the above findings were shared with the Administrator and Director of Nursing and Corporate Consultant. There were no further concerns voiced prior to the survey's exit.