STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495336	A. Building B. Wing	01/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Augusta Nursing & Rehab Center	83 Crossroads Lane Fishersville, VA 22939

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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49456 Based on staff interviews, facility document review, and closed record review, facility staff failed to follow physician's orders to obtain a physician ordered stat x-ray for one of three residents, Resident #3 (R3). The findings included: According to the clinical record review on 1/29/24, R3 was admitted to the facility on [DATE], with diagnosis that included fracture of first lumbar vertebrae, lower back pain, muscle weakness, abnormalities of gait and mobility, atrial fibrillation, and hypertension. According to a 5 day Scheduled Minimum Data Set, with an Assessment Reference Date of 1/1/24, R3 was assessed under Section C (Cognitive Patterns) as being cognitively intact with a summary score of 13 out of 15. According to the facility incident/accident committee minutes, R3 was trying to get out of bed on 12/30/23 at 12:30 a.m. and was found on the floor. According to the physician order dated 12/31/23, a stat x-ray of the ribs was ordered due to R3 presenting with pain and swelling to the right ribcage. According to the progress notes by the FNP (Family Nurse Practitioner) dated 1/3/24, R3 had a fall, landing on right side and complaining of increased pain to right rib area and middle area of right back. The FNP noted that the on-call provider was notified and ordered an x-ray, but given the holiday weekend this has not yet been completed. On 1/29/24 at 3:30 p.m., the Director of Nursing (DON) was interviewed and stated that the expectation that a stat x-ray should be obtained within 3 days but may take longer on holidays. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/29/24 at 3:45 p.m., the facility's Medical Director (MD) was interviewed. The MD stated that the expectation of a stat x-ray should generally be done within 48 hours but with a holiday weekend it may be longer. The MD stated that R3 was seen on 1/3/24 and complained mostly about right shoulder pain. The MD stated, It was unfortunate that the x-ray wasn't obtained but on the other hand fortunate because a CT scan was completed at the hospital . if the x-ray would have been completed at the facility the course of treatment wouldn't have changed. [R3] didn't need to go out to hospital for rib fractures and I wouldn't have ordered a CT [computed tomography] scan to be completed. When questioned further, the MD stated that R3 would have been treated in the facility with pain medications, rest, no coughing or laughing, to prevent pain and would hold therapy only if pain worsened. When questioned if the delay in treatment resulted in the fracture being deemed inoperable, the MD read the hospital report that the L1 fracture compression was worse and stated that it was deemed inoperable at the first fall R3 had, which was prior to coming to the facility, due to the scoliosis. The hospital records were reviewed to verify the information that was provided by the MD during the interview. On 1/30/24 at 9:54 a.m., licensed practical nurse (LPN #2) was interviewed about the process of ordering an x-ray. LPN #2 stated that the order is put in the computer and then they call the x-ray company to confirm the order. LPN #2 stated that the x-ray staff would come out same day or the next day for a stat order. On 1/30/24 at 10:11 a.m., a phone interview was conducted with the x-ray company staff (other staff, OS#4) regarding the availability of x-rays being obtained and if an order for R3 was received on 12/31/23. OS#4 stated that x-rays can be done 24 hours a day and 7 days a week. Stat orders are completed by first come, first served, and are made priority and usually completed same day or the next day. OS#4 stated that no order for R3 on 12/31/23 was showing up in their computer system. On 1/30/24 at 10:23 a.m., another phone call was placed to the x-ray company staff (other staff, OS#5). When questioned about when a stat x-ray would be completed, OS#5 stated that it depends on how many are received that day, but a stat x-ray would usually be completed in the same day. OS#5 also verbalized what OS#4 stated about no order is showing in the computer system for R3 to have a stat x-ray on 12/31/23. On 1/30/24 at 1:30 p.m., the DON was interviewed about why no follow up was done on the stat x-ray ordered. The DON stated, I don't have an answer to why it wasn't followed up on. The DON demonstrated how an x-ray order is put into the computer and stated the nurse who entered R3's order for the stat x-ray into the computer had left areas blank on the form. When questioned further, the DON stated that the incomplete order had not been transmitted to the x-ray company. On 1/30/24 at 2:21 p.m., an interview was conducted with the administrator. The administrator expressed concern that the x-ray was not done timely and was in the process of reviewing this concern. On 1/30/24 at 4:10 p.m., a meeting was held to discuss these findings with the Administrator, Director of Nursing, and the Regional Nurse Consultant. No other information was provided prior to exit conference.