STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495396	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage Hill Health & Rehab Center	6106 Health Center Lane Fredericksburg, VA 22407

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 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. Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for one of four residents in the survey sample, Resident #2. The findings include:For Resident #2 (R2), the facility staff failed to transcribe a physician's order for a treatment to the administration record. A review of R2's clinical record revealed a physician's order dated 5/2/25 that documented, Sacrum - cleanse wound with NS (Normal Saline), pat dry, and apply foam dressing. A review of R2's May 2025 MAR (medication administration record) and TAR (treatment administration record) failed to reveal the physician's order. On 11/19/25 at 11:07 a.m., ASM (Administrative Staff Member) #2 (the Director of Nursing) stated the nurse who entered the 5/2/25 physician's order for R2's treatment into the computer system did not click a schedule for the order so the order did not carry over to the TAR. On 11/19/25 at 12:10 p.m., an interview was conducted with LPN (Licensed Practical Nurse) #2. LPN #2 stated that when entering a physician's order into the computer system, nurses must click whether the order is a verbal order or telephone order, type in the doctor's name, type in the order, select if the order should transcribe onto the MAR or TAR, then select a schedule for the ordered treatment to be completed. LPN #2 stated if a schedule is not selected, the order will just sit in the system and not transcribe to the MAR or TAR. On 11/19/25 at 3:19 p.m. ASM #1 (the Administrator) and ASM #2 were made aware of the above concern. The facility policy titled, GUIDELINES FOR MEDICATION ORDERS documented, 4. Documentation of the Medication Order. a. If a physician or a nurse practitioner/physician assistant (prescriber) writes an order in the Facility, a nurse in the Facility transcribes or enters the complete order onto the medication or treatment administration record or electronic medical records system. No further information was presented prior to exit.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services for the treatment of a pressure injury for one of four residents in the survey sample, Resident #2. The findings include:For Resident #2 (R2), the facility staff failed to thoroughly assess a sacral pressure injury upon admission and failed to provide treatment for the sacral pressure injury 5/3/25 through 5/5/25. A review of R2's clinical record revealed a nursing admission assessment dated [DATE] that documented the resident presented with an open wound on the sacrum. No further descriptors were documented. A physician's order dated 5/2/25 documented, Sacrum - cleanse wound with NS (Normal Saline), pat dry, and apply foam dressing. A review of R2's May 2025 MAR (medication administration record) and TAR (treatment administration record) failed to reveal the physician's order. Further review of R2's clinical record (including the May 2025 MAR, TAR, nurses' notes, and assessments) failed to reveal treatment was provided for R2's sacral pressure injury on 5/3/25, 5/4/25, and 5/5/25. Daily skilled assessments dated 5/3/25, 5/4/25, and 5/5/25 documented, 12. Does the resident have impaired skin and/or a wound that is being monitored or treated? 2. No. A body audit dated 5/5/25 documented R2 presented with a stage three (pressure injury) (1) on the sacrum measuring 3.9 (centimeters in length) by 2.2 (centimeters in width). On 11/19/25 at 11:07 a.m., ASM (Administrative Staff Member) #2 (the Director of Nursing) stated the nurse who entered the 5/2/25 physician's order for R2's treatment into the computer system did not click a schedule for the order so the order did not carry over to the TAR. On 11/19/25 at 11:09 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #1. LPN #1 stated pressure injuries should be assessed on the same day as a resident's admission and the assessment should consist of a measurement, and a description of the color, smell, and drainage. On 11/19/25 at 12:10 p.m., an interview was conducted with LPN #2. LPN #2 stated dressing treatments that need to be done are communicated to nurses via the TAR and nurses evidence treatments are done by signing them off on the TAR. On 11/19/25 at 3:19 p.m. ASM #1 (the Administrator) and ASM #2 were made aware of the above concern. The facility policy titled, Documentation of Wound Treatments documented, 2. The following elements are documented as part of a complete wound assessment in tandem with the skin/wound app: a. Type of wound (pressure injury, surgical, etc.) and anatomical location. b. Stage of the wound, if pressure injury (stage 1, 2, 3, 4, deep tissue pressure injury, unstageable pressure injury) or the degree of skin loss if non-pressure (partial or full thickness). c. Measurements: height, width, depth, undermining, tunneling. d. Description of wound characteristics: i. Color of the wound bed, ii. Type of tissue in the wound bed (i.e., granulation, slough, eschar, epithelium), iii. Condition of the peri-wound skin (dry, intact, cracked, warm, inflamed, macerated), iv. Presence, amount, and characteristics of wound drainage/exudate, v. Presence or absence of odor, and vi. Presence or absence of pain. No further information was presented prior to exit. Reference:(1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device .Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar (dead skin tissue) may be visible. This information was obtained from the website: https://cdn.ymaws.com/npiap.com/resource/resmgr/online_store/npiap_pressure_injury_stages.pdf