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	12/12/2024

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to notify the provider of a need to assess a resident for one of eleven residents in the survey sample, Resident #10. The findings include: For Resident #10 (R10), the facility staff failed to notify the provider of a assess a resident identified as having a change in status on 7/31/24. A review of R10's clinical record revealed the following: 7/29/24 6:15 p.m. New Order O2 (oxygen) at 2 liters/min (per minute) via NC (nasal canula) prn (as needed) for SOB (shortness of breath). The resident received oxygen as ordered for her shortness of breath. 7/31/24 8:38 a.m .Pt (patient) noted to be quieter on this shift and appeared lethargic. Vitals wnl (within normal limits). Pt denies any discomfort but verbalized that she does not feel good. Pls (please) assess. The nurse who wrote this note was not available during the survey. A review of R10's clinical record failed to reveal notification of a provider of the need for an assessment of the resident, or reveal further physical assessment by another nurse or provider for more than 29 hours. On 8/1/24 at 1:25 p.m., R10 tested positive for COVID-19. On 12/12/24 at 12:01 a.m., ASM (administrative staff member) #3, a nurse practitioner, was interviewed. When asked her how often she is physically present in the facility, she stated either she or another NP (nurse practitioner) or physician is in the facility five days a week, and extending over most business hours. She stated she was unaware of any request to assess R10 until after the resident was diagnosed with COVID-19. She stated she assessed the resident in the afternoon on 8/2/24. She stated if she had been requested to assess the resident on 7/29/24, she would have done so. She stated sometimes nurses will verbally report this request, or will put the resident's name on a list to be seen by a provider. She stated she checks this list regularly throughout the day. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/12/24 at 1:59 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated if she felt a resident needed to be assessed for a physical status change, she would document it in a progress note, and document which provider she notified about the need. She stated she would also document the provider's response to her request. On 12/12/24 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were informed of these concerns. A review of the facility policy, Notification of Changes, revealed, in part: The purpose of this policy is to ensure the Center promptly informs the patient, consults the patient's physician/physician extender; and notifies .the patient's legal representative when there is a change requiring notification. No additional 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide care and services to promote the highest level of well-being for five of eleven residents in the survey sample, Residents #10, #4, #5, #6, and #2. The findings include: 1. For Resident #10 (R10), the facility staff failed to assess a resident identified as having a change in status on 7/31/24. A review of R10's clinical record revealed the following: 7/29/24 6:15 p.m. New Order O2 (oxygen) at 2 liters/min (per minute) via NC (nasal canula) prn (as needed) for SOB (shortness of breath). The resident received oxygen as ordered for her shortness of breath. 7/31/24 8:38 a.m .Pt (patient) noted to be quieter on this shift and appeared lethargic. Vitals wnl (within normal limits). Pt denies any discomfort but verbalized that she does not feel good. Pls (please) assess. The nurse who wrote this note was not available during the survey. Further review of R10's clinical record failed to reveal further physical assessment by another nurse or provider for more than 29 hours. On 8/1/24 at 1:25 p.m., R10 tested positive for COVID-19. On 12/12/24 at 12:01 a.m., ASM (administrative staff member) #3, a nurse practitioner, was interviewed. When asked her how often she is physically present in the facility, she stated either she or another NP (nurse practitioner) or physician is in the facility five days a week, and extending over most business hours. She stated she was unaware of any request to assess R10 until after the resident was diagnosed with COVID-19. She stated she assessed the resident in the afternoon on 8/2/24. On 12/12/24 at 1:59 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated if she felt a resident needed to be assessed for a physical status change, she would document it in a progress note, and document which provider she notified about the need. She stated she would also document the provider's response to her request. On 12/12/24 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were informed of these concerns. On 12/12/24 at 4:25 p.m., ASM #1 stated there was no facility policy regarding notifying a provider for the need of a physical assessment for a resident. No additional information was provided prior to exit. 2. For Resident #4 (R4), the facility staff failed to follow physician's orders to administer medications in a timely manner. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R4's medication administration records for August 2024 revealed she received the following medications late, resulting in a failure to follow the physician's orders: Mupirocin (an antibacterial ointment) ordered 8/8/24 at 8:00 a.m., given at 10:23 a.m.; ordered 8/9/24 at 12:00 noon, given at 2:03 p.m.; ordered 8/10/24 at 12:00 noon, given at 1:58 p.m.; ordered 8/9/24 at 8:00 p. m., given at 5:48 p.m. Apixaban (anticoagulant) ordered 8/0/24 at 4:00 p.m., given at 5:48 p.m. Tylenol ordered 8/9/24 at 9:00 p.m., given at 11:38 p.m. Cefdinir (antibiotic) ordered 8/9/24 at 4:00 p.m., given at 5:48 p.m.; ordered 8/10/24 at 4:00 a.m., given at 5:43 a.m. On 12/12/24 at 10:21 a.m., LPN (licensed practical nurse) #3, a unit manager, was interviewed. She stated to comply with a physician's order, a medication should be administered within 60 minutes before or after it is listed as due. She stated if a medication is given late, the nurse is not following the physician's order. On 12/12/24 at 1:56 p.m., LPN #2 was interviewed. She stated all medications should be given within an hour before or after the medication is due. She stated the physician's orders are not followed if the nurse is later than hour after the due time administering the medication. On 12/12/24 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were informed of these concerns. A review of the facility policy, Medication Administration, failed to reveal information about the timing of medication administration. No additional information was provided prior to exit. 3. For Resident #5 (R5), the facility staff failed to follow physician's orders to administer medications in a timely manner. A review of R5's medication administration records for August and November 2024 revealed she received the following medications late, resulting in a failure to follow the physician's orders: Sevelamer (kidney function supplement) ordered 8/20/24 at 8:00 a.m., given at 9:22 a.m.; ordered 11/30/24 at 12:00 noon, given at 2:13 p.m. Carvedilol (for high blood pressure) ordered 8/20/24 at 8:00 a.m., given at 9:21 a.m. Cromolyn (eyedrops) ordered 8/20/24 at 8:00 a.m., given at 9:21 a.m. Augmentin (antibiotic) ordered 8/20/24 at 8:00 a.m., given at 9:20 a.m. Risperidone (antipsychotic) ordered 8/20/24 at 8:00 a.m., given at 9:22 a.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aspirin ordered 8/20/24 at 8:00 a.m., given at 9:20 a.m. Sodium Bicarbonate (kidney function supplement) ordered 8/20/24 at 8:00 a.m., given at 9:23 a.m. On 12/12/24 at 10:21 a.m., LPN (licensed practical nurse) #3, a unit manager, was interviewed. She stated to comply with a physician's order, a medication should be administered within 60 minutes before or after it is listed as due. She stated if a medication is given late, the nurse is not following the physician's order. On 12/12/24 at 1:56 p.m., LPN #2 was interviewed. She stated all medications should be given within an hour before or after the medication is due. She stated the physician's orders are not followed if the nurse is later than hour after the due time administering the medication. On 12/12/24 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were informed of these concerns. No additional information was provided prior to exit. 4. For Resident #6 (R6), the facility staff failed to follow physician's orders to administer medications in a timely manner. A review of R6's medication administration records for 9/28/24 revealed he received the following medication late, resulting in a failure to follow the physician's orders: Lidocaine Patch (for pain) ordered 9/28/24 at 8:00 a.m., given at 10:46 a.m. On 12/12/24 at 10:21 a.m., LPN (licensed practical nurse) #3, a unit manager, was interviewed. She stated to comply with a physician's order, a medication should be administered within 60 minutes before or after it is listed as due. She stated if a medication is given late, the nurse is not following the physician's order. On 12/12/24 at 1:56 p.m., LPN #2 was interviewed. She stated all medications should be given within an hour before or after the medication is due. She stated the physician's orders are not followed if the nurse is later than hour after the due time administering the medication. On 12/12/24 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were informed of these concerns. No additional information was provided prior to exit. 5. For Resident #2 (R2), the facility staff failed to follow physician's orders to administer medications in a timely manner. A review of R2's medication administration records for August and September 2024 revealed she received the following medications late, resulting in a failure to follow the physician's orders: Tramadol (for pain) ordered 8/10/24 at 8:00 a.m., given at 9:12 a.m.; ordered 9/22/24 at 8:00 a.m., given at 12:19 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Memantine (for dementia) ordered 8/10/24 at 8:00 a.m., given at 11:25 a.m.; ordered 9/22/24 at 8:00 a.m., given at 12:16 p.m. Hiprex (to prevent urinary tract infections) ordered 8/10/24 at 8:00 a.m., given at 11:25 a.m.; ordered 9/22/24 at 8:00 a.m., given at 12:17 p.m. Sennosides (stool softener) ordered 8/10/24 at 8:00 a.m., given at 11:25 a.m.; ordered 9/22/24 at 8:00 a.m., given at 12:17 p.m. On 12/12/24 at 10:21 a.m., LPN (licensed practical nurse) #3, a unit manager, was interviewed. She stated to comply with a physician's order, a medication should be administered within 60 minutes before or after it is listed as due. She stated if a medication is given late, the nurse is not following the physician's order. On 12/12/24 at 1:56 p.m., LPN #2 was interviewed. She stated all medications should be given within an hour before or after the medication is due. She stated the physician's orders are not followed if the nurse is later than hour after the due time administering the medication. On 12/12/24 at 4:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were informed of these concerns. No additional information was provided prior to exit.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to maintain resident safety equipment in working order for one of 11 residents in the survey sample, Resident #2. The findings include: For Resident #2 (R2), the facility staff failed to maintain the resident's pacemaker monitor in working order at the resident's bedside. On the following dates and times, R2's room was observed. At each observation, the resident's pacemaker monitor was positioned on her bedside table, and the green light was illuminated, indicating proper functioning: [DATE] at 9:35 a.m. and 4:12 p.m.; [DATE] at 8:18 a.m. A review of R2's provider's orders revealed the following order dated [DATE]: Check pacemaker monitor for function q shift every shift. On [DATE] at 10:21 a.m., LPN (licensed practical nurse) #3, a unit manager, was interviewed. She stated on Monday, [DATE], she returned to work after a week's vacation. She stated R2's daughter was visiting the resident and approached her with questions about R2's pacemaker monitor. The daughter told LPN #3 that the monitor was not on the resident's bedside table, and had not been for some time. LPN #3 stated she could not verify how long the monitor had not been at the resident's bedside, but LPN #3 discovered the monitor in her office when she first entered her office after vacation. She stated that usually the cardiology office calls the facility immediately if they detect that the monitor is not functioning properly. She stated she asked staff if anyone knew how the monitor came to be located in her office, but no one had any information to provide. On [DATE] at 1:59 p.m., LPN #1 was interviewed. She stated she regularly cared for R2 and her roommate. R2's roommate died while LPN #1 was on vacation, and the staff moved items in the room around before and after the resident's death. She stated a day after she returned to work from her vacation in [DATE], she noticed R2's pacemaker monitor was missing from the room. She stated LPN #3 was just returning from vacation that day, and they located the pacemaker monitor in LPN #3's office. The immediately returned the machine to R2's bedside, plugged it in, and the light turned green, indicating the device was functioning correctly. She stated she did not understand why the cardiology office had not called the facility to alert the staff that there was a problem with the pacemaker monitor's functioning. On [DATE] at 4:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #5, the regional director of clinical services were informed of these concerns. A review of the facility policy, Physical Environment: Electrical Equipment, revealed, in part: The facility will maintain all mechanical, electrical, and patient care equipment in safe operating condition. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No additional information was provided prior to exit.