FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495247	B. WING	B. WING			C (10/2017	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
TCC AND REHABILITA	TION-NANSEMOND POINT	:					
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)						(X5) COMPLETION DATE	
F 000 INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/8/17 through 8/10/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code		F	0.00	This Plan of Correction is the center's credible allegation of compliance.		09/22/2017	
				does not constitute admission or agreement by provider of the truth of the facts alleged or cont set forth in the statement of deficiencies. The propertion is prepared and/or executed solely by	the clusions lan of ecause		
investigated during to the census in this 14 134 at the time of the consisted of current #1 through #21) and (Residents #22 through #21) and (Residents #22 through #3.10(g)(10)(i)(11) RESULTS - READILE (g)(10) The resident (i) Examine the result of the facility conducts surveyors and any prespect to the facility (g)(11) The facility must (ii) Post in a place real family members residents, the results the facility. (iii) Have reports with certifications, and corespecting the facility years, and any plan respect to the facility	the survey. 48 certified bed facility was a survey. The survey sample Resident reviews (Residents 13 closed record reviews 14 closed record reviews 15 closed record reviews 15 closed record reviews 16 closed record survey 16 closed record record record record residents, 17 closed record record residents, 18 closed record reco	F	167	survey were posted in the mai lobby entrance of Butler Hall the receptionist desk is located 08/10/2017. 2. The results of facility most receptionist desk is located was checked by the Director of Nursing/designee to ensure plain a place readily accessible to residents, and family members legal representatives of residents. 3. Executive Director/Administra was in-serviced on 09/19/2017 posting the results of facility in recent survey in a place readily accessible to residents, and far members and legal representation of residents at both entrances. 4. The Director of Nursing/desig will review monthly for three months. The Director of Nursing/designee will review monthly that both entrances had the last 3 years of surveys post	n where d on cent by the as aced s and nts. ator on nost y nily ives nee		
NIDEOTODIO CE ESC.		<u> </u>		TITLE		(X6) DATE	
	CORRECTION ROVIDER OR SUPPLIER TCC AND REHABILITA SUMMARY S (EACH DEFICIENC REGULATORY OR INITIAL COMMENTS An unannounced Ma survey was conducte Corrections are requivered to the consisted of current #1 through #21) and (Residents #22 through #21) and (Residents #22 through #21) and (Residents #22 through #3.10(g)(10)(i)(11) RESULTS - READILITY (g)(10) The resident (i) Examine the results of the facility conducts surveyors and any prespect to the facility may respect to the facility to review upon request to review upon request.	CORRECTION A95247 ROVIDER OR SUPPLIER TCC AND REHABILITATION-NANSEMOND POINT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/8/17 through 8/10/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will-follow. Two complaints were investigated during the survey. The census in this 148 certified bed facility was 134 at the time of the survey. The survey sample consisted of current Resident reviews (Residents #1 through #21) and 13 closed record reviews (Residents #22 through #34). 483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must— (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	A BUILD A95247 B. WING ROVIDER OR SUPPLIER TCC AND REHABILITATION-NANSEMOND POINT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/8/17 through 8/10/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints-were investigated during the survey. The census in this 148 certified bed facility was 134 at the time of the survey. 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WING ROVIDER OR SUPPLIER TCC AND REHABILITATION-NANSEMOND POINT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) An unannounced Medicare/Medicaid standard survey was conducted 8/8/17 through 8/10/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two-compleints were investigated during the survey. The census in this 148 certified bed facility was 134 at the time of the survey. 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WING STREET ADDRESS, CITY, STATE, JP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VX. 23343 SUMMARY STATEMENT OF DEFICIENCIES EACH DEPRICENCY MILES DEPRIFYING INFORMATION) INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/8/17 through 8/10/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/reversity fieldow—Tive compliaints were investigated during the survey. The census in this 148 certified bed facility was 134 at the time of the survey. The survey sample consisted of current Resident reviews (Residents #12 through #21) and 13 closed record reviews (Residents #22 through #34). 483.10(g)(10)(f)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility, and (g)(11) The facility must— (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to the facility was plan to correction in meffect with respect to the facility and plan of correction in meffect with respect to the facility was the results of the most recent survey of the facility wing the survey. The Director of Nursing/designed to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility wing the 3 preceding years, and any plan of correction in effect with respect to the facility wing the 3 preceding years, and any plan of correction in effect with respect to the facility unique the survey. The Director of Nursing/designed to ensure the survey in a place readily accessible to residents, and the minute of residents at both entrances. The Director of Nursing/designed to ensure the survey of the facility unique the 3 preceding years, and any plan of correction in effect with respect to the facility unique the 3 preceding yea	A BUILDING 495247 B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434 SUMMARY STATEBENT OF DEPTICEMOUSS GEACH DEPTICIENCY WIST BE PRECEDED BY YPUL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS INITIAL COMMENTS FOOD This Plan of Correction is the censer's credible allegation of compliance with A2 CFR Part 493 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 148 certified bed facility was 134 at the time of the survey. The survey sample consisted of current Resident reviews (Residents 412 through #34). 483.10(3)(10)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility, conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility, and (g)(11) The facility must- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents at both en	

Any deficiency statement ending with an asterisk (*) devotes 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.

Executive Director

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ С 495247 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 167 Continued From page 1 F 167 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced Based on observations the facility staff failed to post location of survey results in the main This Plan of Correction is the center's credible entrance so visitors entering the facility through allegation of compliance. that entrance would have knowledge of past Preparation and/or execution of this plan of correction survey location. does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions The findings include: set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. During general observations of the facility, Performance Improvement which conducted 8/8/17 through 8/10/17, a search for consist of Executive Director. the survey results posting uncovered it was Medical Director, Director of located on a wall of the Holladay Hall entrance. There were no postings of where the survey Nursing, Staff Development, Social results were located in the Main lobby or at the Services Director, Dietitian, C.N.A. Joyner Hall entrance. & Pharmacy. The Main lobby entrance is where the receptionist desk is located and it adjoins the short stay rehabilitation unit. It is also where the receptionist is available for visitor's questions. On 8/10/17 at approximately 11:00 a.m., the receptionist stated if anyone inquired about the survey results she would direct them to the Holladay Hall entrance. Thus, a verbal request must be voiced by a visitor or other interested party in order to view the results.

On 8/10/17 at approximately 5:00 p.m., during the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

PRINTED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495247 B. WING 08/10/2017 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) This Plan of Correction is the center's credible F 167 Continued From page 2 allegation of compliance. 09/22/2017 pre-exit briefing the Administrator, Director of Preparation and/or execution of this plan of correction Nursing and Corporate Director of Clinical does not constitute admission or agreement by the Operations was asked if they knew what percent provider of the truth of the facts alleged or conclusions of visitors per day utilized the Main entrance set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because and/or Joyner entrance. No one was certain and it is required by the provisions of federal and state law. the Administrator stated it was not anything-they had considered. The Administrator stated a F224 posting identical to the Holladay Hall posting Resident #36 and #26 medication would be made for the Main entrance. were PRN for pain, there was no F 224 483.12(b)(1)-(3) PROHIBIT F 224 negative outcome to Resident #36 MISTREATMENT/NEGLECT/MISAPPROPRIATN SS=D or #26 identified. 2. All residents have the potential to §483.12 The resident has the right to be free from be affected by the sited deficiency. abuse, neglect, misappropriation of resident A Narcotic count was conducted on property, and exploitation as defined in this all the medication carts subpart. This includes but is not limited to immediately by the Director of freedom from corporal punishment, involuntary Nursing. No other discrepancies seclusion and any physical or chemical restraint were identified. not required to treat the resident's symptoms. Staff Development Coordinator/Director of Nursing 483.12(b) The facility must develop and completed in-service on 09/20/2017 implement written policies and procedures that: for all staff on Abuse focusing on misappropriation. (b)(1) Prohibit and prevent abuse, neglect, and DNS/Designee will randomly exploitation of residents and misappropriation of conduct narcotic count weekly X 4

§483.95,

resident property,

(b)(2) Establish policies and procedures to

(b)(3) Include training as required at paragraph

This REQUIREMENT is not met as evidenced

record review, facility document review and

Based on staff interview, family interview, clinical

during the course of a complaint investigation the

facility staff failed to ensure 2 of 35 residents in

investigate any such allegations, and

weeks, then Bi-weekly X 1month and monthly X 2 months to ensure

monthly Performance Improvement

meeting which consist of Executive

compliance.

Pharmacy

5. All abuse investigations are reviewed and discussed at the

> Director, Medical Director, Director of Nursing, Staff

Development, Social Services

Director, Dietitian, C.N.A &

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FORM CMS-2567(02-99) Previous Versions Obsolete

care.

1. Resident #35 was admitted to the facility with

The current MDS (Minimum Data Set) was a significant change with an assessment reference date of 5/8/17. The MDS coded the resident as having severely impaired cognitive skills for daily decision making. The resident was on Hospice

The Physician Order Summary included an order dated 3/21/17 for Tramadol Hcl 50 milligrams one

an initial admission date of 8/3/15 and readmission date of 6/21/17 with diagnoses to include but not limited to dementia, and pathological fracture of the right leg.

Event ID: LWF311

Facility ID: VA0169

If continuation sheet Page 4 of 40

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ С 495247 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID 3D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 224 Continued From page 4 F 224 tablet by mouth four time as day as needed for pain not relieved by Tylenol. According to the FRI investigation it was determined that Registered Nurse #3 (RN #3) had taken approximately 14 tablets of Tramadol Hcl-50 milligrams from Resident #35's supply and the sign off narcotic sheet. During the investigation, RN #3 admitted to the Director of Nursing that she had taken the Tramadol and stated she has "a problem and needs help", as This Plan of Correction is the center's credible evidenced in the investigation notes. The nurse allegation of compliance. was terminated. Preparation and/or execution of this plan of correction Adult Protective Services were also notified by does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions the facility and conducted an independent set forth in the statement of deficiencies. The plan of investigation. The investigation concluded based correction is prepared and/or executed solely because on a preponderance of evidence that adult abuse, it is required by the provisions of federal and state law. neglect or exploitation had occurred, the complaint was substantiated. 2. The complainant alleged that the facility informed her that a staff member had taken Tramadol from Resident #26's supply and as a result of the investigation the staff member was terminated. Resident #26 was admitted for a short term Respite/ Holiday relief care stay at the facility on 3/15/17. Diagnoses included but not limited to, diabetes, chronic ischemic heart disease, and an unstageable ulcer of the left heel. The admission MDS (Minimum Data Set) with an assessment reference date of 3/25/17 coded the resident as scoring a 13 out of a possible 15 on

the Brief Interview for Mental Status (BIMS), indicating the resident's cognition was intact.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING_ С B. WING 495247 08/10/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 224 Continued From page 5 F 224 The Physician Order Summary report evidenced an order dated 3/20/17 to administer Tramadol HCL tablet 50 mg (milligrams) every 6 hours as needed for moderate pain. According to the FRI investigation it was determined that Registered Nurse #3 (RN #3) had removed one 50 mg tablet of Tramadol from the resident's supply on 4/2/17 at 7:00 a.m, and on 4/6/17 at 8:00 a.m., without administering the doses. During the investigation RN #3 admitted to This Plan of Correction is the center's credible the Director of Nursing that she had taken the allegation of compliance. Tramadol and stated she has "a problem and Preparation and/or execution of this plan of correction needs help", as evidenced in the investigation does not constitute admission or agreement by the notes. The nurse was terminated. provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because The Treatment Administration Record for April it is required by the provisions of federal and state law. 2017 evidenced there was no administration of Tramadol to Resident #26 on 4/2/17 and 4/6/17. Adult Protective Services were also notified by the facility on 4/17/17 and conducted an independent investigation. The investigation concluded based on a preponderance of evidence that adult abuse, neglect or exploitation had occurred, the complaint was substantiated. COMPLAINT DEFICIENCY 1. Tramadol is used to relieve moderate to

moderately severe pain. Tramadol

extended-release tablets and capsules are only used by people who are expected to need medication to relieve pain around-the-clock.

Tramadol is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to

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PRINTED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ C 495247 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) This Plan of Correction is the center's credible 09/22/2017 F 224 Continued From page 6 F 224 allegation of compliance. Preparation and/or execution of this plan of correction https://medlineplus.gov/druginfo/meds/a695011. does not constitute admission or agreement by the F 278 483.20(g)-(j) ASSESSMENT F 278 provider of the truth of the facts alleged or conclusions ACCURACY/COORDINATION/CERTIFIED SS=E set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. F278 Resident #17, #27, #28, #29, #30, (h) Coordination #31, #32, #33 and #34 has been A registered nurse must conduct or coordinate coded accurately in the Minimum each assessment with the appropriate Data Set (MDS) assessment to participation of health professionals. reflect the resident's status. 2. All residents residing in the facility (i) Certification have been identified as having the (1) A registered nurse must sign and certify that potential to be affected. the assessment is completed. Director of Nursing in-serviced Minimum Data Set (MDS) (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of coordinators on 09/20/2017 to that portion of the assessment. accurately code residents in Minimum Data Set (MDS) to reflect accurate resident's status. (i) Penalty for Falsification DNS/Case Manager/MDS Coordinators will audit 5 residents' (1) Under Medicare and Medicaid, an individual who willfully and knowinglyassessment per week X 12 weeks. then 5 residents' monthly to (i) Certifies a material and false statement in a validate accuracy of MDS resident assessment is subject to a civil money assessments. penalty of not more than \$1,000 for each Audits will be performed by Case

assessment; or

\$5,000 for each assessment.

material and false statement.

(ii) Causes another individual to certify a material

and false statement in a resident assessment is

subject to a civil money penalty or not more than

(2) Clinical disagreement does not constitute a

Manager weekly x three months, then monthly ongoing. Results will

be reviewed by the DNS and Case

Manager in the monthly Quality

Assessment/Performance

Improvement meeting which consists of Executive Director,

Medical Director, Director of

Nursing, Staff Development, Social

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED
	495247	B. WING		: :	C 08/10/2017	
NAME OF PROVIDER OR SUPPLIER KINDRED TCC AND REHABILITATION-NANSEMOND POINT			20	00 WEST CONSTANCE ROAD	1 30.	10/2017
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG				(X5) COMPLETION DATE
This REQUIREMENT by: Based on clinical red documents, staff inter facility's policy, the fa code_Minimum Data	is not met as evidenced ord review, facility views and review of the cility staff failed to accurately Set (MDS) assessments for	F	278	This Plan of Communication		09/22/2017
#34) in the survey sa 1. The facility staff fai Resident #17's Annua "A1500" and "A1510' 2. The facility staff fai Resident #27's Initial assessment at "A060 3. The facility staff fai Resident #28's Initial assessment at "A060 4. The facility staff fai Resident #29's Initial assessment at "A060 5. The facility staff fai Resident #30's Initial assessment at "A050 6. The facility staff fai Resident #31's Initial assessment at "A080 7. The facility staff fa Resident #32's Initial assessment at "A080 8. The facility staff fa Resident #33's Initial assessment at "A060 9. The facility staff fa Resident #34's Initial	In the second of			Preparation and/or execution of this plan of condoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The province is prepared and/or executed solely bit is required by the provisions of federal and statement of the control of the provisions of federal and statement of the provisions of the p	rrection the clusions lan of ecause tate law.	
The Findings include	:					
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR IN GENERAL TORY OR IN This REQUIREMENT by: Based on clinical reconstruction of the staff interfacility's policy, the facode Minimum Data Staff in the facility's policy, the facode Minimum Data Staff of the staff fair Resident #17's Annua "A1500" and "A1510" 2. The facility staff fair Resident #27's Initial assessment at "A060 3. The facility staff fair Resident #28's Initial assessment at "A060 4. The facility staff fair Resident #30's Initial assessment at "A080 5. The facility staff fair Resident #30's Initial assessment at "A050 6. The facility staff fair Resident #31's Initial assessment at "A080 7. The facility staff fair Resident #32's Initial assessment at "A080 8. The facility staff fair Resident #33's Initial assessment at "A080 9. The facility staff fair Resident #33's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A080 9. The facility staff fair Resident #34's Initial assessment at "A	TCC AND REHABILITATION-NANSEMOND POINT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 This REQUIREMENT is not met as evidenced	CORRECTION A95247 B. WING ROVIDER OR SUPPLIER TCC AND REHABILITATION-NANSEMOND POINT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility documents, staff interviews and review of the facility's policy, the facility staff failed to accurately code. Minimum Data Set (MDS) assessments for 9 of 35 residents, (Resident #17, and #27 through #34) in the survey sample. 1. The facility staff failed to accurately code Resident #17's Annual MDS assessment at "A1500" and "A1510". 2. The facility staff failed to accurately code Resident #28's Initial Admission MDS assessment at "A0600A and A0600B". 3. The facility staff failed to accurately code Resident #29's Initial Admission MDS assessment at "A0800". 5. The facility staff failed to accurately code Resident #30's Initial Admission MDS assessment at "A0800". 6. The facility staff failed to accurately code Resident #31's Initial Admission MDS assessment at "A0800". 7. The facility staff failed to accurately code Resident #32's Initial Admission MDS assessment at "A0800". 7. The facility staff failed to accurately code Resident #32's Initial Admission MDS assessment at "A0800". 8. The facility staff failed to accurately code Resident #33's Initial Admission MDS assessment at "A0800". 9. The facility staff failed to accurately code Resident #33's Initial Admission MDS assessment at "A0800, A0900, and A0600A". 9. The facility staff failed to accurately code Resident #33's Initial Admission MDS assessment at "A0800, A0900, and A0600A". 9. The facility staff failed to accurately code Resident #33's Initial Admission MDS assessment at "A0800". 1. The facility staff failed to accurately code Resident #33's Initial Admission MDS assessment at "A08000". 1. The facility staff failed to accurately code Resident #34's Initial Admission MDS assessment at "A0800".	A BUILDING	A BUILDING 495247 B. WIND STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA. 23434 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility documents, staff interviews and review of the facility's policy, the facility staff failed to accurately code. Minimum Data Set (MDS) assessments for 9-0-95 Sresidents, (Resident #17- and #27-through #349) in the survey sample. 1. The facility staff failed to accurately code Resident #17's Annual MDS assessment at "A1500" and "A1510" 2. The facility staff failed to accurately code Resident #27's initial Admission MDS assessment at "A0600A and A0600B". 3. The facility staff failed to accurately code Resident #29's Initial Admission MDS assessment at "A0600A and A0600B". 4. The facility staff failed to accurately code Resident #30's Initial Admission MDS assessment at "A0800". 5. The facility staff failed to accurately code Resident #30's Initial Admission MDS assessment at "A0600 And A0600A". 6. The facility staff failed to accurately code Resident #31's Initial Admission MDS assessment at "A0600 and A0600A". 7. The facility staff failed to accurately code Resident #32's Initial Admission MDS assessment at "A0600 and A0600A". 8. The facility staff failed to accurately code Resident #33's Initial Admission MDS assessment at "A0600 and A0600A". 9. The facility staff failed to accurately code Resident #33's Initial Admission MDS assessment at "A0600 and A0600A". 9. The facility staff failed to accurately code Resident #34's Initial Admission MDS assessment at "A0600 and A0600A". 9. The facility staff failed to accurately code Resident #34's Initial Admission MDS assessment at "A0600". 9. The facility staff failed to accurately code Resident #34's Initial Admission MDS assessment at "A0600 and A0600A". 9. The facility staff failed to accurately code Resident #34's Ini	A SULDING 495247 B. WING STREETADORESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCES GEAR DEFICIENCY MINISTERMATION POLICIPIENCES GEAR DEFICIENCY MINISTERMATION SUMMARY STATEMENT OF DEFICIENCES GEAR DEFICIENCY OF LSC IDENTIFYING INFORMATION) Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility documents, staff interviews and review of the facility's policy, the facility staff falled to accurately code Minimum Data Set (MDS) assessment at "A1510". 1. The facility staff falled to accurately code Resident #27's initial Admission MDS assessment at "A0600A and A0600B". 3. The facility staff falled to accurately code Resident #27's initial Admission MDS assessment at "A0600A And A0600B". 4. The facility staff falled to accurately code Resident #27's initial Admission MDS assessment at "A0600A and A0600B". 5. The facility staff falled to accurately code Resident #27's initial Admission MDS assessment at "A0600A and A0600B". 6. The facility staff falled to accurately code Resident #27's initial Admission MDS assessment at "A0600A and A0600B". 7. The facility staff falled to accurately code Resident #31's initial Admission MDS assessment at "A0600A and A0600B". 8. The facility staff falled to accurately code Resident #31's initial Admission MDS assessment at "A0600A. 9. The facility staff falled to accurately code Resident #31's initial Admission MDS assessment at "A0600A. 9. The facility staff falled to accurately code Resident #33's initial Admission MDS assessment at "A0600A. 9. The facility staff falled to accurately code Resident #33's initial Admission MDS assessment at "A0600A. 9. The facility staff falled to accurately code Resident #33's initial Admission MDS assessment at "A0600A. 9. The facility staff falled to accurately code Resident #34's initial Admission MDS assessment at "A0600A. 9. The facility staff falled to accurately code Resident #34's initial Admission MDS assessment at

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION CASH PROVIDER/SUPPLIER/CLIA C

PRINTED:	09/18/201
FORM A	APPROVE[
OMB NO.	0938-039

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		495247	B. WING_			C /10/2017
	ROVIDER OR SUPPLIER TCC AND REHABILITAT	TION-NANSEMOND POINT		STREET ADDRESS, CITY, STATE, 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		10/2017
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE
F 278	F 278 Continued From page 8 1. Resident #17 was originally admitted to the facility 4/8/08 and readmitted 4/4/16 after an acute hospitalization. The current diagnoses included intellectual disability, cerebral palsy, and a seizure disorder. The Annual Minimum Data-Set (MDS) assessment with an assessment reference date (ARD) of 5/1/17 coded the resident as not completing the Brief Interview for Mental Status (BIMS). The staff interview indicated the resident was with long and short term memory problems and severely impaired decision making abilities. The Virginia Level II Preadmission Screening and Resident Review (PASRR) summary of findings completed 9/14/08 revealed Resident #17's disability was severe mental retardation with related conditions of cerebral palsy and a seizure disorder. The assessor further stated the resident does not communicate verbally and her orientation level was unable to be determined. The PASRR Determination Summary read " sensory stimulation is recommended to involve the resident with her environment and provide a medium for interaction." Review of the 5/1/17 MDS assessment revealed at "A1500" a response of "no" to the question; "Is this resident currently considered by the state level PASRR process to have serious mental illness and/or intellectual disability ("mental retardation" in federal regulation) or a related condition?"		F2	278		
				This Plan of Correction is the allegation of compliance. Preparation and/or execution does not constitute admission provider of the truth of the first forth in the statement of a correction is prepared and/o	on of this plan of correction in or agreement by the acts alleged or conclusions deficiencies. The plan of or executed solely because	
				it is required by the provision	ns of federal and state law.	
	The Resident Assess October 2016 stated	ment instrument dated at page A-18 read;		ŀ		

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		OMB NO. 0				
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY	
		495247	B. WING	B. WNG		I	C /10/2017	
NAME OF P	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2017	
KINDRED	TCC AND REHABILITAT	ION-NANSEMOND POINT		200	WEST CONSTANCE ROAD FFOLK, VA 23434			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	l l	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETION DATE	
F 278	Continued From page	9	F.	278				
	certified nursing facility PASRR completed to illness (MI), intellectual retardation" (MR) in fergulation)/developments related conditions reg	ental disability (DD), or ardless of the resident's						
	method of payment (please contact your local State Medicaid Agency for details regarding PASRR requirements and exemptions).				This Plan of Correction is the center's credi allegation of compliance.			
	*Individuals who have or are suspected to have MI or ID/DD or related conditions may not be admitted to a Medicaid-certified nursing facility unless approved through Level II PASRR determination. Those residents covered by Level II PASRR process may require certain care and services provided by the nursing home, and/or specialized services provided by the State.				Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or a set forth in the statement of deficiencies. The correction is prepared and/or executed sole, it is required by the provisions of federal and the control of the provisions of federal and the provisions	by the conclusions to plan of to because		
	Developmental disabilities Resident Review (RR significant change in temperature) mental condition. The Change in Status Assigned to notify the authority, intellectual disability authority (definitheir State) in order resident's change in significant (iii) of the Social Section	disability or developmental epending on which operates to notify them of the status. Section 1919(e)(7)(B)						

On 8/10/17 at approximately 1:40 p.m., an

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2017

FORM APPROVED

FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			DING	(X3) DATE COMP	LETED	
		495247	B. WING			0
	ROVIDER OR SUPPLIER	ATION-NANSEMOND POINT		STREET ADDRESS, CITY, STATE, ZIP CO 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		10/2017
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 278	assigned to Reside stated she did not MDS assessment a MDS Coordinators what PASRR was;	age 10 lucted with Social Worker #2, ent #17. Social Worker #2 code section "A1500" of the and after speaking with the she learned they did not know therefore, they did not code it	F	278		
	assessment the MI information for sec assessment was a accordance with re Coordinator stated on MDS completion of the Resident Ass. On 8/10/17 at appr pre-exit briefing the Nursing and Corpo Operations were more assessment the MI information of the MI information	OS Coordinator certified the		This Plan of Correction is the cerallegation of compliance. Preparation and/or execution of does not constitute admission or provider of the truth of the facts a set forth in the statement of deficic correction is prepared and/or exeit is required by the provisions of	this plan of correction agreement by the alleged or conclusions encies. The plan of	
	Facility Administrat "Missing Obra Asso "Missing Obra Asso by the MDS coordi approximately 3:30 When the MDS Co eight names remai Assessment Report	ordinator #4 was asked why ned on the "Missing Obra t", she stated, "I'll be honest ow. I will find out and am				
		nes remained on the "Missing Report". On 8/8/17 at				

PRINTED: 09/18/201/ FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECT ON IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495247	B. WING		1	C 10/2017
	ROVIDER OR SUPPLIER	ION-NANSEMOND POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		10/2017
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	stated that seven had was referred to the C On 8/10/17 all eight F	e 11 m. the MDS Coordinator #4 I been corrected and one orporate RN for assistance. Resident names were no g Obra Assessment Report"	F 2	.78		
	6/7/16. Resident #27 (Minimum Data Set - with an ARD (Assess 6/12/16 documented Mental Status) score cognitive impairment. Resident #27's Diagn	an assessment protocol) ment Reference Date) of a BIMS (Brief Interview for of 3 indicating a severe osis included but was not in other diseases classified havioral disturbance.		This Plan of Correction is the centerallegation of compliance. Preparation and/or execution of this does not constitute admission or agree provider of the truth of the facts alle set forth in the statement of deficien correction is prepared and/or executit is required by the provisions of features.	s plan of correction reement by the eged or conclusions cies. The plan of tted solely because	
	inaccurately affecting information in the followance NA0600-3 Medicare NA0600-A Social Security administrating findings during a brie approximately 5:30 p	Resident #27's identifying bwing MDS sections: umber rity Number ation was informed of the				
	Facility Administrator "Missing Obra Asses	sment Report" was provided tor on 8/8/17 at				

DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					J: U9/18/2017 M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495247	B. WING			I.	C
NAME OF D	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 08/	10/2017
NAME OF F	NOVIDER OR SUPPLIER				00 WEST CONSTANCE ROAD		
KINDRED	TCC AND REHABILITAT	ON-NANSEMOND POINT			UFFOLK, VA 23434		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 278	eight names remained Assessment Report", with you, I don't know willing to correct and	linator #4 was asked why d on the "Missing Obra she stated, "I'll be honest . I will find out and am	F 2	278			
	Obra Assessment Re approximately 5:03 p. stated that seven had was referred to the Co On 8/10/17 all eight R longer on the "Missing run on 8/10/17. Resident #28 was add 5/5/16. Resident #28 ARD of 5/25/16 code indicating no cognitive Resident #28's Diagn limited to: Failure to Resident #28's initial inaccurately affecting information in the follo A0600-B Medicare No A0600-A Social Secu The facility administrating findings during a brief approximately 5:30 p.	port". On 8/8/17 at m. the MDS Coordinator #4 been corrected and one proporate RN for assistance. esident names were no g Obra Assessment Report" mitted to the Facility on 's Discharge MDS with an d a BIMS score of 13 e impairment. MDS was coded Resident #28's identifying pwing sections: umber rity Number			This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of codes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The correction is prepared and/or executed solely it is required by the provisions of federal and s	orrection the nclusions plan of because	

4. During the Initial Tour and meeting with the Facility Administrator, a request was made for the

"Missing Obra Assessment Report". The

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		PLETED		
		495247	B. WING _		I	C /10/2017	
	ROVIDER OR SUPPLIER TCC AND REHABILITAT	ION-NANSEMOND POINT		STREET ADDRESS, CITY, STATE, ZIP COD 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		16,2017	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 278	by the MDS coordinately 3:30 p. When the MDS Coordinately 3:30 p. When the MDS Coordinately 4:50 p. Assessment Report",	sment Report" was provided tor on 8/8/17 at .m. dinator #4 was asked why d on the "Missing Obra she stated, "I'll be honest	F 2	78			
	with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 3/10/17. Resident #29 was admitted to the Facility on			This Plan of Correction is the center allegation of compliance. Preparation and/or execution of this does not constitute admission or age provider of the truth of the facts alleget forth in the statement of deficient correction is prepared and/or execution is required by the provisions of feed.	is plan of correction greement by the eged or conclusions ocies. The plan of uted solely because		
	ARD of 6/17/15 coder indicating no cognitive Resident #29's Diagn limited to: Generalize Muscular Wasting and Resident #29's initial inaccurately affecting information in the following A0800 Resident #29 when she is a female. The facility administrating findings during a brief approximately 5:30 p.	noses included but were not ed Muscle Weakness and d Disuse Atrophy. MDS was coded Resident #29's identifying owing section: was initially listed as a male					

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495247	B. WING		C 08/10/2017	
	ROVIDER OR SUPPLIER TCC AND REHABILITAT	ON-NANSEMOND POINT	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONSTANCE ROAD UFFOLK, VA 23434	3 00/10/2017	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 278	Continued From page	: 14	F 278	: ! :		
	Facility Administrator, "Missing Obra Assess	ment Report" was provided		:		
	eight names remained Assessment Report", with you, I don't know willing to correct and I Eight Resident names Obra Assessment Re approximately 5:03 p. stated that seven had	linator #4 was asked why d on the "Missing Obra she stated, "I'll be honest . I will find out and am earn."		This Plan of Correction is the center's credicallegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. The correction is prepared and/or executed sole it is required by the provisions of federal and	f correction by the conclusions he plan of ly because	
	longer on the "Missing run on 8/10/17. Resident #30 was adr 10/14/16. Resident #	esident names were no g Obra Assessment Report" mitted to the Facility on 30's Discharge Death In BIMS score of 15 indicating ent.				
	limited to: Pneumonia	MDS was inaccurately ent #30's identifying owing sections: ty Number				

FORM APPROVED

PRINTED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495247 B. WNG 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 15 F 278 The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings. 6. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. This Plan of Correction is the center's credible When the MDS Coordinator #4 was asked why allegation of compliance. eight names remained on the "Missing Obra Preparation and/or execution of this plan of correction Assessment Report", she stated, "I'll be honest does not constitute admission or agreement by the with you, I don't know. I will find out and am provider of the truth of the facts alleged or conclusions willing to correct and learn." set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Eight Resident names remained on the "Missing Obra-Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 3/10/17.

impairment.

limited to: Sepsis.

Resident #31 was admitted to the Facility on 11/17/14. Resident #31's Discharge MDS coded a BIMS score of 15 indicating no cognitive

Resident #31's Diagnosis included but was not

Resident #31's initial MDS was inaccurately coded affecting Resident #31's identifying

INTEREST NO PERFORMANCE ON PROVIDER SUPPLIER A SULDING 495247 INAME OF PROVIDER OR SUPPLIER KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUBMINITY SUBMINITY (ACCOUNTS OF CONTINUED BY A SUBMINITY OF CONTINUED BY A SULDING A SUBMINITY OF CONTINUED BY A SUBMINITY OF CONTINUED	CENTER	RS FOR MEDICARE &	MEDICAID SERVICES			OMB NO	D. 0938-039
NAME OF PROVIDER OR SUPPLIER KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY) PRETIX (FACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) FERRIX (FACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) F 278 Continued From page 16 information in the following section: ABBO was coded as a male when Resident is formate The facility administration was informed of the findings during a briefing on 87/017 at approximately 6-30 p.m. The facility did net present any further information about the findings. 7. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report" was provided by the MDS coordinator on 88/17 at approximately 3-30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know, I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" unon 8/10/17. Resident #32 was admitted to the Facility on 10/21/16. Resident #32's Doath in Facility Discharge MDS code Resident #32's a having		(, , , , , , , , , , , , , , , , , , ,		1 ` ′			SURVEY
INAMEO PROVIDER OR SUPPLIES KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUMMARY STATEMENT OF DEFINIORISES (PACH DEPICIARY OR USE TO ENTRY NING INFORMATION) FORETY TAG F278 Continued From page 16 Information in the following section: A0800 was coded as a male when Resident is female The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 6-30-p-m. The facility did not present any further information about the findings. 7. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report" in the finding of correction is prepared and/or executed sofely because it is required by the provisions of federal and state law. Fight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 3:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was refereed to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" un on 8/10/17. Resident #32 was admitted to the Facility on 10/21/16. Resident #32's Death in Facility on 10/21/16. Resident Resident R2's Death in Facility on 10/21/16. Resident Resident R2's Death in Facility on 10/21/16. Resident Radio Radio Radio Resident R2's Death in Facility on 10/21/16. Resident Radio Radio Radio Radio Radio Radio Resident R2's Death in Facility on 10/21/16. Resident R2's Death in			495247	B. WING	·i		
SUMMARY STATEMENT OF DETRICIPACIES DECEMBENT OF DETRICIPACIES CAPACITOR			TON-NANSEMOND POINT		200 WEST CONSTANCE ROAD		110/2017
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		7. During the Initial Tracility Administrator, "Missing Obra Assess "Missing Obra Assess by the MDS coordinate approximately 3:30 p. When the MDS Coordinate approximately 4:30 p. With you, I don't know willing to correct and Eight Resident names Obra Assessment Reapproximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the Coordinate approximately 5:03 p. stated that seven had was refereed to the	formation about the findings. Our and meeting with the a request was made for the sment Report". The sment Report" was provided tor on 8/8/17 at m. dinator #4 was asked why d on the "Missing Obra she stated, "I'll be honest be remained on the "Missing port". On 8/8/17 at m. the MDS Coordinator #4 d been corrected and one dorporate RN for assistance. Resident names were no g Obra Assessment Report" mitted to the Facility on 32's Death In Facility d Resident #32 as having		allegation of compliance. Preparation and/or execution of the does not constitute admission or ag provider of the truth of the facts all set forth in the statement of deficien correction is prepared and/or execution.	is plan of correction greement by the leged or conclusions ncies. The plan of uted solely because	

PRINTED: 09/18/2017

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ \mathcal{L} 495247 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION)-TAG TAG DEFICIENCY) F 278 | Continued From page 17 F 278 limited to: Failure to Thrive. Resident #32's initial MDS was inaccurately coded affecting Resident #32's identifying information in the following sections: A0800 was coded as female when Resident is The facility administration was informed of the findings during a briefing on 8/10/17 at approximately 5:30 p.m. The facility did not present any further information about the findings. This Plan of Correction is the center's credible allegation of compliance. 8. During the Initial Tour and meeting with the Preparation and/or execution of this plan of correction Facility Administrator, a request was made for the does not constitute admission or agreement by the "Missing Obra Assessment Report". The provider of the truth of the facts alleged or conclusions "Missing Obra Assessment Report" was provided set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because by the MDS coordinator on 8/8/17 at it is required by the provisions of federal and state law. approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest with you, I don't know. I will find out and am willing to correct and learn." Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was refereed to the Corporate RN for assistance. On 8/10/17 all eight Resident names were no longer on the "Missing Obra Assessment Report" run on 8/10/17.

Resident #33 was admitted to the Facility on 12/7/14 with a readmission of 9/7/15. Resident

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2017

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PRINTED: 09/10/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CÈNTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ C 495247 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 278 Continued From page 18 F 278 #33's Discharge MDS coded Resident #33 as having a 15 BIMS score, indicating no cognitive impairment. Resident #33's Diagnosis included but was not limited to: End Stage Renal Disease. Resident #33's initial MDS was inaccurately coded affecting Resident #33's identifying information in the following sections: A0600 Medicare Number This Plan of Correction is the center's credible A0900 Date of Birth allegation of compliance. A0600A Social Security Number Preparation and/or execution of this plan of correction The facility administration was informed of the does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions findings during a briefing on 8/10/17 at set forth in the statement of deficiencies. The plan of approximately 5:30 p.m. The facility did not correction is prepared and/or executed solely because present any further information about the findings. it is required by the provisions of federal and state law. 9. During the Initial Tour and meeting with the Facility Administrator, a request was made for the "Missing Obra Assessment Report". The "Missing Obra Assessment Report" was provided by the MDS coordinator on 8/8/17 at approximately 3:30 p.m. When the MDS Coordinator #4 was asked why eight names remained on the "Missing Obra Assessment Report", she stated, "I'll be honest

with you, I don't know. I will find out and am

Eight Resident names remained on the "Missing Obra Assessment Report". On 8/8/17 at

approximately 5:03 p.m. the MDS Coordinator #4 stated that seven had been corrected and one was referred to the Corporate RN for assistance.

willing to correct and learn."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495247	B. WING_		0:	C B/10/2017
	ROVIDER OR SUPPLIER TCC AND REHABILITAT	ION-NANSEMOND POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		3/10/2017
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 278	On 8/10/17 all eight R	esident names were no	F 2	278		
	run on 8/10/17.	g Obra Assessment Report" mitted to the Facility on			· !	
	4/5/17. Resident #34 Resident #34 as havir	s Admission MDS coded				
	Resident #34 Diagnosis included but was not limited to: Chronic Obstructive Pulmonary Disease. Resident #34's initial MDS was inaccurately coded affecting Resident 34's identifying information in the following sections: A0800 Resident coded as Male when Resident is Female			This Plan of Correction is the center allegation of compliance.	's credible	
				Preparation and/or execution of this does not constitute admission or agree provider of the truth of the facts alles set forth in the statement of deficience correction is prepared and/or executit is required by the provisions of fed	eement by the ged or conclusions vies. The plan of ged solely because	
	Coordinator stated that Facility Resident Asset User's Manual Version	nately 11:20 a.m. the MDS at the RAI (Long Term Care assment Instrument 3.0 n 1.14 October 2016) acts				
	Coordinator #4 stated previously on the 8/8/	mately 11:20 a.m. the MDS that all 8 Residents 17 "Missing Obra are off and that she was so			;	
	and the encoded data to the state database. The transmitted data i	Release date of				

FORM APPROVED OMB NO. 0938-0391

	F CORRECTION	IDENTIFICATION NUMBER:	` '		CONSTRUCTION	СОМ	PLETED	
		495247	B. WING			l i	C 9/10/2017	
	SUMMARY S' (EACH DEFICIENC	TION-NANSEMOND POINT IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	20 S X	TREET ADDRESS, CITY, STATE, ZIP CODE TO WEST CONSTANCE ROAD UFFOLK, VA 23434 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIAN DEFICIENCY)		(X5) COMPLETION DATE	
F 278	(Center for Medicare The Facility Policy tit Resident's Health St	e 20 edits defined by CMS Service) and the State." led, "Documentation of atus, Needs and Services" 09 date, documented the	F	278	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of cordoes not constitute admission or agreement by the provider of the truth of the facts alleged or concest forth in the statement of deficiencies. The placorrection is prepared and/or executed solely be it is required by the provisions of federal and statements.	he lusions an of ecause	09/22/2017	
F 285 SS=D	"Documentation shot complete and timely." The facility administr findings during a brie approximately 5:30 present any further in 483.20(e)(k)(1)-(4) PFOR MI & MR (e) Coordination. A facility must coording pre-admission scree (PASARR) program of this part to the man avoid duplicative test includes: (1) Incorporating the PASARR level II determined and the evaluation report into care planning, and the evaluation for level II is significant change in (k) Preadmission Screen (k) Preadmission Preadmissio	ation was informed of the sting on 8/10/17 at o.m. The facility did not information about the findings. ASRR REQUIREMENTS nate assessments with the ining and resident review under Medicaid in subpart C iximum extent practicable to ting and effort. Coordination recommendations from the ermination and the PASARR or a resident's assessment,	F	285	 Community Service Board has contacted for resident #17 to incorporate resident's care and services recommendations from PASRR level 11 determination meet requirement for MI & MI residents. All residents residing in the fact have been identified as having potential to be affected. Revie all residents for MI/MR, PASS Level II diagnosis and if requirements are met. The Executive Director in-serv on 09/19/2017 the Director of Social Services on the policy for incorporating the recommendation from the PASRR level 11 determination and the PASRR evaluation report into a resident assessment, care planning, and transitions of care to meet the requirement for MI & MR residents. All new admissions to be reviewed in clinical morning meeting for PASSR level II determination to determine if appropriate recommendations a care plan addresses disability. 	n to R cility the wed circed circed trons		

PKINTED: 09/18/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3)		SURVEY
		495247	B. WING				1	C /10/2017
	ROVIDER CR SUPPLIER	TON-NANSEMOND POINT		20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONSTANCE ROAD UFFOLK, VA 23434		001	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE		(X5) COMPLETION DATE
F 285	January 1, 1989, any (i) Mental disorder as	must not admit, on or after new residents with: defined in paragraph (k)(3)	F	285				09/22/2017
·	authority has determindependent physical performed by a personant State mental health at (A) That, because of condition of the individual contents and the second condition of the individual contents and the second contents are determined in the second condition of the individual contents and the second contents are determined in the second contents are determined in the second contents and the second contents are determined in the second contents	and mental evaluation on or entity other than the authority, prior to admission, the physical and mental dual, the individual requires provided by a nursing facility; equires such level of a individual requires			This Plan of Correction is the center's crediballegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement by provider of the truth of the facts alleged or consett forth in the statement of deficiencies. The correction is prepared and/or executed solely it is required by the provisions of federal and	correctly the onclust plan where	ions of use	
	(k)(3)(ii) of this section intellectual disability authority has determed. (A) That, because of condition of the individual reservices, whether the specialized services.	or developmental disability ned prior to admission- the physical and mental dual, the individual requires provided by a nursing facility;			4. Results of all Residents with PASRR II determination will be reviewed and discussed by the Executive Director, reviewed a analyzed by the interdisciplinar Team which consist of Executi Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy at the monthly Qual Assessment and Performance Improvement meeting for three months with a subsequent plan correction as needed.	nd Ty ve		

		ID HUMAN SERVICES MEDICAID SERVICES		:	FOR	ED: 09/18/2017 MM APPROVED O. 0938-0391
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DAT	E SURVEY
	; ;	495247	B. WING		OE	C 3/10/2017
	ROVIDER OR SUPPLIER TCC AND REHABILITAT	ION-NANSEMOND POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 285	for determinations in to a nursing facility of being admitted to the transferred for care in (ii) The State may che preadmission screening paragraph (k)(1) of this to a nursing facility of (A) Who is admitted to hospital after receiving hospital, (B) Who requires nurse condition for which the hospital, and (C) Whose attending to before admission to the likely to require less facility services. (3) Definition. For pure (i) An individual is condisorder if the individual disorder defined in 48 (ii) An individual is conditionally intellectual disability if	s section need not provide the case of the readmission an individual who, after nursing facility, was a hospital. Soese not to apply the approgram under is section to the admission an individual- Of the facility directly from a gracute inpatient care at the sing facility services for the endividual received care in physician has certified, and facility that the individual sthan 30 days of nursing reposes of this section-sidered to have a mental sal has a serious mental 3.102(b)(1). Insidered to have an apply the median in §483.102(b)(3)	F 285	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of condess not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The processes for the provision is prepared and/or executed solely it is required by the provisions of federal and sections.	orrection the aclusions plan of because	
	described in 435.1010 (k)(4) A nursing facilit mental health authorit	y must notify the state				

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STATEMENT	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE:	. 0938-0391 SURVEY .ETED	
		495247	B. WING				8/1	; 0/2017	
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		,0,	0/2011	1
KINDRED	TCC AND REHABILITATI	ON-NANSEMOND POINT		20	00 WEST CONSTANCE ROAD UFFOLK, VA 23434	ļ			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE		(X5) COMPLETION DATE	
F 285	significant change in t condition of a resident intellectual disability for This REQUIREMENT by:	applicable, promptly after a he mental or physical t who has mental illness or	F	285					
	failed to ensure that a disability, care and se recommendations from determination and to de Service Board services resident's assessmen	ensure further Community s were incorporated into the ts and care plan for 1 of 35 17), in the survey sample.			This Plan of Correction is the center's credicallegation of compliance. Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or set forth in the statement of deficiencies. The correction is prepared and/or executed sole it is required by the provisions of federal and	f correction by the conclusion ne plan of ly because	ıs		
	4/8/08 and readmitted hospitalization. The crintellectual disability, or disorder. The Annual Minimum assessment with an a (ARD) of 5/1/17 coded completing the Brief II (BIMS). The staff interwas with long and sho and severely impaired. Review of the 5/1/17 at "A1500" a response this resident currently	Data Set (MDS) ssessment reference date d the resident as not nterview for Mental Status rview indicated the resident ort term memory problems d decision making abilities. MDS assessment revealed e of "no" to the question Is considered by the state to have serious mental							

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495247	B. WING		00	C /10/2017
	ROVIDER OR SUPPLIER TCC AND REHABILITAT	ON-NANSEMOND POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		/10/2017
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F 285	retardation" in federal condition?	regulation) or a related	F 285	5		
	Resident Review (PAS- completed 9/14/08 review disability was severed related conditions of control disorder. The assessed does not communicate orientation level was at the PASRR Determines sensory stimulation is	nable to be determined. ation Summary read " recommended to involve environment and provide a		This Plan of Correction is the center's creallegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged a set forth in the statement of deficiencies. correction is prepared and/or executed sit is required by the provisions of federal	n of correction ent by the or conclusions The plan of olely because	
	rebalancing services at towards supporting percomply with the Supre Olmstead vs L.C. (199 with Disabilities Act, in cannot be required to receive public benefits community-based settiadvance person-center assuring that psychological functional needs are of personal goals and preterm care.	99), under the Americans dividuals with disabilities be institutionalized to that could be furnished in ings. PASRR can also ered care planning by ogical, psychiatric, and				
		e person-centered care plan 7/17 did not address the lagnosis, neither did it				

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OR SUPPLIER	495247	B. WING_	· · · · · · · · · · · · · · · · · · ·	30	C 3/10/2017
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ND REHABILITAT	ION-NANSEMOND POINT		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		į
(EACH DEFICIENC		ID PREFIX TAG		SHOULD BE	(X5) COMPLETION DATE
ss coordination ommunity Servi ipation in planni tesident Assess	of care and services with ces Board to include ng person centered care. ment Instrument dated	F 2	85		
Level II PASRE ation report specialized responsible do by the State. State is responsible do residents es (in other State) arovided in other state for provided in other intrices to be paradior specialized to the responsible do provide allowed to the responsible to the responsible do not be paradior specialized in the plantifies individuals ent. Review uponsible was conducted assigned to Responsible do not report to the responsible do not report to	R determination and the cify services to be provided and/or specialized services sible for providing to individuals with MI or as specialized services are in Medicaid-certified tes specialized services are reacility types such as a The nursing home is 1 other care and services sident's condition. Provided by the nursing zed services provided by the ed in the Level II PASRR to evaluation report should be an of care. So who are subject to the condition."		allegation of compliance. Preparation and/or execution of this does not constitute admission or agre provider of the truth of the facts alleg set forth in the statement of deficienc correction is prepared and/or execut	plan of correction vement by the ged or conclusions ies. The plan of ed solely because	
	nued From page ess coordination ommunity Servicipation in planning Resident Assess our 2016 stated. Level II PASRF ation report speed by the State. State is responalized services to be provided in other State or ovided in other state or ovided in other state. It is serviced to provide allopriate to the residents of the planting that are specification and the essed in the plantifies individuals dent Review upon 10/17 at approxite was conducted to Review upon 10/17 at approxite was conducted as assigned to Review dent Review upon 10/17 at approxite was conducted as assigned to Review dent Review upon 10/17 at approxite was conducted as assigned to Review dent Review den	Level II PASRR determination and the ation report specify services to be provided a nursing home and/or specialized services	nued From page 25 ess coordination of care and services with ommunity Services Board to include cipation in planning person centered care. Resident Assessment Instrument dated per 2016 stated at page A-19; Planning for elevation in report specify services to be provided enursing home and/or specialized services and by the State. State is responsible for providing alized services to individuals with MI or one in the interior of the interior	nued From page 25 ess coordination of care and services with community Services Board to include sipation in planning person centered care. Resident Assessment Instrument dated per 2016 stated at page A-19; Planning for PLevel II PASRR determination and the ation report specify services to be provided an ursing home and/or specialized services and by the State. State is responsible for providing alized services to individuals with MI or D. In some States specialized services are and to residents in Medicald-certified ies (in other States specialized services are reprovided in other facility types such as a histric hospital). The nursing home is red to provide all other care and services private to the resident's condition. services to be provided by the nursing home is red to provide all other care and services private to the resident's condition. services to be provided by the nursing home is red to provide all other care and services private to the resident's condition. services to be provided by the nursing home is red to provide all other care and services private to the resident's condition. services to be provided by the nursing home is red to provide all other care and services private to the resident's condition. services to be provided by the nursing home is red to provide all other care and services private to the resident's condition. services to Resident's condition. services to be provided by the nursing home is required by the provisions of fed to the resident's condition.	nued From page 25 sss coordination of care and services with ommunity Services Board to include ipation in planning person centered care. Resident Assessment Instrument dated per 2016-stated-at page A-19; Planning for Level II PASRR determination and the ation report specify services to be provided en pursing home and/or specialized services and by the State. State is responsible for providing alized services are led to resident's in Medicald-certified ies (in other States specialized services are lited to resident's condition. Services to be provided by the nursing service to the resident's condition. services to be provided by the nursing and/or specialized services provided in other States specialized services provided by the that are specified in the Level II PASRR mination and the evaluation report should be seed in the plan of care. Intifies individuals who are subject to lent Review upon change in condition."

דתוואוןבט. טאווסובטוו

PRINTED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495247 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 285 Continued From page 26 F 285 MDS Coordinators she learned they did not know what PASRR is. Social Worker #2 also stated she has never coordinated with the Community Service Board on Resident #17's behalf and was not aware this was required. As a result the resident had not been followed by the Community Service Board since admission. Social Worker. #2 stated the Community Service Board was This Plan of Correction is the center's credible contacted and an appointment was scheduled for allegation of compliance. 8/29/17 for someone to come to the nursing Preparation and/or execution of this plan of correction facility and update the screening and assign a does not constitute admission or agreement by the new caseworker for Resident #17. provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. On 8/10/17 at approximately 5:00 p.m., during the pre-exit briefing the Administrator, Director of Nursing and Corporate Director of Clinical Operations were made aware of the above information. No additional information was presented but the Corporate Consultant stated the only information they have regarding PASRR was what was included in the facility's Mental and Psychosocial Functioning policy with a release dated of 9/28/18. The policy read at #5; "Patients newly diagnosed with mental illness triggers a PASSR review by the state mental health authority." There was no information for the Level

to maintain.

F 315

SS=D

II PASSR screening or updates.

RESTORE BLADDER

(e) Incontinence.

483.25(e)(1)-(3) NO CATHETER, PREVENT UTI,

(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible F 315

•		D HUMAN SERVICES MEDICAID SERVICES			FO	ED: 09/18/2017 RM APPROVED	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IPLE CONSTRUCTION	(X3) DA	O. 0938-0391 TE SURVEY MPLETED	
	4	495247	B. WING _			C 8/10/2017	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 315	on the resident's compactification facility must ensure the	urinary incontinence, based prehensive assessment, the	F3	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of condess not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The procedure of the propared and/or executed solely	orrection; the aclusions; plan of	09/22/2017	
	indwelling catheter is resident's clinical cond catheterization was not catheterization was not (ii) A resident who ent indwelling catheter or is assessed for remove as possible unless the demonstrates that cat and (iii) A resident who is it receives appropriate to prevent urinary tract in continence to the external catheter (3) For a resident with on the resident's complicating must ensure the incontinent of bowel for treatment and service bowel function as poson This REQUIREMENT by: Based on resident interclinical record review, policy the facility staff resident (Resident #8) received necessary external resident record review, policy the facility staff resident (Resident #8) received necessary external resident record review, policy the facility staff resident (Resident #8) received necessary external resident record review, policy the facility staff resident (Resident #8) received necessary external resident record review, policy the facility staff resident received necessary external resident record review, policy the facility staff resident received necessary external resident record review, policy the facility staff resident received necessary external resident record review, policy the facility staff resident received necessary external resident record review.	not catheterized unless the dition demonstrates that ecessary; ers the facility with an subsequently receives one al of the catheter as soon resident's clinical condition heterization is necessary ncontinent of bladder reatment and services to affections and to restore nt possible. fecal incontinence, based orehensive assessment, the at a resident who is eceives appropriate as to restore as much normal sible. is not met as evidenced erview, staff interview, and review of the facility's failed to ensure 1 of 35 in the survey sample		F315 1. Resident #8 care plan has bee updated to include the provise bed pan at bedside to decreas urinary incontinence. 2. All residents residing in the f have been identified as havin potential to be affected. 3. The Staff Development Coort (SDC) in-serviced License N and Certified Nursing Assistat (C.N.A) on 09/20/2017 and on going to ensure the resident's wishes/rights are honored and information is updated in the of care. DNS/designee will perform random audit 3X weemonth and then monthly x 2 r to validate that resident wishes are honored. 4. Results of audit will be taken monthly Performance Improvementing which consist of Exe Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, correcti	en ion of e acility g the dinatorurses int a lekly 1 months es/right to the ement cutive		

prevention of urinary incontinence episodes.

a bedpan for use when in bed.

The facility staff failed to provide Resident #8 with

action will be initiated if

appropriate.

		ID HUMAN SERVICES					FED: 09/1	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					NO. 0938	
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) D	TE SURVE	
		495247	B. WING _				C 08/10/201	17
NAME OF P	ROVIDER OR SUPPLIER	1		STR	REET ADDRESS, CITY, STATE, ZIP CODE		70/10/20	
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F 315	Continued From page	28	F3	315				
	The findings included:	:						
	8/6/16 and readmitted	nally admitted to the facility I 3/6/17. The current pilateral below the knee						
	heart failure requiring The quarterly Minimur assessment with an a (ARD) of 5/20/17 code completing the Brief Ir (BIMS) and scoring 15 indicated Resident #8' decision making were (Physical functioning) requiring extensive as bed mobility, transfers section "H0300" frequiring An interview was cond	m Data Set (MDS) ssessment reference date ed the resident as nterview for Mental Status out of a possible 15. This 's cognitive abilities for daily intact. In section "G" the resident was coded as sistance of 1 person with			This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or corset forth in the statement of deficiencies. The provision is prepared and/or executed solely it is required by the provisions of federal and statement of the statement of the solely it is required by the provisions of federal and statement.	orrection the aclusions plan of because		
	stated she loves her rebut she had two grieves she expressed was the provide her with a bed decrease episodes undecrease episodes epis	oom and life in the facility ances. The first grievance e staff's resistance to I pan when in bed to inary incontinence. The utilized bilateral lower gs and she removed them to but when the urge to so to get up, don the insfer to the bedside by the time she does that						
		ted on herself. The resident uested to have a bedpan for						

PRINTED: 09/18/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG	СФМ	E SURVEY PLETED
		495247	B. WING_		l	/10/2017
	ROVIDER OR SUPPLIER TCC AND REHABILITAT	ION-NANSEMOND POINT	·	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
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F 315	on the bedpan faster prosthetic legs and tra commode but the faci to the idea and they of her problem. The resi	he felt she could put herself than she could don the ansfer to the bedside ility staff was not receptive offered_no other solutions to dent stated the facility staff ok good to have a bed pan	FS	315	,	
	on 8/9/17 stated Residuring the group inter a bedpan overnight a refrigerator use to be Resident #8's care plate 8/16/17 was reviewed of resident) noted to be related to impaired m. The goal read; "Patie breakdown due to incompaire through the review dainterventions were; "Cas required for incontinence care. Er day to promote prompestablish voiding patt signs/symptoms of ur burning, blood tinged increased pulse, incre	an with a revision dated of d. The problem read, "(name be incontinent of bladder oblitty and use of diuretic." In will remain free of skin continence and brief use ate 8/29/17." The Check patient frequently and inence. Wash, rinse and dry othing as needed after incourage fluids during the oted voiding responses. Honitor/document for inary tract infection; pain, urine, cloudiness, no output, eased temperature, urinary ing urine, fever, chills, change in behavior,		This Plan of Correction is the center's allegation of compliance. Preparation and/or execution of this ideas not constitute admission or agree provider of the truth of the facts alleg set forth in the statement of deficiencic correction is prepared and/or execute it is required by the provisions of federal constitutions.	plan of correction tement by the tred or conclusions ties. The plan of ted solely because	
	1	ducted with the Director of				

PRINTED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING __ C 495247 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 315 Continued From page 30 F 315 Director of Nursing stated Resident #8 could have a bedpan at bedside and she proceeded to inform the staff of such. The Director of Nursing presented a care plan on 8/9/17 at approximately 3:00 p.m., with a new intervention which read (name of resident) may have a bed pan at bedside. The surveyor spoke with Resident #8 on 8/10/17 This Plan of Correction is the center's credible at approximately 11:40 a.m., the resident was allegation of compliance. pleased the facility staff had made steps to aid Preparation and/or execution of this plan of correction her in decreasing urinary incontinence episodes, does not constitute admission or agreement by the they provided her with a bed pan for use. provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility's policy titled "Urinary Incontinence" with a release date of 5/31/15 read; based on the patient's comprehensive assessment, care and treatment are provided to help the patient restore his/her highest level of normal bladder function as possible and to prevent urinary tract infection. Under procedure #4 the policy read; individualize interventions that address the incontinence including the patients capabilities and underlying factors that can be removed, modified, or stabilized and by monitoring the effectiveness of the interventions and modifying them as appropriate. This may include restorative nursing programs.

presented.

On 8/10/17 at approximately 5:00 p.m., during the pre-exit briefing the Administrator, Director of Nursing and Corporate Director of Clinical Operations were made aware of the above information. No additional information was

PRINTED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495247 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 333 Continued From page 31 This Plan of Correction is the center's credible F 333 09/22/2017 allegation of compliance. 483.45(f)(2) RESIDENTS FREE OF F 333 F 333 SIGNIFICANT MED ERRORS SS=E Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion 483.45(f) Medication Errors. set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because The facility must ensure that itsit is required by the provisions of federal and state law (f)(2) Residents are free of any significant F333 medication errors. MAR and physician order sheet for This REQUIREMENT is not met as evidenced resident #9 reviewed by DNS for by: accuracy. Med variance report Based on observation, staff interview, clinical completed 08/09/2017. The record review and facility document review, the physician and family member were facility staff failed to ensure 1 of 35 residents in notified of the medication variance the survey sample, Resident #9, was free of on 08/09/2017. Performance significant medication error. Improvement and reeducation done with license nurse on The facility staff failed to administer the correct 09/20/2017 and on-going. dosage of Eliquis (1) tablet for Resident #9. Eliquis tablet 5 mg (milligrams) two times a day All residents residing in the facility was administered by the nurses for 5 1/2 days have been identified as having the instead of Eliquis 10 mg two times a day, as potential to be affected. (what did ordered by the physician. do to assure all The findings included: All licensed nurses were in-Resident #9 was admitted to the facility on serviced/reeducated by Staff 7/30/17. Diagnoses for Resident #9 included but Development Coordinator (SDC) not limited to, muscle weakness, UTI (urinary on the five (5) rights of medication tract infection), high blood pressure, depression, administration and on policy and anxiety disorder, and post-surgical care. procedure for event reporting of

decision making are intact.

The most recent Minimum Data Set with an

assessment reference date of 8/6/17, coded

Resident #9 with a score of 15 out of possible 15 on the Brief Interview for Mental Status (BIMS),

indicating Resident #9's cognitive abilities for daily

on-going.

medication errors, documentation

and monitoring on 09/20/2017 and

Medication Competency completed

by Staff Development Coordinator

All licensed nurses will have

PRINTED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE:CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING _ 495247 B. WING 08/10/2017 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION IĐ (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 333 Continued From page 32 F 333 09/22/2017 On 8/8/17 at approximately 5:00 PM, during the medication pass observation, LPN (Licensed This Plan of Correction is the center's credible Practical Nurse) #2 administered the Eliquis 5 allegation of compliance. mg. tablet (one tablet) to Resident #9. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the The Medication Administration Record (MAR) provider of the truth of the facts alleged or conclusion indicated, "Eliquis 5 mg Tablet EA (each); Give 10 set forth in the statement of deficiencies. The plan of mg by mouth two times a day for 7 days". The correction is prepared and/or executed solely because medication pack of Eliquis contained 5 mg it is required by the provisions of federal and state law. tablets. LPN #2 should have given Resident #9 two 5 mg tablets to give a total of 10 mg, as (SDC) on med pass administration ordered. and during orientation then annually thereafter. Any nurse with The medication cart used by LPN #2 stored two > 5% med error rate will have packs of Eliquis 5 mg tablets for Residents #9. further in-servicing from Each pack had a total number of 28 tablets; this SDC/designee. equaled to 56 tablets. One pack showed 4 tablets Medication pass will be randomly were used with 24 tablets remaining; the other pack showed 7 tablets were used with 21 tablets monitored weekly X4 weeks. . remaining; therefore, a total of 11 tablets were monthly x 2 months, then quarterly used. It was evident that Eliquis 5 mg was only thereafter by DNS/ designee and given as 1 tablet, instead 2 tablets, for 5 1/2 days pharmacy nurse consultant (11 doses). If administered correctly per quarterly. Findings will be physician's order, a total of 22 tablets should presented to the Performance have been given, not 11 tablets. Improvement Committee which

8/5/2017.

The Pharmacy Shipment Order # R2772004

indicated 28 Eliquis 5 mg tablets were filled,

Resident #9. The second shipment order #

filled on 7/31/2017, shipped and delivered on

shipped and delivered to the facility on 7/31/17 for

R2772100 indicated 28 Eliquis 5 mg tablets were

On 8/9/17 at 11:00 am, LPN #1, who worked 7-3 shift, was interviewed and was asked how many tablets of Eliquis Resident #9 had received on his shift and he stated, "I gave two tablets this am. She gets two tablets of 5 mg tablets, which totals

consist of Executive Director,

Medical Director, Director of

for further recommendations.

required.

Nursing, Staff Development, Social

Services Director, Dietitian, C.N.A

& Pharmacy X3 months, quarterly

Corrective action will be initiated if

		ID HUMAN SERVICES		l de la companya de	RINTED: 09/18/2017 FORM APPROVED
STATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION (X:	MB NO. 0938-0391 B) DAITE SURVEY COMPLETED
		495247	B. WING		C 08/10/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
KINDRED	TCC AND REHABILITAT	ON-NANSEMOND POINT		200 WEST CONSTANCE ROAD SUFFOLK, VA 23434	
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F 333		PM, RN (Registered Nurse)	F;	333	
		garding the incorrect ils. She stated that she was and the physician had been			
	forward with the currer orthopedic (2) surgeo discontinue the currer investigaled the incide tabs (tablets) should hecked with all three Resident #9 had no sibleeding. She stated that staff development cooleducated and will be pass. RN #9 was asked outcome for giving Restricted that she medication and she coagulation for clotting. On 8/10/17 at 12:45 For conducted with the Dishe stated that she all Eliquis and stated that been given. A medica filled out, according to "The Nurse Manager observation with nurs what could be the outerror and she stated, harm now but if it commore at risk for blood." The clinical records we Physician Order Sheet.	ent and she stated, "Two have been given". She had shifts and found that gns and symptoms of that, in coordination with the ordinator, nurses will be observed during medication ed what could be the esident #9 incorrect doses of the stated, "not enough g." PM, an interview was rector of Nursing (DON) and ready saw the two packs of t two tablets should have tion error report had been of the DON, and she added, is doing medication pass es now". She was asked come of this medication "There's no outcome of tinues, that would put her clots."		This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of corre does not constitute admission or agreement by the provider of the truth of the facts alleged or concluset forth in the statement of deficiencies. The plan correction is prepared and/or executed solely becauties is required by the provisions of federal and state.	sions of ause

two times a day for DVT (3) prophylaxis (4) for 7

PRINIED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ 495247 B. WING d8/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 333 | Continued From page 34 F 333 days. Start date: 8/4/2017 0900; 2. Eliquis Tablet 5 mg. Give 1 tablet by mouth 2 times a day for DVT prophylaxis. Start date: 8/12/2017 0900." The Medication Administration Record (MAR) for Eliquis Tablet 10 mg by mouth two times a day for 7 days, dated 08/01/2017 - 08/31/2017, showed the nurses initialed the MAR on 8/4/17 through 8/8/17 at 0900 and 1700; on 8/9/17 at 1700. Resident #9's Comprehensive Resident Centered This Plan of Correction is the center's credible Plan of Care, dated 8/1/17, stated the resident allegation of compliance. was at risk for bruising, abnormal bleeding, or Preparation and/or execution of this plan of correction hemorrhage due to anticoagulant (5) use. The does not constitute admission or agreement by the goal for this problem was that the resident "will be provider of the truth of the facts alleged or conclusions free from signs and symptoms of abnormal set forth in the statement of deficiencies. The plan of bleeding through next review date". correction is prepared and/or executed solely because it is required by the provisions of federal and state law Interventions/Tasks directed the staff to: "Administer anticoagulants as currently prescribed by the physician; Monitor for and report to nurse any of the following signs and symptoms of bleeding; bleeding gums, nose bleeds, unusual bruising, tarry/black stools, pink or discolored urine: Obtain labs per physician order; Report to physician any signs and symptoms of abnormal bleeding or hemorrhage." Review of the Nurses Notes from 7/30/17 through 8/9/17 revealed no signs and symptoms of bleeding for Resident #9. On 8/9/17, a copy of the Medication

Administration Policy was requested from the DON and received a copy of a document titled, "Oral Medication Administration". It was a copy of the Competency Checklist titled, "Oral Medication Administration" dated 4/28/09. The procedure included the following: "...Procedure #7. Practices the five rights before giving the medication: ...c.

PRINTED. USITOIZUTI DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495247 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION DATE REGULATORY OR LSC-IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 333 Continued From page 35 F 333 Right dose - Checks each medication to verify dosage of medication is correct. Note to Observer: When observing medication administration, verify that the correct dosage of the medication is being prepared. If the incorrect dosage is prepared and the employee intends to administer the medication, intervene with administration of the medication. Count the intent to administer the medication as an "Unsatisfactory Demonstration of Skill" even though the medication was not given." This Plan of Correction is the center's credible The Administrator, DON and District Director of allegation of compliance. Clinical Operations were made aware of these findings on 8/10/17 at approximately 4:55 PM. No Preparation and/or execution of this plan of correction further information was provided. does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions

Definition:

(1) Eliquis (Apixaban) - is used help prevent strokes or blood clots in people who have atrial fibrillation (a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes) that is not caused by heart valve disease. (Source: https://medlineplus.gov/druginfo/meds/a613032.h tml#why)

(2) Orthopedics - a branch of medicine concerned with the correction or prevention of deformities. disorders, or injuries of the skeleton and associated structures (as tendons and ligaments). (Source: http://c.merriam-webster.com/medlineplus/orthop

(3) DVT prophylaxis - a condition marked by the formation of a thrombus within a deep vein (as of set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

FORM CMS-2567(02-99) Previous Versions Obsolete

edics)

Event ID; LWF311

Facility ID: VA0169

If continuation sheet Page 36 of 40

PRINTED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495247 **B WING** 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 333 Continued From page 36 09/22/2017 F 333 This Plan of Correction is the center's credible allegation of compliance. the leg or pelvis) that may be asymptomatic or be accompanied by symptoms (as-swelling and pain) Preparation and/or execution of this plan of correction and that is potentially life threatening if does not constitute admission or agreement by the dislodgment of the thrombus results in pulmonary provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of embolism, (Source: correction is prepared and/or executed solely because http://c.merriam-webster.com/medlineplus/deep% it is required by the provisions of federal and state law 20vein%20thrombosis) F431 (4) Prophylaxis - measures designed to preserve A container of ammonium lactate health and prevent the spread of disease: 1% and a bottle of Triamcinolone protective or preventive treatment. (Source: Acetonide 1% located in resident http://c.merriam-webster.com/medlineplus/prophy #14 room on Butler Hall on laxis) 08/10/2017 was stored properly per policy and procedure on (5) Anticoagulant - a substance (as a drug) that 08/10/2017. hinders coagulation and especially coagulation of Residents with physician's orders the blood. (Source: for topical medications have been http://c.merriam-webster.com/medlineplus/antico identified as having the potential to agulant). be affected. 8/10/2017 DNS/Staff F 431 483.45(b)(2)(3)(g)(h) DRUG RECORDS, F 431 looked in 100% of rooms for any LABEL/STORE DRUGS & BIOLOGICALS SS=D creams/medications stored in rooms. None were identified. The facility must provide routine and emergency Licensed nursing staffs have been drugs and biologicals to its residents, or obtain in-serviced by Staff Development them under an agreement described in Coordinator (SDC) on 09/20/2017 §483.70(g) of this part. The facility may permit on proper medication storage. unlicensed personnel to administer drugs if State ADNS/Unit Managers will conduct law permits, but only under the general observation rounds on each unit supervision of a licensed nurse. weekly X3 weeks, then monthly x2 months to validate that medications (a) Procedures. A facility must provide are stored appropriately in

pharmaceutical services (including procedures

that assure the accurate acquiring, receiving,

dispensing, and administering of all drugs and

(b) Service Consultation. The facility must

employ or obtain the services of a licensed

biologicals) to meet the needs of each resident.

medication Carts. Results of these

observation audits will be

documented on an audit tool.

Director, Medical Director,

Audit tools will be presented to Performance Improvement

Committee consists of Executive

		ID HUMAN SERVICES				FC	(RM APPROVED
CENTERS FOR ME	DICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
STATEMENT OF DEFICIENS AND PLAN OF CORRECTIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION		ATE SURVEY MPLETED
		495247	B. WING		· ·		C 08/10/2017
NAME OF PROVIDER OR		ION-NANSEMOND POINT		20	REET ADDRESS, CITY, STATE, ZIP CODE	· l	
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
pharmac (2) Estab disposition detail to s	lishes a sys n of all cont enable an ac	tem of records of receipt and rolled drugs in sufficient ecurate reconciliation; and	F	431	This Plan of Correction is the center's credible allegation of compliance.	;	09/22/2017
that an amaintains (g) Label Drugs an labeled improfession appropriation instruction applicable (h) Stora (1) in acceptable (1) in acceptable (2) The facility locked controls, have acceptable (2) The facility permanent controlle Compreficient (2) The facility permanent controlle (2) The facility permanent (2) The	ccount of all ed and period ing of Drugs discordance nal principle ate accessor ns, and the ee. ge of Drugs cordance with y must store ampartments and permit dess to the kneed difference of 1976 accept when drug distributed and distributed accept when drug distributed and permit of the kneed accept when drug distributed and permit of the kneed accept when drug distributed and permit of the kneed accept when drug distributed and permit of the kneed accept when drug distributed and permit of the kneed accept when drug distributed and permit of the kneed accept when drug distributed and permit of the kneed accept when drug distributed and permit of the kneed accept when drug distributed accept and permit of the kneed accept when drug distributed accept and permit of the kneed accept accept and permit of the kneed accept and permit of the kneed accept ac	rug records are in order and controlled drugs is dically reconciled. and Biologicals. a used in the facility must be with currently accepted s, and include the y and cautionary expiration date when and Biologicals. h State and Federal laws, all drugs and biologicals in a under proper temperature only authorized personnel to eys. provide separately locked, compartments for storage of d in Schedule II of the y Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can			Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The procedure is prepared and/or executed solely it is required by the provisions of federal and some different procedure. Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy. monthly for three months for review, recommendation and continuenced for further monitoring to sustain compliance.	the actusion alan of because atate law	5

Based on observation, resident interview, clinical record review and facility document review the facility staff failed to ensure topical (external)

by:

PRINTED: 09/18/2017

		ID HUMAN SERVICES MEDICAID SERVICES				FC	RM	09/18/2017 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		MPL	URVEY ETED
		495247	B. WNG		,		C 08/1	0/2017
NAME OF P	ROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
KINDRED	TCC AND REHABILITAT	ION-NANSEMOND POINT			00 WEST CONSTANCE ROAD SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE
F 431	residents in the surver A container of ammor cream and a bottle of medication cream we Resident #14's room. The findings included Resident #14 was ad 7/25/17 following a hopulmonary (lung) emit pulmonary artery) and The current MDS (Mi admission with an as 8/1/17 coded the resident #15 on the Britanian and the survey a	perly stored for 1 of 35 y sample, Resident #14. nium lactate 1% medication Triamcinolone 1% re observed stored inside : mitted to the facility on ospitalization for a oolism (a blockage in the d generalized weakness.	F	431	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or corset forth in the statement of deficiencies. The provision is prepared and/or executed solely it is required by the provisions of federal and statement of	orrection the nclusion plan of because	s	
	the side of the bed. of drawer were two med container of ammonic cream and a bottle of 1%. The resident staffrom home. The Order Summary physician order dated Acetonide Cream 1% topically every day a On 8/9/17 at 10:15 a	#14 was observed sitting on Observed on the bedside dication creams. One fium lactate 1% medication for Triamcinolone Acetonide ated these were brought in						

cream was observed in the same spot, on the

PRINTED: 09/18/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 495247 08/10/2017 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 WEST CONSTANCE ROAD KINDRED TCC AND REHABILITATION-NANSEMOND POINT SUFFOLK, VA 23434 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From page 39 F 431 F 431 bedside drawer. The resident stated the bottle of Triamcinolone 1% cream was now inside a second drawer. The second drawer was inspected with permission of the resident. Stored inside one drawer was a pink wash basin, inside the basin was the Triamcinolone 1% cream. On 8/9/17 at approximately 7:00 p.m., the above findings was shared with the Administrator and the Director of Nursing. The DON stated she was This Plan of Correction is the center's credible unaware of this and would look into it. allegation of compliance. On 8/10/17 at 5:10 p.m., the DON stated the Preparation and/or execution of this plan of correction does not constitute admission or agreement by the resident was educated last evening that these provider of the truth of the facts alleged or conclusions medications could not be stored at the bedside set forth in the statement of deficiencies. The plan of and placed them inside her office for safekeeping correction is prepared and/or executed solely because until the resident was discharged. She stated she it is required by the provisions of federal and state law. did not want to store them inside the medication room as she did not want them to be accidentally sent for disposal to the pharmacy. The DON evidenced the resident had been sent a tube of the Triamcinolone 1% cream from the facility pharmacy that was stored inside the treatment cart. The facility's pharmacy Policy titled "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" with a revision date of 1/1/03 read, in part: "This Policy 5.3 sets forth the procedures relating

and visitors."

to the storage and expiration dates of

biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents

3. General Storage Procedures:

medications, biologicals, syringes and needles.

3.3 Facility should ensure that all medications and