FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CDNSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495299 B. WING 04/27/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD **ELIZABETH ADAM CRUMP HEALTH AND REHAB** GLEN ALLEN, VA 23060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The statements made on this plan of E 000 **Initial Comments** E 000 correction are not an admission to and do not constitute an agreement An unannounced Emergency Preparedness with the alleged deficiencies herein. survey was conducted on 4/26/18. Corrections are required for compliance with 42 CFR Part To remain in compliance with all 483.73, Requirement for Long-Term Care federal and state regulations, the Facilities. center has taken or is planning to E 020 Policies for Evac. and Primary/Alt. Comm. E 020 take the actions set forth in the CFR(s): 483.73(b)(3) SS=C following plan of correction. The [(b) Policies and procedures. The [facilities] must following plan of correction develop and implement emergency preparedness constitutes the center's allegation of policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk compliance. All alleged deficiencies assessment at paragraph (a)(1) of this section. cited have been or are to be and the communication plan at paragraph (c) of corrected by the date or dates this section. The policies and procedures must be indicated. reviewed and updated at least annually. At a minimum, the policies and procedures must 5/29/18 E020 address the following:1 1. Facility emergency preparedness Safe evacuation from the [facility], which includes plan now includes an alternate form consideration of care and treatment needs of evacuees; staff responsibilities; transportation; of communication. Facility purchased identification of evacuation location(s); and a 2-way radio. primary and alternate means of communication with external sources of assistance. 2. No other concerns noted. \*[For RNHCs at §403.748(b)(3) and ASCs at 3. Maintenance staff educated on §416.54(b)(2):1 using the 2-way radio during an Safe evacuation from the [RNHCI or ASC] which emergency with no other includes the following: (i) Consideration of care needs of evacuees. communication sources are (ii) Staff responsibilities. available. (iii) Transportation. (iv) Identification of evacuation location(s). 4. Audits of 2-way radio is available (v) Primary and alternate means of will be conducted weekly for four

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE LNHA

communication with external sources of

TITLE Administrator

week then monthly for three

(X6) DATE

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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

assistance.

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STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA AND PLAN OF CORRECTION IOENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
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	PROVIOER OR SUPPLIER ET <b>H AD</b> AM CRUMP H	EALTH AND REHAB		3	TREET AOORESS, CITY, STATE, ZIP COOE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 04/	21/2016
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€ 020	* [For CORFs at §4 Rehabilitation Ager §485.727(b)(1), an §494.62(b)(2):] Safe evacuation for Rehabilitation Ager Agencies as Provio Therapy and Speed Services; and ESR staff responsibilities. * [For RHCs/FQHC evacuation from the appropriate placem responsibilities and This REQUIREMED by:  Based on staff intereview it was determined to have a compreparedness plan.  The facility staff fail that the emergency policies and procedure facility and that elements; specificate communication.  The findings include On 4/26/18 at 9:15 comprehensive emwas reviewed with all that the comprehensive emwas reviewed with all that the comprehensive emwas reviewed with all that the emergency policies and procedure facility and that elements; specificate communication.  The findings include On 4/26/18 at 9:15 comprehensive emwas reviewed with all that the comprehensive emwas reviewed with all that the emergency policies and procedure facility and that elements; specificate communication.	Iss.68(b)(1), Clinics, acies, OPT/Speech at d ESRD Facilities at om the [CORF; Clinics, acies, and Public Health lers of Outpatient Physical ch-Language Pathology D Facilities], which includes s, and needs of the patients.  Is at §491.12(b)(1):] Safe e RHC/FQHC, which includes ent of exit signs; staff needs of the patients.  NT is not met as evidenced erview and facility document mined that the facility staff inplete emergency  ed to evidence documentation of preparedness plan included lures for safe evacuation from it includes all of the required lly alternate forms of exit signs; staff and the required lay alternate forms of the facility's ergency preparedness plan the facility Administrator, ASM	E	020	months. Results of audits will be reviewed at the monthly QAPI meeting for three months to sus compliance.		

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Event IO: TQ6711

Facility IO: VA0083

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E 020	of alternate forms of listed cell phones at the Administrator strong communication work asked what the facture electronic/digital for cell phones and intradios or other such just the internet.  On 4/36/18 at 3:15 conducted, due to a locate or identify so secondary to being	of communication. The plan s primary source. At this time, tated that the alternate form of all be the internet. When	EO	20			
	was asked again. A Staff Member) the present in assisting review. When asked alternate communic satellite radios or semergency. OSM used to be but that On 4/26/18 at 5:24 the Administrator at (ASM #2) were marked.	At this time, OSM #6 (Other Maintenance Director was the administrator with the ed if there were other forms of cations the facility used, i.e. imilar such devices, in an #6 stated no. He stated there they all disappeared.  PM at the end of day meeting, and the Director of Nursing de aware of the findings. No		E031	1		
E 031 SS=C	survey. Emergency Official CFR(s): 483.73(c)(  [(c) The [facility] mu emergency prepare that complies with I and must be review	was provided by the end of the s Contact Information 2) ust develop and maintain an edness communication plan Federal, State and local laws wed and updated at least munication plan must include	E	31 inforfacil 2. N 3. 5t office	mergency Officials Contact rmation has been added to ity emergency plan. o other concerns noted. taff educated on emergency cials contact information add the facility emergency plan.	,	5/29/18

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILE		(X3) DATE SURVEY CDMPLETED			
		495299	B. WING	i		IF.	27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		3	STREET ADDRESS, CITY, STATE, ZIP CODE 6600 MDUNTAIN RDAD GLEN ALLEN, VA 23060		
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E 031	all of the following:  (2) Contact informa (i) Federal, State emergency prepare (ii) Other sources  *[For LTC Facilities information for the (i) Federal, State, tr emergency prepare (ii) The State Licens (iii) The Office of th Ombudsman. (iv) Other sources of  *[For ICF/IIDs at §4 information for the (i) Federal, State, tr emergency prepare (ii) Other sources of (iii) The State Licens (iv) The State Licens (iv) The State Licens (iv) The State Prote This REQUIREMENT by: Based on staff inter review it was determ failed to have a compreparedness plan.  The facility staff fail that the emergency all required Emerge information in the co 911.	ation for the following: In tribal, regional, and local edness staff. It of assistance.  at §483.73(c):] (2) Contact following: Itibal, regional, or local edness staff. It is and Certification Agency. It is assistance. It is and Certification Agency. It is not met as evidenced arview and facility document mined that the facility staff inplete emergency. It is not met as evidenced arrowed the energency in the energy of the energy o		031	4. Audits of emergency official contacts information will be conto to ensure information is current weekly for four weeks then mon for three months. Results of aud will be reviewed at the monthly meeting for three months to sus compliance.	thly its QAPI	
	The findings include	<del>2</del> ;					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 27/2018		
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		2172010		
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E 031	comprehensive em was reviewed with #1 (Administrative failed to reveal any information for all F and local emergency when asked about the Administrator was the 911 number Officials contact information on 4/36/18 at 3:15 conducted, due to a locate or identify so secondary to being question of the listing Federal, State, tribs emergency prepare again. Such listing reflected in the compreparedness plan On 4/26/18 at 5:24 the Administrator at (ASM #2) were mare	AM, a review of the facility's pergency preparedness plan the facility Administrator, ASM Staff Member). This review evidence of a listing of contact Federal, State, tribal, regional cy preparedness officials. The listing, the only number was able to identify in the plan er. No other Emergency formation was included.  PM, a follow up review was ASM #1 being unable to initially ome parts of the plan new at the facility. The ng of contact information for all al, regional and local edness officials was asked still was not provided or imprehensive emergency.  PM at the end of day meeting, and the Director of Nursing de aware of the findings. No	EC	031				
	survey. EP Testing Require CFR(s): 483.73(d)(		ΕŒ	1. Facility to conduct a tab	letop	5/29/18		
	RNHCIs and OPOstest the emergency [facility, except for all of the following:	cility, except for LTC facilities, s] must conduct exercises to plan at least annually. The RNHCls and OPOs] must do at §483.73(d):] (2) Testing.		exercise and a full-scale exercise and a full-scale exercise and a full-scale exercise so the full-scale exercises to include of analysis of exercises.	ercise. d. op and			

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Event ID: TQ6711

Facility ID: VA0083

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	PROVIDER OR SUPPLIER	EALTH AND REHAB		3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1	.,,,,
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E 039	The LTC facility muthe emergency plar unannounced staff procedures. The LT following:]  (i) Participate in a frommunity-based of exercise is not acceptacility-based. If the actual natural or marequires activation of [facility] is exempt frommunity-based of full-scale exercise of the actual event.  (ii) Conduct an addinclude, but is not lift (A) A second full community-based of (B) A tabletop executed incally-relevant exercises of the incally-relevant exercises, and emergency plan.  (iii) Analyze the [fact maintain document exercises, and emergency plan.  *[For RNHCls at §4 §486.360] (d)(2) Temust conduct exercises, and emergency plan. The [RNHCl at §4 §486.360] (d)(2) Temust conduct exercises, and emergency plan. The [RNHCl at §4 §486.360] (d)(2) Temust conduct a paper (i) Conduct a paper (ii) Conduct a paper (iii) Conduct a paper (iiii) Conduct a paper (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	at least annually, including drills using the emergency of a facility must do all of the facility] experiences an an-made emergency that for the emergency plan, the facility of the emergency plan, the facility-based for 1 year following the onset of facility to the following:  -scale exercise that may mited to the following: -scale exercise that is or individual, facility-based. Facility-based facilitator, using a narrated, facilitator, using a narrated, facilitator, using a narrated, facility of the emergency scenario, and a set ents, directed messages, or designed to challenge an fallity's] response to and fall drills, tabletop ergency events, and revise the		)39	4. Audits of tabletop and full-sca exercises will be conducted year Results of audits will be reviewed the monthly QAPI meeting for the months to sustain compliance.	ly. d at	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	, ZIP CODE	<u> </u>	2112010
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E 039	clinically relevant e of problem stateme prepared questions emergency plan.  (ii) Analyze the [RI to and maintain doexercises, and eme [RNHCl's and OPC needed.  This REQUIREMED by:  Based on staff interview it was determeded to have a corpreparedness plan.  The facility staff fair documentation of the efforts to identify ar full-scale exercise,	facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an NHCl's and OPO's] response cumentation of all tabletop ergency events, and revise the O's] emergency plan, as NT is not met as evidenced erview and facility document mined that the facility staff implete emergency	ΕO	039			
	of the facility's eme conducted with ASI member) #1, the Ac facility's emergency evidence documen participation in, or e participate in locally tabletop exercise, outilized as an exercipreparedness. The	5 a.m. a review and interview rgency preparedness plan was M (administrative staff dministrator. Review of the preparedness plan failed to tation of the facility's efforts to identify and preparedness plan actual facility event					

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	! · ·		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER ETH ADAM CRUMP H			36	REET ADDRESS, CITY, STATE, ZIP CODE 000 MOUNTAIN ROAD LEN ALLEN, VA 23060	1 0-4/2	27/2010	
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F 000	had no evidence of On 4/36/18 at 3:15 conducted, due to locate or identify sign secondary to being question of evidentiality's participatic participate in locall tabletop exercise, utilized as an exercipreparedness, was Administrator state. On 4/26/18 at 5:24 the Administrator at (ASM #2) were materither information survey. INITIAL COMMEN.  An unannounced survey was conductive complaints we Corrections are refollowing 42 CFR F. Care requirements survey/report will for the census in this 165 at the time of the consisted of 35 cures at the time of the consisted of 3	fy a local full scale exercise but f that.  PM, a follow up review was ASM #1 was unable to initially ome parts of the plan g new at the facility. The ce of documentation of the on in, or efforts to identify and y, a full-scale exercise, or an actual facility event cise in emergency asked again. The ed she didn't have anything.  PM at the end of day meeting, and the Director of Nursing ade aware of the findings. No was provided by the end of the TS  Medicare/Medicaid standard cited 4/24/18 through 4/27/18. Per investigated during survey, quired for compliance with the Part 483 Federal Long Term is. The Life Safety Code		0000	The statements made on this please correction are not an admission and do not constitute an agreer with the alleged deficiencies he To remain in compliance with a federal and state regulations, the center has taken or is planning take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegatic compliance. All alleged deficiencited have been or are to be corrected by the date or dates indicated.	n to ment rein. II ne to ne		

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Event ID: TQ6711

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	<del></del>	12112016
EL IZADE	TH ADAM CRUMP H	EALTH AND BEHAD		3600 MOUNTAIN ROAD		
ELIZADI	TH ADAM CRUMP H	EALIT AND REHAD		GLEN ALLEN, VA 23060		
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F 000 F 558 SS=D	#269, #268, #167 a Reasonable Accom CFR(s): 483.10(e)(3) §483.10(e)(3) The r services in the facil accommodation of preferences except endanger the health other residents. This REQUIREMEN by: Based on observat determined that the the call bell was wit residents in the sur	nd #71. modations Needs/Preferences (3) right to reside and receive (ity with reasonable resident needs and when to do so would or or safety of the resident or (NT) is not met as evidenced (ion and staff interview it was facility staff failed to ensure (hin reach for one of 42 vey sample, Resident #118's reach. During multiple (lent #118's call bell was out of	F 558  1. Resident # 118's call bell was replaced and now is within reach.  2. A review of residents was conducted to ensure call bells wer in reach.  3. Staff will be re-educated on ensuring call bells are within reach the residents.  4. Audits of call bells being in reach of the residents will be conducted weekly for four weeks then month for three weeks. Results of audits be reviewed at the monthly QAPI		each.  Is were  In reach of  In reach  In reac	5/29/18
	02/14/18 with diagn not limited to: dyspl Down Syndrome (2) Resident # 118's m MDS (minimum dat assessment with ar date) of 02/21/18, o scoring a 0 (zero) o status (BIMS) of a severely impaired o decisions.	admitted to the facility on oses that included but were nagia (1), bladder cancer, and pain.  ost recent comprehensive a set), an admission ARD (assessment reference oded Resident # 118 as n the brief interview for mental score of 0 - 15, 0- being f cognition for making daily accoded as requiring extensive		compliance.		

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	CO	(X3) OATE SURVEY COMPLETEO C		
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F 558	assistance of one daily living.  An observation on p.m., revealed Refloor, appeared clewas observed under the head of the betwhen asked if he Resident # 118 was a company. The revealed Refloor is a company of the head. When asked at the head of the head. When asked Resident # 118 was a company of the call bell under head of the bed all an observation on a.m., revealed Refloor is a company of the call bell was of pillow at the head of the head of the head of the bed all was of pillow at the head of the head of the bed all was of pillow at the head of the head of the head of the bed all was of pillow at the head of the head	staff member for activities of  04/24/18 at approximately 1:56 sident # 118 was in bed, low to ean. Resident # 118's call bell ler Resident # 118's pillow at ad above Resident # 118's head. could reach his call bell as unable to reach for it.  04/24/18 at approximately 3:26 sident # 118 in bed. The call under Resident # 118's pillow bed above Resident # 118's ed if he could reach his call bell as unable to reach for it.  04/25/18 at approximately 1:55 sident # 118 in bed asleep, with Resident # 118's pillow at the cove Resident # 118's head.  04/25/18 at approximately 8:54 sident # 118 in bed asleep and beerved under Resident # 118's of the bed above Resident # 118's of the bed above Resident # 118's of the bed above Resident # 118 in bed asleep. The ing off the frame of the bed s.		58			
	for Resident # 118 falls related to: Ne (range of motion)	ve care plan dated 03/01/2018 documented, Focus. At risk for w environment, impaired ROM in BLEs (bilateral lower UE (left upper extremity)."					

AND DUANTOE CODDECTION DENTIFICATION NUMBER.				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER ET <b>H AD</b> A <b>M CRUMP</b> HI			3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 04//	21/2016
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F 558	Under "Intervention personal items ava Initiated: 03/01/201 On 04/26/18 at appinterview was cond practical nurse) # 9 informed of the about 118's call bell being "It should have bee call bells are check hours to make sure reach them." On 04/26/18 at appobservation of Resilying in bed and a rulying next to his right On 04/26/18 at appinterview was cond asked about Reside 9 stated, "We put it pressure switch. (Fisqueeze his hand a instead of pressing On 04/27/18 at appinterview was conditionally in the pressure switch. (Fisqueeze his hand a instead of pressing On 04/27/18 at appinterview staff	is" it documented, "Call light or ilable and in easy reach. Date 8."  proximately 1:30 p.m., an ucted with LPN (licensed , unit manager C-wing. When ove observations of Resident # out of reach, LPN # 9 stated, in put within his reach. The ed during rounds, every two the residents are able to proximately 2:40 p.m., an ident # 118 revealed he was new call bell was observed in hand.  Proximately 2:40 p.m., an ucted with LPN # 9. When ent #118's new call bell, LPN # in right after we spoke. It is a Resident # 118) is able to and activate the call bell a button."  Proximately 11:30 a.m. ASM f member) # 1, the asM # 2, director of nursing	F	5558			
	References:	ion was provided prior to exit. sorder. This information was					
		n.gov/medlineplus/swallowingdi					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
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F 558	chromosomes instered chromosome cause body and brain dev of the most common This information was https://medlineplus Notify of Changes (CFR(s): 483.10(g)(S483.10(g)(14) Notify A facility must inconsult with the resconsistent with his representative(s) with the resconsistent with his representative(s) with the resconsistent with his representative (s) with the resconsistent with the resconsistent with the resconsistent with his representative (s) with the resconsistent with the res	ion in which a person has 47 and of the usual 46. The extra es problems with the way the elop. Down syndrome is one in causes of birth defects. It is obtained from the website: gov/ency/article/000997.htm. Injury/Decline/Room, etc.) 14)(i)-(iv)(15)  iffication of Changes. Indent's physician; and notify, for her authority, the resident hen there isolving the resident which has the potential for requiring on; ange in the resident's physical, ocial status (that is, a lith, mental, or psychosocial threatening conditions or	F 5	1. Resonotific when physic 2. A resonotific when physic 3. Lick education of the control of the	ensed nursing staff will be i ated on administering odrine as ordered by the	er the re- cted nthly	5/29/18

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING	i			C 27/2018
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB	<u> </u>	3 <b>60</b>	REET ADDRESS, CITY, STATE, ZIP CODE O MOUNTAIN ROAD EN ALLEN, VA 23060	1 0-1	2112010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION OATE
F 580	as specified in §48 (B) A change in re State law or regular (e)(10) of this section (iv) The facility multipudate the address phone number of representative(s).  §483.10(g)(15) Admission to a conthat is a composite §483.5) must discrite the special configuration of the facility staff in the facility staff faresidents in the sum of the findings included the special configuration of the findings included the special continuous falled to notify and regarding a need for the facility staff faresidents in the sum of the findings included the special continuous falled to the findings included the special continuous falled to the special continuous falled the specia	om or roommate assignment 33.10(e)(6); or sident rights under Federal or ations as specified in paragraphition.  Ist record and periodically s (mailing and email) and the resident  Imposite distinct part. A facility edistinct part (as defined in lose in its admission agreement uration, including the various prise the composite distinct ecify the policies that apply to ween its different locations 9).  ENT is not met as evidenced erview and clinical record ermined that the facility staff consult with the physician to alter treatment for one of 42 arvey sample, Resident #20.  Isled to notify and consult ysician when the resident's rine (1) was administered but held per physician's order.	F	580			

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

Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 13 of 211



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING		04	C //27/2018
	PROVIDER OR SUPPLIER ET <b>H ADAM CRUM</b> P <b>HI</b>	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		12112016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SH <b>O</b> ULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 580	disorder (2). Resid (minimum data set) an ARD (assessme coded the resident Review of Resident a physician's order milligrams one time a systolic blood prediastolic blood prediastolic blood presof Resident #20's Administration reconsultation and the reside was greater than 10 was greate	ent #20's most recent MDS b, a quarterly assessment with ent reference date) of 1/24/18, as being cognitively intact.  #20's clinical record revealed dated 2/6/18 for Midodrine 2.5 a day, hold the medication for ssure greater than 100 or a sure greater than 90. Review pril 2018 MAR (medication rd) revealed the resident was drine on the following dates (as ck mark and nurses' initials) ent's systolic blood pressure floor or diastolic blood pressure floor or diastolic blood pressure floor dias		580		
	mean on the MAR.	LPN #9 stated, "It means it		•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION DING	COM	(X3) DATE SURVEY COMPLETED	
		495299	B. WING	·		C / <b>27/2018</b>
	PROVIDER OR SUPPLIER ET <b>H ADAM CRUMP H</b>	EALTH AND REHAB	1	STREET ADDRESS, CITY, STATE, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		2772010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE
F 580	was done." LPN # physician order for should be done if the pressure is greater pressure is greater should be held and (medical doctor) be next step for orders. Resident #20's Micadministered on the aware of the reside above dates. LPN should have been contact who administered the dates may have conhave said to give the confirmed there was evidence this.	age 14 9 was read Resident #20's Midodrine and asked what he resident's systolic blood than 100 or diastolic blood than 90. LPN #9 stated, "It you should contact the MD ecause you need to find out the s." LPN #9 was made aware lodrine was initialed as e above dates, and was made ent's blood pressures on the #9 stated the medication held and the doctor should ed. LPN #9 stated the nurses he Midodrine on those above htacted the doctor and he may he medication. LPN #9 as no documentation to	F	580		
	to Resident #20 on 4/22/18 were not a On 4/26/18 at 4:43 was conducted with initialed administra Midodrine on 4/2/1 should be documed medication is held, the exact number. Ilegend. I don't known there is a little box and we write a note order for Midodrine LPN #10 was asked resident's systolic by 100 or diastolic bloop was asked to the systolic by 100 or diastolic by 100 or d	4/1/18, 4/10/18, 4/14/18 and vailable for interview.  p.m., a telephone interview in LPN #10 (the nurse who tion of Resident #20's 8). LPN #10 was asked what inted on the MAR if a LPN #10 stated, "I don't know There is a number on the law if it's a three or a seven. It that pops up that says hold it." Resident #20's physician's was read to LPN #10 and d what should be done if the blood pressure is greater than od pressure is greater than 90. You will hold it." LPN #10 was				

		IDENTIFICATION NUMBER:	1	A. BUILDING			COMPLETED	
		495299	B. WING	i		04	C /27/2018	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB	<u></u>	360	REET ADDRESS, CITY, STATE, ZIP CODE 10 MOUNTAIN ROAD EN ALLEN, VA 23060	1 04	12112010	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 580	asked if she recalled Midodrine. LPN #1 the medication on a saked if she recalled April 2018, LPN #1 consistently. I don't (name of Resident On 4/26/18 at 5:32 staff member) #1 (the director of nursabove concern.  On 4/27/18 at approximate surveyor asked AS regarding physician titled, "REPORTING POA (POWER OF PARTY VERSUS E not document infornotification.  No further informate (1) "Midodrine is us hypotension (suddoccurs when a persposition). Midodrine causing blood vesses blood pressure." The from the website: https://medlineplustml  (2) "Bipolar disorded People who have it the sake of the causing blood pressure." The causing blood pressure.	age 15 ed ever holding Resident #20's 10 stated she recalled holding several occasions. When ed holding the medication in 0 stated, "I don't have her It know the last time I had #20) so I can't say for certain." p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the  oximately 8:30 a.m., this M #1 for a facility policy n notification. The facility policy n notification. The facility policy SCHANGE OF CONDITION: ATTORNEY), RESPONSIBLE EMERGENCY CONTACT" did mation regarding physician  ion was provided prior to exit. sed to treat orthostatic en fall in blood pressure that son assumes a standing the is in a class of medications are gic agonists. It works by sels to tighten, which increases this information was obtained  .gov/druginfo/meds/a616030.h  er is a serious mental illness. To go through unusual mood from very happy, "up," and		580				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		495299	B. WING		C 04/27/2018	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HE	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		12772010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 584 SS=D	inactive, and then be normal moods in be called mania. The of This information was https://vsearch.nlm.meta?v%3Aproject:medlineplus-bundle=2.1717494.6719681477942321 Safe/Clean/Comfor CFR(s): 483.10(i)(1) §483.10(i) Safe Environmental Safe Amount of the safe and how but not limited to resupports for daily limited to	ack again. They often have etween. The up feeling is down feeling is depression." Is obtained from the website: .nih.gov/vivisimo/cgi-bin/query=medlineplus&v%3Asources=8 query=bipolar+disorder&_ga 5706.1525089773-139120270.  Itable/Homelike Environment )-(7)  Vironment.  right to a safe, clean, melike environment, including ceiving treatment and ving safely.  Divide- e, clean, comfortable, and ent, allowing the resident to bonal belongings to the extent suring that the resident can ervices safely and that the facility maximizes resident does not pose a safety risk.  exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly,	F 5		ersonal ducted to ean. usekeeping ated on eaning erators. e-educated ques of d to ensure erators are ks then . Results of d at the ethree	5/29/18

		IDENTIFICATION NUMBER:	1, ,	ING		COMPLETED		
		495299	B. WING		04	C I/ <b>27/2018</b>		
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		12112010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION OATE		
F 584	§483.10(i)(4) Private resident room, as §483.10(i)(5) Adelevels in all areas; §483.10(i)(6) Comlevels. Facilities in 1990 must maintate 81°F; and §483.10(i)(7) For sound levels. This REQUIREMED by: Based on observed document review, staff failed to main activities room an survey sample, Referred liquid from the 1. The facility staff dried liquid from the 2. The facility staff clean environment personal refrigeration. An observation p.m. of residents were mare sidents were obtoof the pizza.  An observation was of the activities room and the activities room and the pizza.	ate closet space in each specified in §483.90 (e)(2)(iv); quate and comfortable lighting aftertable and safe temperature sitially certified after October 1, ain a temperature range of 71 to the maintenance of comfortable ENT is not met as evidenced ation, staff interview and facility it was determined the facility it was determined the facility it acident environment in the difference of 42 residents in the esident #33.  If failed to clean cheese and the activities room.  If failed to maintain a safe and the resident #33. Her tor was not cleaned.		584				

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

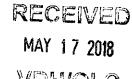
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING	i		C <b>04/27/2018</b>	
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		30	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION OATE
F 584	An observation was of the activities ronoted on the floor several brown sports of the activities ronoted on the floor several brown sports was in the room rows in the room rows a.m. with OSM (ohousekeeper. Who common area roots atted, "Every day An interview was p.m. with OSM #8 and laundry. Whe room was cleaned sweep it up every did if there were he stated it would be writer observed the floor in the accidean this up right On 4/26/18 at 5:1 member) #1, the	ots noted on the floor. An ant the floor.  as made on 4/25/18 at 3:00 p.m. om. There was grated cheese by two chairs. There were ots noted on the floor.  as made on 4/26/18 at 8:05 a.m. om. There was grated cheese by two chairs. There were ots noted on the floor. A resident eading a newspaper.  conducted on 4/26/18 at 10:10 ther staff member) #17, a sen asked how often the oms are cleaned, OSM #17 //."  conducted on 4/26/18 at 3:00 g., the manager of housekeeping on asked how often the activities d., OSM #8 stated, "They'll day." When asked what staff brown spots on the floor, #8 cleaned. OSM #8 and this see cheese and brown spots on tivities room. OSM #8 stated, "I'll		584			
		ility's policy titled, rocedures" did not specifically the activities room.					

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

Event ID: TQ6711

Facility ID: VA0083

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495299	B. WING		C 04/27/2018		
	PROVIDER OR SUPPLIER	EALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE  3600 MOUNTAIN ROAD  GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 584	Continued From pa	age 19	F 5	584			
	No further informat	ion was provided prior to exit.					
	COMPLAINT DEFI	CIENCY					
	2. The facility staff failed to maintain a safe and clean environment for Resident #33. Her personal refrigerator was not cleaned.  Resident #33 was admitted to the facility on 7/23/14 with diagnoses that included but were not limited to: dementia, vitamin D deficiency, dry eye syndrome, pain and depression.						
J	assessment, a qua assessment refere resident as scoring interview for menta	DS (minimum data set) rterly assessment, with an nce date of 1/31/18, coded the a "8" on the BIMS (brief I status) score, indicating she paired to make cognitive daily					
	on 4/24/18 at approwas a small refrige Resident #33's bed doors. One for the refrigerator. The recola. The freezer occurainer of ice cresubstance frozen a appeared to be an refrigerator was ob 11:50 a.m. 4/26/18 was observed, again the freezer.	rade of Resident #33's room eximately 11:00 a.m. There rator in the room, next to i. It had two compartment freezer and one for the frigerator contained a bottle of contained a thermometer and a am bites. There was a brown II over in the freezer. It exploded soda. This room and served again on 4/25/18 at at 10:30 a.m., the refrigerator in with the brown substance in					
		A (certified nursing assistant)					

495299 NAME OF PROVIDER OR SUPPLIER	B. WING	STREET ADDRESS, CITY, STATE, ZIP (	C 04/27/2018
NAME OF PROVIDER OR SUPPLIER		· ·	
ELIZABETH ADAM CRUMP HEALTH AND REHAB		3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	CODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	N SHOULD BE COMPLETION
#23. When asked who is responsible for clear the residents' refrigerators, CNA #23 stated, believe it's the staff's responsibility." CNA #2 opened Resident #33's refrigerator/freezer astated, "That's gross. Her family brings her snacks and puts them in there."  An interview was conducted with LPN (licens practical nurse) #14 on 4/26/18 at 11:24 a.m regarding who is responsible for cleaning a personal refrigerator. LPN #14 stated, "I belit's the CNA's responsibility." When asked he the temperature could be tested if the only thermometer was located in the freezer, LPN stated, "You got us there. I don't understand someone would document (temperatures) it (thermometer) isn't even there (the refrigeral An interview was conducted with LPN #15, tunit manager, on 4/26/18 at 11:27 a.m. When asked if she was aware that Resident #33 herefrigerator in her room, LPN #15 stated, "You when asked who is responsible for keeping clean, LPN #15 stated, "The CNAs can do it they see it is dirty and should be cleaned out."  An interview was conducted with RN (register nurse) #4, the assistant director of nursing, 4/26/18 at 11:35 a.m. When asked who is responsible for maintaining a refrigerator in resident's room, RN #4 stated, "The temperare taken by the nurses. Cleaning of it, the copart the CNAs and housekeeping do. The firm aintains the inside. If the family doesn't cothen the staff will do it. We monitor the refrigerator temperatures on all of them in her roods from Visitors" documented in part, "5	aning "I 3 nd sed ieve bw I #14 why if it tor)." ne n ad a es." it If cred bn atures outer amily me in buse."	584	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B. WING _		C 04/27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLÉTION
F 584	in by visitors will be equipped with them monitored daily for (Fahrenheit) and fr for refrigerated storany food items that (greater than) 7 da and shelf stable ite days.) Cleaned we The administrator a made aware of the 5:15 p.m.	rs for storage of foods brought properly maintained and mometers, have temperature refrigerators < (less than) 41 Feezer < 10 F. Daily monitoring rage duration and discard of have been stored for > ys. (Storage of frozen foods ms may be retained for 30	F 58		
F 600 SS=D	Free from Abuse a CFR(s): 483.12(a)( §483.12 Freedom of Exploitation The resident has the neglect, misappropand exploitation as includes but is not corporal punishme any physical or chetreat the resident's §483.12(a) The factory security security security involuntary security. Based on staff into	rom Abuse, Neglect, and re right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from ht, involuntary seclusion and mical restraint not required to medical symptoms.  ility must- use verbal, mental, sexual, or reporal punishment, or	F 60	<ol> <li>1. Resident #150 is safe from abuse. Resident #268 and Ref #269 were immediately place one on one and no longer ref the facility.</li> <li>2. Each residents has the position affected.</li> <li>3. Staff will be re-educated abuse policy and procedure ensure residents are free from abuse.</li> <li>4. Audits will be conducted staff understanding of abuse to include sexual abuse week.</li> </ol>	esident ed on eside in otential of on facility s to om sexual to ensure e policy

AND PLAN DF CORRECTION   IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED	
		495299	B. WING			1	C <b>27/2018</b>
	PRDVIDER OR SUPPLIE	R HEALTH AND REHAB	<b>.</b>	36	TREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD ILEN ALLEN, VA 23060	<u>,                                     </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 600	the survey sample Resident #150.  1. a. The facility s #150 was free fro #268. On 11/12/1 Resident #150's t 1. b. The facility s #150 was from se On 12/11/17, staff hand down Resident #150 was free fro #268. On 11/12/1 Resident #150's t Resident #150's t Resident #150's t Resident #150's t The MDS (minimaround the time of assessment, with of 11/7/17, and cozero on the BIMS status) score, indimpaired to make Resident #150 was Resident #150 w	to ensure one of 42 residents in e, was free from sexual abuse, taff failed to ensure Resident m sexual abuse by Resident 7, Resident # 268 grabbed breast.  Itaff failed to ensure Resident exual abuse by Resident # 269. If found Resident #269 with his ent #150's pants in the dining de:  Itaff failed to ensure Resident m sexual abuse by Resident 7, Resident # 268 grabbed breast.  Itaff failed to ensure Resident m sexual abuse by Resident 7, Resident # 268 grabbed breast.  Itaff failed to the facility on moses that included but were not mer's dementia, diabetes, and depression, and seizures.  Itaff the incidents, was a quarterly an assessment reference date by the incidents, was a quarterly an assessment reference date by the incidents of the incident as scoring a (brief interview for mental icating she was severely daily cognitive decisions. Italians in the dinamental icating one to	F	600	four weeks then monthly for thre months. Results of the audits will reviewed at the monthly QAPI meeting for three months to ens compliance.	l be	
	resident was code directed toward o	the look back period. The ed as having behaviors not thers one to three days during iod. Resident #150 was coded					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495299	B. WING _			/27/2018	
	PROVIDER OR SUPPLIER	EALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE	
F 600	Continued From pa	age 23	F 60	0			
	as requiring extensive assistance of one or more staff members for all of her activities of daily living.						
	4/13/17 with diagnoral limited to: chronic land dementia, high block congestive heart far characterized by circetention of salt and The MDS (minimuraround the time of quarterly assessmenterence date of 1 resident as scoring interview for mental was cognitively intal Resident #268 was assistance for mover personal hygiene. It supervision of one moving on and off the resident was coded Resident #268 was sesident #268 was serial resident was coded Resident resident	sadmitted to the facility on oses that included but were not cidney disease, mood disorder, od pressure, stroke and illure (abnormal condition reulatory congestion and dwater by the kidneys). (1) in data set) assessment the incident, 11/12/17, was a cent, with an assessment 2/13/17, and coded the a 13 on the BIMS (brief I status) score indicating he act to make daily decisions. It coded as requiring extensive ing in the bed, dressing, and he was coded as requiring staff member for transfers, the unit and toileting. The das independent for eating. It is coded as having restrictions ion on one side of his one arm					
	11/12/17 document Allegation of abuse incident: It was rep am that (Resident i #150)'s breast. Th separated and (Re	ed Incident (FRI) dated ted in part, "Incident Type - Incident In					
		ated, 11/12/18 at 11:09 a.m. t in Resident #150's record,					

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Event ID: TQ6711

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	0	(X3) DATE SURVEY COMPLETED		
		495299	B. WING	S		C 04/27/2018	
	PROVIDER OR SUPPLIEF ET <b>H ADAM CRUMP I</b>	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	CODE	04/27/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
F 600	"Around 10:50 a.m another resident v (Resident #150)'s did stop the inapp member instructed was (sic) immedia assessed breast a noted, no pain or assessment. Rp (medical doctor) a changes."  Review of Resided plan dated 11/5/15 to evidence any draw documented, "SS resident for a 1:1 wandering the hall psychosocial distrearlier to visit." The services note was second incident w Review of the psy Resident #150 was 11/3/17, prior to the 12/15/17 after a second incident wrong the witness state. CNA (certified nur Resident #268 and in part, "I (name of another resident) rubbing (Resident words).	n. Staff report to writer that was witnessed feeling on breast area, the other resident ropriate touching when the staff d him too (sic). Both residents ately separated. Writer area no bruising or abnormality discomfort noted during (responsible party) and MD aware will continue to monitor for the #150's comprehensive care and revised on 3/8/17, failed occumentation of the incident on as note in Resident #150's ed, 11/13/17 at 1:58 p.m., (social service) met with supportive visit. Resident I of A wing per usual. No ess noted. Husband was in e next documented social dated, 12/11/17, after the ith another resident. Chiatric notes, revealed s seen by psychiatry on is incident, and then not until	F	600			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION  NG	COV	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C /27/2018		
	PROVIDER OR SUPPLIER T <b>H ADAM CRUMP I</b>	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		2772010		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 600	and asked if I had yes rt (right) here. (sic) she asked hi Wt (weight). I ask what happened." interview.  An interview was member (OSM) # workers, regarding #150) after this improbably had psycoprobably checked husband and he vasked if the compupdated regarding with interventions OSM #7 and OSM When asked how would feel after the person, OSM #7 stated, "A victim." patient advocates  An interview was staff member (AS on 4/26/18 at 3:10 followed for proteincident of 11/12/man on 1:1 super (psychiatry) see h (Resident #268) with (Resident #1 upset." ASM #3 st 1:1 supervision. V	If member) came down the hall seen (Resident #268) I said I told her what happened an m to come back to C wing for a ed her to tell the charge nurse This CNA was not available for conducted with other staff 7 and OSM #10, the social g what was done for (Resident cident. OSM #7 stated, "We ch (psychiatry) see her. I up on her. I spoke with her was very understanding. When rehensive care plan should be g the sexual abuse that occurred to keep the resident safe, both M #10 stated, "Yes, it should be." they thought Resident #150 is incident being a reasonable stated, "Not good." OSM #10 OSM #10 stated, "We are and we failed her."  conducted with administrative M) #3, the former administrator, p.m., regarding the process cting Resident #150 after the vision. We had psych im. It was questionable if was cognitively intact. I spoke 50)'s husband and he was not tated, "We had the man put on We wanted her to be able to						
		around the facility and we t by putting the man on 1:1						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		495299	B. WING	·		C 04/27/2018	
	PROVIDER OR SUPPLIER		1	3 <b>60</b> 0	EET ADDRESS, CITY, STATE, ZIP CODE  D MOUNTAIN ROAD  EN ALLEN, VA 23060	<u>  04//</u>	21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	<b>I</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	DBE	(X5) COMPLETION DATE
F 600	in part, "It is inhere each resident at Fabasic human rights from abuse, negled misappropriation of the facility recog establishes the folloprocedures to proteestablish a disciplir fair and timely treat resident abuseAr omission, which maphysical, psychologinjury to a resident depressive a resident are absolucause for disciplina and possible crimin the Administration resident abuse can resident abuse are the Licensed Nurse the Licensed Nurse the Licensed Nurse the Licensed Nurse are to be complete Coordinator or his/investigationThe Director of Nursing from the victim, the witnesses including vicinity of the allegisecure all physical the investigation, a	Resident Abuse" documented int in the nature and dignity of acility that he/she be afforded in including the right to be free of, including the right to be free of, mistreatment, and/or of property. The management inized these rights and hereby owing statements, policies and exit these rights and to hary policy, which results in the timent of occurrences of in abusive act is any act or any cause or causes actual gical or emotional harm or or any act which willfully ent of his rights by law or as so of abuse directed against attely prohibited. Such acts are any action, including dismissal hal prosecution. Furthermore, of Facility recognized that in the committed by other or volunteersAll incidents of to be reported immediately to be in Charge, Director of and delivered to the Abuse her designee for an Abuse Coordinator and/or shall take written statements a suspect(s) and all possible gall other employees in the ed abuse. He/she shall also evidence. Upon completion of detailed report shall be		600			
	preparedThe Abu	use Coordinator of Facility will dents and reports of resident					

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		495299	B. WING			C 04/27/2018	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H			3 <b>6</b> (	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	U-1/2	2772010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 600	abuse to the approach abuse to the approach aware of the 5:15 p.m.  No further informat (1) Barron's Diction Non-Medical Read Chapman, page 11.  1. b. The facility structure and the facility and the	and director of nursing were above findings on 4/26/18 at tion was provided prior to exit.  hary of Medical Terms for the ler, 5th edition, Rothenberg and	F	500			

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

Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 2B of 211



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED		
		495299	B. WING			C 04/27/2018	
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		,2172010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE	
F 600	The Facility Report 12/9/17 documents Resident to Reside At approximately 4: Administrator recei observed (Residen #150)'s pants in the was assessed and (Resident #269) wa investigation has be The nurse's note didocumented, "CNA reported to writer the C- wing with his hapants. Full body as injuries were noted pain or discomfort is aware."	ed Incident (FRI) dated ed in part, "Incident Type - ent Abuse. Describe Incident: ed:15 p.m. on this date, the eved a call that a nurse aide ed: #269)'s hand down (Resident ed: dining room. (Resident #150) ed: no injury was observed. ed: placed on 1:1. Our		500			
	to evidence any do 12/9/17.  The Social Service dated, 12/11/17 at "Resident up in hal around the facility a distress noted. SS assist with her need Review of the nurs revealed the follow 6:49 p.m., "CNA obtain other resident's event site. Writer as	s notes, for Resident #150, 11:48 a.m. documented, lway propelling her self (sic) as usual. No psychosocial will continue to follow and					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 04/27/2018	
	ROVIDER OR SUPPLIER	IEALTH AND REHAB		30	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 049	2772010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION				PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 600	separated the two notified immediate R/P (responsible pmade aware. Res supervision at this  The social service dated, 12/15/17 at "Writer met with relinformed resident charges if he inappagain. Resident unhe was sorry. End SS (social services assist with his nee An interview was conursing assistant) When asked to de 12/9/17, CNA #18 hallway on C wing. (dining room). (Reright. That's when her (Resident #150 wheelchair. I said by you doing.' He respull his hand away nurse. She came a situation, he told her back to her unway back and told. An interview was copractical nurse) #8 asked to describe with Resident #150 wi	ck me out. Immediately writer parties involved. Supervisor ly. MD (medical doctor) and arty) notified and Administrator ident was placed on 1:1 close time."  s notes for Resident #269 11:30 a.m. documented, esident for a 1:1 supportive visit. that he could potentially face propriately touched someone inderstood and expressed that souraged appropriate behavior.		600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	FIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 04/27/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		21/2010	
(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 CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 600	(name of director of administrator). The his way. I called be informed them of the #269's RP stated shim so wanted him (Resident #269) or did for Resident #1 "We assessed her baseline. It was un asked the staff to k supervisor that day because she was a When asked if she how that would hav "She would feel vio vulnerable."	to talk to the nurse. I called f nursing) and (name of e administrator said he was on th responsible party's (RP) and ne occurrence. Resident he had noted a difference in to see a psychiatrist. I put in 1:1." When asked what she 50, the victim, LPN #8 stated, for injury. Her demeanor was clear how it affected her. I seep an eye on her. I was the it. I felt so sorry for her that day, a target for those two men." were a reasonable person, we affected her, LPN #8 stated, lated and angry. She's	F 6	00			
	member (OSM) #7 workers at the facil When asked if Res sexual abuse, OSM knowledge." A copy was requested.  The copy of the se 9/29/17, document The sex offenders after Resident #269 An interview was c staff member (ASM on 4/26/18 at 3:10 process followed for after the incident or put the man on 1:1	and OSM #10, the two social ity, on 4/25/18 at 3:50 p.m. sident #269 has any history of M #10 stated, "Not to our y of his sex offenders registry was dated, ed he was not on the registry. registry was done one day 9 was admitted to the facility. onducted with administrative M) #3, the former administrator, p.m. When asked about the or protecting Resident #150 f 12/9/17, ASM #3 stated, "We supervision. We had psych m. I spoke with (Resident					

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ING	(X3) DATE SURVEY COMPLETED	
		495299	B. WING		C 04/27/2018	
	OVIDER OR SUPPLIER	ALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CDDE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 04/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	_ `	D BE COMPLÉTION	
# st Va a p k lo o T m 5 N (1 N C D C Sin Sin M sto Sin	tated, "We had the Ve wanted her to be round the facility and utting the man on a cept him on 1:1 untility boking for alternate of the incident."  The administrator and ade aware of the action-Medical Reade chapman, page 437 (evelop/Implement FR(s): 483.12(b)(1) Prohiting the second of the secon	d he was not upset. ASM #3 man put on 1:1 supervision. e able to continue to travel nd we accomplished that by 1:1 supervision. We actually 1 his transfer. We were placement for him at the time and director of nursing were above findings on 4/26/18 at on was provided prior to exit.  ary of Medical Terms for the r, 5th edition, Rothenberg and 7. Abuse/Neglect Policies )-(3)  ity must develop and colicies and procedures that:  but and prevent abuse, ation of residents and	F6	F607  1. Facility is following policies an procedures for reporting an allegation of abuse to appropria state agencies.  2. Each residents has the potent being affected.  3. Staff will be re-educated on fa abuse policy and procedures to ensure reporting an allegation of abuse to appropriate state agen.  4. Audits will be conducted to eastaff understanding of reporting.	ial of acility f cies.	

NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 607  Continued From page 32 a complaint investigation, it was determined that the facility staff failed to implement and follow the	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED C		
ELIZABETH ADAM CRUMP HEALTH AND REHAB  (X4) ID PREFIX TAG  F 607  Continued From page 32 a complaint investigation, it was determined that the facility staff failed to implement and follow the  STREET ADDRESS, CITY, STATE, ZIP CODE  3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 607  Continued From page 32  a complaint investigation, it was determined that the facility staff failed to implement and follow the			495299	B. WING		04/27/2018		
F 607  Continued From page 32 a complaint investigation, it was determined that the facility staff failed to implement and follow the  FREFIX TAG  PREFIX TAG  PRE				STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD				
a complaint investigation, it was determined that the facility staff failed to implement and follow the state agencies weekly for four weeks then monthly for three months.	RÉFIX	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR		N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE		
policies for an allegation of abuse for one of 42 residents in the survey sample, Resident # 319.  The facility staff failed to implement and follow policies and procedures to report an allegation of abuse to appropriate state agencies after Resident # 319 reported an allegation of abuse to the facility staff.  The findings include:  Resident # 319 was admitted to the facility on 09/18/17 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease (1), dementia (2), gastroesophageal reflux disease (3), hypertension (4), atrial fibrillation (5), muscular dystrophy (6), depression, dysphagia (7), and post mastectomy (8).  Resident # 319's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 09/18/17, coded Resident # 319 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 319 was coded as requiring extensive assistance of one staff member for activities of daily living.  The statement given by Resident # 319 and taken by OSM (other staff member) # 10, social worker dated 09/19/2017 documented, "Last night patient (Resident # 319) reported to SS (social services) that she was having trouble sleeping so she used		a complaint invest the facility staff fail policies for an alle residents in the sure The facility staff fail policies and proceabuse to appropria Resident # 319 rethe facility staff.  The findings include Resident # 319 was 09/18/17 with diagnot limited to: chrodisease (1), demereflux disease (3), fibrillation (5), must depression, dysphoral (8).  Resident # 319's reflux disease (3), fibrillation (5), must depression, dysphoral (8).  Resident # 319's reflux disease (1), demereflux disease (3), fibrillation (5), must depression, dysphoral (8).  Resident # 319's reflux disease (3), fibrillation (5), must depression, dysphoral (8).  The statement with a cognitively intact for Resident # 319 was assistance of one daily living.  The statement gives by OSM (other stated 09/19/2017 (Resident # 319) resident #	igation, it was determined that led to implement and follow the gation of abuse for one of 42 rvey sample, Resident # 319.  illed to implement and follow dures to report an allegation of ate state agencies after ported an allegation of abuse to de:  as admitted to the facility on inoses that included but were onic obstructive pulmonary intia (2), gastroesophageal hypertension (4), atrial scular dystrophy (6), agia (7), and post mastectomy most recent comprehensive ata set), an admission an ARD (assessment reference coded Resident # 319 as e brief interview for mental score of 0 - 15, 15- being or making daily decisions. as coded as requiring extensive staff member of activities of decimented, "Last night patient reported to SS (social services)		state agencies weekly for then monthly for three m Results of the audits will I at the monthly QAPI mee	four weeks onths. be reviewed ting for		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l`'		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 04/27/2018	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB		30	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 04/2	21/2010
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	the bed. Patient st and this time nurse the third time the nurse the third time the nurse and walked on nurse was mad. Troom but about 4 (if was a male] nurse stated they grabbe in the wheelchair. Were not gentle with Once she was up a scared because of giving her. She as chair but nobody wherself on the floor did stated to SS that would sue them be nurses just laughed On 04/25/18 at 10: conducted OSM (of worker regarding and OSM # 10 stated significant states and states are grading and OSM # 10 stated significant would sue them be nurses just laughed OSM # 10 stated significant would sue them be nurse just laughed OSM # 10 stated significant would sue them be nurse just laughed OSM # 10 stated significant would sue them be nurse just laughed OSM # 10 stated significant would sue them be nurse just laughed OSM # 10 stated significant would sue them be nurse just laughed OSM # 10 stated significant would sue them be nurse just laughed OSM # 10 stated significant with AS member) # 2, director of nursing over the investigation of the properties of the propertie	and helped patient straighten ated she called for help again at came in and helped again but urse came in and made a but. Patient stated that the he nurse came back in the four) to 5 (five) [one of them was also with her. Patient d her up and through [sic] her According to the patient they h her and attack [sic] her. at the nurse's station she felt the nurse looks they were ked for a more comfortable rould help her so she put to get comfortable. Patient at she has been a victim of outside of this facility). Patient at she told the nurses that she cause of what they did and the d."  30 a.m., an interview was ther staff member) # 10, social complaint by Resident # 319. he recalled who Resident # 319 shift staff were verbally and her. OSM # 10 stated, "I took statement and the DON) and the administrator took	F	607			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	FIPLE CONSTRUCTION NG	COV	TE SURVEY MPLETED
		495299	B. WING		C <b>04/2</b> 7/ <b>20</b> 18	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 0 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		72772010
(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 CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA <b>T</b> E	(X5) COMPLETION OATE
F 607	# 319, ASM # 2 state (staff) grabbed her wheelchair." Where allegation of abuse On 04/27/18 at 7:4 conducted with ASI member) # 2, direct asked if a "Facility completed for Resi abuse. ASM # 2 stadministrator was thave it would have we would have a conceive we determined the FRI be to locate it.  On 04/27/18 at 9:10 was conducted with administrator. Whe completed regarding of abuse, ASM # 3 the case with ASM refresh his memory discuss it.  On 04/27/18 at 10: was conducted with administrator regarallegation of abuse reported to me as a asked if he reviewed at the time of the indidn't review the interport in a timely mere taken. In retriabuse or mistreator report in a timely mere taken.	ted, "The resident stated they up and threw her in her asked if this was an ASM # 2 stated, "Yes."  5 a.m., an interview was M (administrative staff tor of nursing. ASM #2 was Report Incident (FRI)" was dent #319's allegation of ated, "The previous he abuse coordinator. If we been filed with your office and opy in our FRI book." ASM # 2 ook and stated she wasn't able of a.m., a telephone interview a ASM # 3, previous an asked if a FRI was ang Resident # 319's allegation stated he would like to review # 2, director of nursing to and would call back to and would call back to an allegation of abuse." When a ASM # 3, previous ding Resident # 319's  12 a.m., a telephone interview and ASM # 3, previous ding Resident # 319's  13 ASM # 3 stated, "It was not an allegation of abuse." When a sked if the arding abuse was followed	F6	07		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 04/27/2018	
	PROVIDER OR SUPPLIER	1 ,,,,,		STREET ADDRESS, CITY, ST 3600 MOUNTAIN ROAD GLEN ALLEN, VA 2306		U4/Z1	72018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPORTICIENCY)	BE	(X5) COMPLETION DATE
F 607	Facility will refer an of resident abuse to agencies."  On 04/27/18 at app (administrative staf administrator and Awere made aware on the ware made aware of the complaint deficient and the complaint of the complaint and the compla	"Resident Abuse" The Abuse Coordinator of y or all allegations and reports to the appropriate state  proximately 11:30 a.m. ASM of member) # 1, the ASM # 2, director of nursing of the findings.  Join was provided prior to exit.  This information the website:  Junction that occurs with certain memory, thinking, language, avior. This information was website:  Jegov/ency/article/000739.htm.  Junts to leak back, or reflux, into a irritate it. This information the website:  Jegov/medlineplus/gerd.html.  Junction that occurs with certain memory, thinking, language, avior. This information was website:  Jegov/ency/article/000739.htm.  Junts to leak back, or reflux, into the website:  Jegov/medlineplus/gerd.html.	F	007			
		the speed or rhythm of the ormation was obtained from					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495299	B. WING			04/2	7/2018
	PROVIDER OR SUPPLIER TH ADAM CRUMP H	EALTH AND REHAB		360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	1 04/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION OATE
F 607	on.html.  (6) A group of mor They all cause muloss. Some forms childhood. Others age or later. The difference they affect, which the symptoms are as the person's multiple with MD eventually is no cure for muscan help with the scomplications. The therapy, orthopedimedications. Som cases that worsen disabling and sever obtained from the https://medlineplus.  (7) A swallowing dobtained from the https://www.nlm.nisorders.html.	h.gov/medlineplus/atrialfibrillati e than 30 inherited diseases. scle weakness and muscle of MD appear in infancy or may not appear until middle lifferent types can vary in whom muscles they affect, and what . All forms of MD grow worse uscles get weaker. Most people y lose the ability to walk. There cular dystrophy. Treatments symptoms and prevent ey include physical and speech c devices, surgery, and e people with MD have mild slowly. Others cases are ere. This information was website: s.gov/musculardystrophy.html. isorder. This information was website: ch.gov/medlineplus/swallowingdi		607			
	the time, some of removed. The sur- breast cancer. The from the website: https://medlineplus	move the entire breast. Most of the skin and the nipple are also gery is most often done to treat is information was obtained s.gov/ency/article/002919.htm. onable Suspicion of a Crime	F	608	F608  1. Facility will report a reasonable		5/29/18
99=D		cility must develop and			suspicion of a crime. Resident #29 and Resident #269 are no longer residents of the facility.	bŏ	

AND PLAN OF CORRECTION	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495299	B. WING			C 04/27/2018		
(71715	MENT OF DEFICIENCIES	1D	36	TREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD LEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION	
PREFIX (EACH DEFICIENCY M	MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	PREFI; TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		COMPLETION DATE	
§483.12(b)(5) Ensure occurring in federally-facilities in accordance Act. The policies and but are not limited to (i) Annually notifying of defined at section 118 individual's obligation reporting requirement (A) Each covered individual's for the political facility is located any crime against any individual's individual's obligation reporting requirement (B) Each covered individual's individual's located any crime against any individual's obligation reporting care from the suspicion do not result in set located any crime against any individual's obligation reporting care from (B) Each covered	ereporting of crimes -funded long-term care be with section 1150B of the diprocedures must include the following elements. covered individuals, as 50B(a)(3) of the Act, of that is to comply with the following ts. ividual shall report to the e or more law enforcement al subdivision in which the reasonable suspicion of a lividual who is a resident of, om, the facility. lividual shall report later than 2 hours after in, if the events that cause the rious bodily injury, or not the events that cause the office than 150B(d)(3) of the exerciting retaliation, as 50B(d)(1) and (2) of the Act. It is not met as evidenced view, facility document review view, it was determined the	F6	608	<ol> <li>Each residents has the potential being affected.</li> <li>Staff will be re-educated on factor abuse policy and procedures to ensure reporting a reasonable suspicion of a crime.</li> <li>Audits will be conducted to enstaff understanding of reporting reasonable suspicion of a crime weekly for four weeks then monfor three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.</li> </ol>	sility sure a		



	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		/27/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATIDN)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (CEACH CORRECTIVE ACTION SHOUTH CORREST TO THE APPORT OF THE APPORT	OULD BE	(X5) COMPLETION OATE	
F 608	2. The facility staff allegation of sexual The findings included 1. The facility staff allegation of sexual Resident #268 was 4/13/17 with diagnolimited to: chronic I dementia, high blocongestive heart facharacterized by circtention of salt and The MDS (minimularound the time of quarterly assessmanter for esident as scoring interview for mental was cognitively intages assistance for move personal hygiene. Supervision of one moving on and off resident #268 was in his range of moderal moderal moderal moderal factors.  Resident #150 was 11/4/15 with diagnolimited to: Alzheim muscle weakness, MDS (minimum data for the sexual minimum data for the sexual muscle weakness, MDS (minimum data for the sexual muscle weakness).	failed to report to the police an I abuse by Resident #269.	F 60	08			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495299	B. WING	·			C <b>27/2018</b>	
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		3(	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICIENCY)	D BE	(X5) COMPLETION DATE	
F 608	coded the residen (brief interview for she was severely cognitive decision wandering one to period. The reside behaviors not dire days during the lowas coded as requie one or more staff of daily living.  The Facility Report 11/12/17 documer Allegation of abusincident: It was ream that (Resident #150)'s breast. The separated and (Reference to the complete that the period one). The bottom left cowhich agencies we been notified.	and any and a series of 11/7/17, the assoring a zero on the BIMS of mental status) score, indicating impaired to make daily soon as three days during the look back and the action as the color of the c	F	608				
	workers at the fac regarding this inci police. When ask	7 and OSM #10, the social ility, on 4/25/18 at 3:55 p.m., dent being reported to the ed if this incident should have he police, OSM #10 stated,						
	staff member (AS ASM #2, the direct 4:10 p.m. When a	conducted with administrative M) #1, the administrator and tor of nursing, on 4/25/18 at sked about the process staffing a crime in the building. ASM						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TQ6711

Facility ID: VA0083

(f continuation sheet Page 40 of 211



AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  A. BUILDING			MPLETED			
		495299	B. WING			C <b>I/27/2018</b>
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP O 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		HZ11Z010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		I SHOULD BE	(X5) COMPLETION DATE
F 608	#2 stated, "If there abuse coordinator and notify the age appropriate." Whet touched on her brodown her pants, wabuse and should ASM #1 stated, "Yreported."  On 4/26/18 at 3:10 conducted with AS regarding the incice Resident #150 on notified the police, remember. When the police, ASM # police will not star case number if the dementia and/or it press charges." When	e is a suspicion of a crime, the would initiate an investigation ncies, including the police, if an asked if a resident has been east and a male had his hands would that constitute sexual this be reported to the police, which is sexual this be reported to the police, which is sexual this be reported to the police, which is sexual this be reported to the police, which is sexual this be reported to the police, which is sexual this sexual that constitute sexual this be reported to the police, which is sexual that constitute sexual this sexual		508		
	Reporting Suspect Elder Justice Act.' "Procedure: Staff staff suspect a cri resident at the Faincident to SSA (slaw enforcement. a crime to the staff one local law enforcement designated time from the staff telephone. The incident incide	"Policy & Procedure for ted Crimes under the Federal documented in part, Reporting Requirements: When me has occurred against a cility, they must report the tate survey agency) and local Staff must report a suspicion of the survey agency and at least brocement entity with in a stame by e-mail, fax or dividual does not need to ocal law enforcement entity to of crime; but must report to at a perforcement entity. This will				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		СОМ	(X3) DATE SURVEY COMPLETED		
		495299	B. WING				C <b>27/2018</b>
	PROVIDER OR SUPPLIER	EALTH AND REHAB		3600	EET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN ROAD EN ALLEN, VA 23060	1 04/	2112010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 608	The administrator, nursing, ASM #2 w findings on 4/26/18 No further informat  (1) Barron's Diction Non-Medical Read Chapman, page 13 2. The facility staff allegation of sexual Resident #269 was 9/28/17 with diagnoral limited to: high blood disease (a slowly provided by disorder charactering ait, stooped posture fingers, drooling an sometimes with embranding the resident as scored interview for mental resident was capalled decisions. The resident was capalled assistance of member for all of his Section E - Behavion thaving any behinder in the staff of the section.	ASM #1 and director of ere made aware of the above at 5:15 p.m.  ion was provided prior to exit.  eary of Medical Terms for the er, 5th edition, Rothenberg and		608			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 . 1	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C <b>4/27/2018</b>
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		4/2//2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 608	Resident to Reside At approximately 4: Administrator receivobserved (Resident #150)'s pants in the was assessed and (Resident #269) wainvestigation has be of the form docume notified. "Law Enfo as having been and to practical nurse) #8 asked if the above of sexual abuse, LPN if it should be reported to the incident between a sexual abuse. An interview was conformer administrator when asked if he incident between Refunction on 12/9/17, Astremember. ASM #3 county) police will nassign it a case nur have dementia and to press charges." It regulations docume required to report to the administrator, increasing, ASM #2 we findings on 4/26/18	d in part, "Incident Type - nt Abuse. Describe Incident: 15 p.m. on this date, the yed a call that a nurse aide if #269)'s hand down (Resident dining room. (Resident #150) no injury was observed. Is placed on 1:1. Our egun." The bottom left corner ented which agencies were rement" was not documented fied.  Inducted with LPN (licensed on 4/25/18 at 3:14 p.m. When occurrence is considered #8 stated, "Yes." When asked ted to the local police, LPN #8 opened outside the facility, it crime."  Inducted with ASM #3, the or, on 4/26/18 at 3:10 p.m. otified the police regarding the esident 269 and Resident SM #3 stated he couldn't is stated, "The (name of ot start an investigation or onber if the residents involved for if the family does not want when asked what the ent, ASM #3 stated, "We are of the police."  ASM #1 and director of ore made aware of the above	F6	608		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING				C 27/2018
	PROVIDER OR SUPPLIER  TH ADAM CRUMP H	EALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 608	Continued From pa	ige <b>4</b> 3	Fθ	808			
		ary of Medical Terms for the er, 5th edition, Rothenberg and 7.					
F 609 SS≃D	Reporting of Allege CFR(s): 483.12(c)(	d Violations	F6	609	F609		5/29/18
	neglect, exploitation must:  §483.12(c)(1) Ensure involving abuse, nemistreatment, inclusion after the alleguage of the events that cause the administrator of the administrator of officials (including the administrator of officials (includi	onse to allegations of abuse, in, or mistreatment, the facility are that all alleged violations reglect, exploitation or ding injuries of unknown ropriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to f the facility and to other of the State Survey Agency and vices where state law provides ingeterm care facilities) in ate law through established out the results of all the administrator or his or her entative and to other officials in ate law, including to the State hin 5 working days of the alleged violation is verified inve action must be taken.  Note that all alleged violation is verified in a tellow, including to the State hin 5 working days of the alleged violation is verified inve action must be taken.  Note that all alleged violation is verified in a tellow, including to the State hin 5 working days of the alleged violation is verified inve action must be taken.  Note that all alleged violation is verified in a tellow, including to the State hin 5 working days of the alleged violation is verified inve action must be taken.  Note that all alleged violation is verified in a tellow in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state hin 5 working days of the alleged violation is verified in the state			resident #319 is no longer a resident at the facility. Facility reporting allegations of abuse appropriate state agencies, in and follow-up reports.  2. Each residents has the pote being affected.  3. Staff will be re-educated or abuse policy and procedures the ensure reporting an allegation abuse to appropriate state agencies will be conducted to staff understanding of report allegation of abuse to appropriate state agencies weekly for four then monthly for three months at the monthly QAPI meeting three months to ensure complete.	to to itial ential of facility to n of gencies. ensure ing an oriate r weeks hs. eviewed ; for	

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- Event ID: TQ6711

Facility ID: VA0083

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED C		
		495299	B. WING	;			27/2018	
	PROVIDER OR SUPPLIER ET <b>H</b> A <b>DAM CRUMP H</b>	HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 0-0.2		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION OATE	
F 609	and clinical record complaint investig the facility staff fai abuse to the state in the survey sample. The facility staff fai follow-up report we required five days abuse for Resident # 319 was 09/18/17 with diagnot limited to: chrodisease (1), demereflux disease (3), fibrillation (5), must depression, dysphromatical (BIMS) of a cognitively intact of Resident # 319 was assistance of one daily living.  The statement gives by OSM # 10, sood documented, "Las reported to SS (schaving trouble sleeping to the state of the sta	review and in the course of a ation, it was determined that led to report an allegation of agency for one of 42 resident's ole, Resident # 319.  illed to file an initial and ith the state agency within the after a reported allegation of it # 319.		609				

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		495299	B. WING			04/2	27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		36	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 609	Patient stated she of time nurse came in time the nurse came in time the nurse came walked out. Patien mad. The nurse can about 4 (four) to 5 (nurse was also with grabbed her up and wheelchair. Accordant gentle with her was up at the nurse because of the nurse because of the nurse he asked for a monobody would help floor to get comfort that she has been a (outside of this facilithat she told the nurse because of what the laughed."	d patient straighten the bed. called for help again and this and helped again but the third in and made a noise and it stated that the nurse was ame back in the room but (five) [one of them was a male] in her. Patient stated they if through [sic] her in the ding to the patient they were and attack [sic] her. Once she is station she felt scared se looks they were giving her. Once omfortable chair but her so she put herself on the able. Patient did stated to SS a victim of abuse in the past lity). Patient did state to SS irses that she would sue them ey did and the nurses just	F	609			
	conducted OSM (o worker regarding a OSM # 10 stated s 319 was. She state that night shift staff abusing her. OSM # 319"s) statement nursing) and the ac investigation.  On 04/26/18 at 9:5 conducted with ASI	30 a.m., an interview was ther staff member) # 10, social complaint by Resident # 319. he recalled who Resident # ed that Resident # 319 told her were verbally and physically # 10 stated, "I took (Resident and the DON (director of dministrator took over the 0 a.m., an interview was M (administrative staff					
	member) # 2, direct staff member) # 10 complaint by Resid	of tor of nursing and OSM (other b, social worker regarding a lent # 319. When asked why as initiated regarding Resident					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495299	B. WING	j	04	C / <b>27/2018</b>	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H			STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SH <b>O</b> ULD BE E APPROPRIATE	(X5) COMPLETION OATE	
F 609	# 319, ASM # 2 sta (staff) grabbed her wheelchair." When allegation of abuse On 04/27/18 at 7:4 conducted with AS member) # 2, direct a "Facility Report If for Resident #319's stated, "The previous abuse coordinators filed with your offic our FRI book." AS and stated she was On 04/27/18 at 9:1 was conducted with administrator. Who completed regarding of abuse, ASM # 3 the case with ASM refresh his memor discuss it.  On 04/27/18 at 10 was conducted with administrator regarding allegation of abuse reported to me as asked if he review at the time of the indidn't review the inwere taken. In retrabuse or mistreator report in a timely in the facility's policy.	ated, "The resident stated they up and threw her in her in asked if this was an asked if this was an a ASM # 2 stated, "Yes."  5 a.m., an interview was M (administrative staff ctor of nursing. When asked if incident (FRI)" was completed a allegation of abuse, ASM # 2 bus administrator was the lif we have it would have been and we would have a copy in M # 2 reviewed the FRI book son't able to locate it.  0 a.m., a telephone interview h ASM # 3, previous en asked if a FRI was ang Resident # 319's allegation a stated he would like to review # 2, director of nursing to y and would call back to  12 a.m., a telephone interview h ASM # 3, previous raing Resident # 319's allegation as a allegation of abuse." When a led Resident # 319's statement and Resident # 319's statem		609			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, .	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING		1	0
	PROVIDER OR SUPPLIER  TH ADAM CRUMP H	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 04/	27/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION OATE
F 609	Facility will refer an of resident abuse to agencies."  On 04/27/18 at app (administrative staff administrator and Awere made aware of the ware made aware of the was obtained from https://www.nlm.nit (2) A loss of brain f diseases. It affects judgment, and behobtained from the whittps://medlineplus (3) Stomach content was obtained from the esophagus and was obtained from https://www.nlm.nit in the sillow was obtained from https://www.nlm.nit in the sillow was obtained from https://www.nlm.nit	y or all allegations and reports of the appropriate state.  broximately 11:30 a.m. ASM if member) # 1, the ASM # 2, director of nursing of the findings.  ion was provided prior to exit.  broximately 11:30 a.m. ASM if member) # 1, the ASM # 2, director of nursing of the findings.  ion was provided prior to exit.  broximately 11:30 a.m. ASM if member) # 1, the ASM # 2, director of nursing of the findings.  ion was provided prior to exit.  broximately 11:30 a.m. ASM if member in the website:  angov/medlineplus/copd.html.  broximately 11:30 a.m. ASM if member in the website:  angov/medlineplus/gerd.html.  broximately 11:30 a.m. ASM if member in the website:  angov/medlineplus/gerd.html.  broximately 11:30 a.m. ASM if member in the website:  angov/medlineplus/gerd.html.		609		
	(5) A problem with heartbeat. This inf the website:	.gov/lowbloodpressure.html. the speed or rhythm of the ormation was obtained from n.gov/medlineplus/atrialfibrillati				

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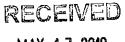
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 04/27/2018	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		21/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE	
F 609	(6) A group of more They all cause must loss. Some forms of childhood. Others mage or later. The differ they affect, which makes the person's must with MD eventually is no cure for must can help with the sycomplications. They therapy, orthopedic medications. Some cases that worsen a disabling and sever obtained from the whittps://medlineplus.	e than 30 inherited diseases. Incle weakness and muscle of MD appear in infancy or may not appear until middle offerent types can vary in whom muscles they affect, and what All forms of MD grow worse scles get weaker. Most people lose the ability to walk. There ular dystrophy. Treatments of mptoms and prevent of include physical and speech devices, surgery, and people with MD have mild slowly. Others cases are referent information was overbesite:  gov/musculardystrophy.html.	F6	09			
	sorders.html.  (8) A surgery to rem the time, some of the removed. The surger breast cancer. This from the website: https://medlineplus. Transfer and Disch. CFR(s): 483.15(c)(1) \$483.15(c)(1) Facility in the facility must	1)(i)(ii)(2)(i)-(iii) r and discharge-	F 6	F622  1. Facility will provide docur in the residents' medical recommunicate appropriate information to the receiving care institution or provider care plan goals.	cord and	5/29/18	

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Event ID: TQ6711

Facility ID: VA0083

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING				C 27/2018
	PROVIDER OR SUPPLIER  TH ADAM CRUMP HE  SUMMARY STA	EALTH AND REHAB TEMENT OF DEFICIENCIES	ID	3€	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD LEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	`	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	COMPLETION OATE
F 622	discharge the reside (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or because the reside sufficiently so the reservices provided b (C) The safety of inendangered due to status of the reside (D) The health of in otherwise be endand (E) The resident has appropriate notice, under Medicare or I Nonpayment applies submit the necessary payment or after the Medicare or Medicare or Medicare or Medicare or Medicare or Information (F) The facility cease (ii) The facility may resident while the as \$431.230 of this charge notice frow 431.220(a)(3) of this discharge or transferor safety of the resifacility. The facility.	ent from the facility unless- discharge is necessary for the nd the resident's needs e facility; discharge is appropriate nt's health has improved esident no longer needs the y the facility; dividuals in the facility is the clinical or behavioral nt; dividuals in the facility would agered; s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. s if the resident does not ry paperwork for third party e third party, including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid; ses to operate. not transfer or discharge the ppeal is pending, pursuant to napter, when a resident r right to appeal a transfer or om the facility pursuant to § s chapter, unless the failure to er would endanger the health dent or other individuals in the must document the danger fer or discharge would pose.	F	522	<ol> <li>Each residents has the potention being affected.</li> <li>Licensed nurses will be reeducated on documenting in the residents medical record and communicating appropriate information to the receiving hear care institution or provider inclucate plan goals.</li> <li>Audits will be conducted to endicensed staff document in the residents' medical record and communicate appropriate information to the receiving hear care institution or provider inclucate plan goals has been completed weekly for four weeks then more for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.</li> </ol>	Ith ding nsure Ith ding eted nthly	

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		495299	B. WING			C <b>27/2018</b>
	PROVIDER OR SUPPLIER TH ADAM CRUMP H	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION :	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 622	resident under any in paragraphs (c) (1) section, the facility or discharge is door medical record and communicated to tinstitution or provid (i) Documentation must include: (A) The basis for the (ii) of this section. (B) In the case of a section, the specific be met, facility atteneds, and the serfacility to meet the (ii) The documentation (2)(i) of this section (A) The resident's discharge is necessification (B) A physician who necessary under put this section. (iii) Information promust include a minust inclu	ansfers or discharges a of the circumstances specified (i)(i)(A) through (F) of this must ensure that the transfer cumented in the resident's dappropriate information is he receiving health care ler. in the resident's medical record ne transfer per paragraph (c)(1) (a) of this cresident need(s) that cannot empts to meet the resident vice available at the receiving need(s). In must be made byphysician when transfer or estary under paragraph (c) (1) ection; and en transfer or discharge is aragraph (c)(1)(i)(C) or (D) of evided to the receiving provider attorned to the practitioner erace of the resident. Sentative information including nuctions or precautions for appropriate.	F	622		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING	-	<b>I</b>	C <b>27/2018</b>
	PROVIDER OR SUPPLIER	REALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
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F 622	a safe and effective This REQUIREMED by: Based on staff intreview, and clinical determined that far appropriate transformer in the surfacility in the surfacility in the respective of the respe	entation, as applicable, to ensure we transition of care. ENT is not met as evidenced derview, facility document all record review, it was acility staff failed to meet the er requirements for seven of 42 drvey sample, Resident #157, 318, and 46.  157, facility staff failed to equired information was ceiving provider for a ansfer on 4/6/18.  110, facility staff failed to equired information was ceiving provider for a ansfer on 2/21/18.  181, facility staff failed to equired information was ceiving provider for a ansfer on 12/28/18.  168, facility staff failed to equired information was ceiving provider for a ansfer on 3/16/18.  167 failed to ensure Resident # cals were provided to the for a facility-initiated transfer to desident # 318's care plan goals.	F	522		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED	
		495299	B. WING_			C /27/2018
	PROVIDER OR SUPPLIER  TH ADAM CRUMP H	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)				(X5) COMPLETION DATE
F 622	7. The facility staff facility a copy of Refor a facility initiated.  The findings include.  1. Resident #157 w 3/23/18 with diagnoral limited to Non-Alzhencephalopathy, m weakness. Reside (minimum data set) assessment with a date) of 3/30/18. Resident with a limited in continuing to go up Pupils not dilated. Lespirations even a solution of the properties of the propert	failed to provide the receiving saident # 46's care plan goals of transfer.  e:  ras admitted to the facility on oses that included but were not eimer's dementia, depression, ood disorder and muscle of the facility on one seement and muscle of the facility on object of the facility on one facility of the facility on one facility of the facility of	F 62			
		e clinical record revealed that admitted back to the facility agnosis of Sepsis.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ļ ' '	TIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED	
		495299	B. WING		i	C / <b>27/2018</b>	
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(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 (  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO T  DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 622	information; Resideresponsible party of Resident #157's can hospital for the facilion on 4/26/18 at 2:20 conducted with LPI the unit manager, raresident is sent of stated the nurses stormake him aware doctor wants the resident sare sert the nurses would the and/or emergency documents are sert transfer to the hospiface sheet, physicists sheet would be ser asked if the care plan. When as note regarding the with the resident for "No, we don't norm with them.  On 4/26/18 at 5:09 staff member) #1 the DON (Director of the above concerns.)	ence that all the required ent #157's advanced directives, ontact information, and are plan was provided to the ility-initiated transfer on 4/6/18.  p.m., an interview was N (licensed practical nurse) #4, regarding the nurse's role when out to the hospital. LPN #4 should call the medical doctor of the situation, and if the esident sent out to the hospital, nen call the power of attorney contact. When asked what not with the resident for a contact. When asked what the twith the residents. When the an orders, and the transfer not with the residents. When the nurses do not send the sked if the nurses document a documentation that was sent or a transfer, LPN #4 stated, really document paper work sent p.m., ASM (administrative the administrator, and ASM #2, of Nursing) were made aware the erns.	F6				
ı	2. For Resident #1	10, facility staff failed to					

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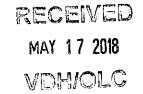
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  F 622  Continued From page 54 evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 2/21/18.  Resident #110 was admitted to the facility on 2/17/17 and readmitted on 4/16/18 with diagnoses that included but were not limited to end stage renal disease with dependence on dialysis, atrial fibrillation, high blood pressure, and major depressive disorder. Resident #110's most	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 622  Continued From page 54 evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 2/21/18.  Resident #110 was admitted to the facility on 2/17/17 and readmitted on 4/16/18 with diagnoses that included but were not limited to end stage renal disease with dependence on dialysis, atrial fibrillation, high blood pressure, and major depressive disorder. Resident #110's most			495299	B. WING	j	_	
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 622  Continued From page 54 evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 2/21/18.  Resident #110 was admitted to the facility on 2/17/17 and readmitted on 4/16/18 with diagnoses that included but were not limited to end stage renal disease with dependence on dialysis, atrial fibrillation, high blood pressure, and major depressive disorder. Resident #110's most				<del>.</del>	3600 MOUNTAIN ROAD	ATE, ZIP CODE	HZ1/Z010
evidence that all required information was provided to the receiving provider for a facility-initiated transfer on 2/21/18.  Resident #110 was admitted to the facility on 2/17/17 and readmitted on 4/16/18 with diagnoses that included but were not limited to end stage renal disease with dependence on dialysis, atrial fibrillation, high blood pressure, and major depressive disorder. Resident #110's most	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECTIVE CROSS-REFERENCED	E ACTION SHOULD BE O TO THE APPROPRIATE	(X5) COMPLETION DATE
a quarterly assessment with and ARD  (assessment reference date) of 1/24/18. Resident #110 was coded as being intact in cognitive function scoring 15 out of possible 15 on the BIMS (Brief Interview for Mental Status) exam.  Review of Resident #110's nursing notes revealed that she had been transferred to the hospital on 2/21/18, the following nursing note was documented, "Resident sent out to ER (Emergency room) due to difficulty breathing and 02 (oxygen) sat (saturation) was 81 with 4 lit (liters) of oxygen via N/C (nasal cannula). HOB (head of bead) elevated to assist with breathing. Resident encouraged to breath in deep through her nose and out her mouth (with lips and small opening). Resident has no SOB (shortness of breath) noted but does have some anxiety and refused all interventions. Response: On call notified, ordered to send out. (sic) Around (sic) 4.45 (sic) am resident was transported through (Name of ambulance) to (Name of Hospital). RP (responsible party) called and notified."  Further review of the clinical record revealed that Resident #110 was admitted back to the facility	F 622	evidence that all reprovided to the receptable facility-initiated transcription and reading facility-initiated transcription and stage renal diagnoses that inceed the stage renal diagnoses that inceed the sesses of t	equired information was beiving provider for a surfer on 2/21/18.  Is admitted to the facility on suffice on 4/16/18 with suffice on 4/16/18 with suffice on 4/16/18 with suffice on sease with dependence on suffice of the	F	522		

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

Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 55 of 211



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495299	B. WING			1	7/2018
	EALTH AND REHAB	1	3	600 MOUNTAIN ROAD		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)				(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
There was no evide information; Resider responsible party of Resident #110's cathospital for the fact 2/21/18.  On 4/26/18 at 2:20 conducted with LPI the unit manager, raresident is sent of stated the nurses sto make him award doctor wants the rette nurses would thand/or emergency documents are ser transfer to the hosp face sheet, physicis sheet would be ser asked if the care pLPN #4 stated that care plan. When a note regarding the with the resident for "No, we don't norm with them.  On 4/26/18 at 5:09 staff member) #1 to the DON (Director of the above concerns.)	ence that all the required ent #110's advanced directives, ontact information, and are plan was provided to the lity-initiated transfer on p.m., an interview was N (licensed practical nurse) #4, regarding the nurse's role when but to the hospital. LPN #4 should call the medical doctor of the situation, and if the esident sent out to the hospital, nen call the power of attorney contact. When asked what he with the resident for a poital, LPN #4 stated that the an orders, and the transfer not with the residents. When lan is ever sent with residents', the nurses do not send the sked if the nurses document a documentation that was sent or a transfer, LPN #4 stated, heally document paper work sent or p.m., ASM (administrative he administrator, and ASM #2, of Nursing) were made aware erns.		622			
exit.						
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From pa breath.  There was no evide information; Reside responsible party of Resident #110's ca hospital for the faci 2/21/18.  On 4/26/18 at 2:20 conducted with LPI the unit manager, r a resident is sent of stated the nurses of to make him aware doctor wants the reference of the nurses would the and/or emergency documents are sent transfer to the hosp face sheet, physici sheet would be sen asked if the care p LPN #4 stated that care plan. When a note regarding the with the resident for "No, we don't norm with them.  On 4/26/18 at 5:09 staff member) #1 t the DON (Director of the above concern	PROVIDER OR SUPPLIER  TH ADAM CRUMP HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 55 breath.  There was no evidence that all the required information; Resident #110's advanced directives, responsible party contact information, and Resident #110's care plan was provided to the hospital for the facility-initiated transfer on 2/21/18.  On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager, regarding the nurse's role when a resident is sent out to the hospital. LPN #4 stated the nurses should call the medical doctor to make him aware of the situation, and if the doctor wants the resident sent out to the hospital, the nurses would then call the power of attorney and/or emergency contact. When asked what documents are sent with the resident for a transfer to the hospital, LPN #4 stated that the face sheet, physician orders, and the transfer sheet would be sent with the residents. When asked if the care plan is ever sent with residents', LPN #4 stated that the nurses do not send the care plan. When asked if the nurses document a note regarding the documentation that was sent with the resident for a transfer, LPN #4 stated, "No, we don't normally document paper work sent with them.  On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.  No further information was presented prior to	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 55 breath.  There was no evidence that all the required information; Resident #110's advanced directives, responsible party contact information, and Resident #110's care plan was provided to the hospital for the facility-initiated transfer on 2/21/18.  On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager, regarding the nurse's role when a resident is sent out to the hospital. LPN #4 stated the nurses should call the medical doctor to make him aware of the situation, and if the doctor wants the resident sent out to the hospital, the nurses would then call the power of attorney and/or emergency contact. When asked what documents are sent with the residents. When asked if the care plan is ever sent with residents', LPN #4 stated that the face sheet, physician orders, and the transfer sheet would be sent with the residents. When asked if the care plan is ever sent with residents', LPN #4 stated that the nurses do not send the care plan. When asked if the nurses document a note regarding the documentation that was sent with the resident for a transfer, LPN #4 stated, "No, we don't normally document paper work sent with them.  On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.  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There was no evidence that all the required information; Resident #110's advanced directives, responsible party contact information, and Resident #110's are plan was provided to the hospital for the facility-initiated transfer on 2/21/18.  On 4/26/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager, regarding the nurse's role when a resident is sent out to the hospital. LPN #4 stated the nurses should call the medical doctor to make him aware of the situation, and if the doctor wants the resident sent out to the hospital, the nurses would then call the power of attorney and/or emergency contact. When asked what documents are sent with the residents for a transfer to the hospital, LPN #4 stated that the nurses do not send the care plan is ever sent with residents, When asked if the care plan is ever sent with residents, When asked if the care plan is ever sent with residents, LPN #4 stated that the nurses do not send the care plan. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE  3000 MOUNTAIN ROAD GLEN ALLEN, VA 23060  SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 55 breath.  There was no evidence that all the required information, Resident #110's advanced directives, responsible party contact information, and Resident #110's care plan was provided to the hospital for the facility-initiated transfer on 2/21/18.  On 4/28/18 at 2:20 p.m., an interview was conducted with LPN (licensed practical nurse) #4, the unit manager, regarding the nurse's role when a resident is sent out to the hospital. LPN #4 stated the nurses should call the medical doctor to make him waver of the situation, and if the doctor wants the resident sent out to the hospital, the nurses would then call the power of attorney and/or emergency contact. When asked what documents are sent with the resident for a transfer to the hospital, the hospital, LPN #4 stated that the face sheet, physician orders, and the transfer sheet would be sent with the residents. When asked if the nurses document a note regarding the documentation that was sent with the resident for a transfer, LPN #4 stated, "No, we don't normally document paper work sent with them.  On 4/26/18 at 5:09 p.m., ASM (administrative staff member) #1 the administrator, and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.

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F 622	3. For Resident #8 evidence that all reprovided to the recapitation facility-initiated transport Resident #81 was a 11/18/16 with diagrant limited to high the disorder, arthritis, of dementia, depress Resident #81's moset) assessment with a date) of 2/19/18. For being severely improved for Mental Review of Resident at the had been to 12/28/18. The follow Resident has dark left side of jaw and (status/post) fall date or right and left mand (centimeters) x 3.5 on left side 1.5 cm 3.5 cm. Resident in suspicion of an antiwith minimal separ (Name of hospital)	in an an analysis of the service of		522			
	Resident #81 arrive	ne clinical record revealed that ed back to the facility on gnosis of a mandibular					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 27/2018	
	PROVIDER OR SUPPLIER	EALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE  3600 MOUNTAIN ROAD  GLEN ALLEN, VA 23060				
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F 622	There was no evided information; Resider responsible party or Resident #81's care hospital for the facili 12/28/18.  On 4/26/18 at 2:20 conducted with LPN the unit manager, rua resident is sent of stated the nurses so to make him aware doctor wants the rethe nurses would the and/or emergency of documents are sent transfer to the hospiface sheet, physicial sheet would be sent asked if the care plan. When as note regarding the with the resident for "No, we don't normal with them.  On 4/26/18 at 5:09 staff member) #1 the series of the care plan.	ence that all the required ent #81's advanced directives, ontact information, and e plan was provided to the lity-initiated transfer on p.m., an interview was N (licensed practical nurse) #4, egarding the nurse's role when ut to the hospital. LPN #4 hould call the medical doctor of the situation, and if the sident sent out to the hospital, are call the power of attorney contact. When asked what the with the resident for a sital, LPN #4 stated that the an orders, and the transfer the with the residents. When an is ever sent with residents', the nurses do not send the sked if the nurses document a documentation that was sent a transfer, LPN #4 stated, ally document paper work sent p.m., ASM (administrative ne administrator, and ASM #2, of Nursing) were made aware		DEFICIENCY)			
		tion was presented prior to					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 622	evidence that all reprovided to the receptacility-initiated transcription of the receptacility-initiated transcription of the receptacility-initiated transcription of the receptacility-initiated but with the receptacient of th	68, facility staff failed to quired information was eiving provider for a asfer on 3/16/18.  6 admitted to the facility on itted on 5/1/12 with diagnoses ere not limited to unspecified weakness, anorexia, high d atrial fibrillation. Resident MDS (minimum data set) quarterly assessment with an reference date) of 2/7/18.  6 coded as being severely refunction scoring 99 on the ew for Mental Status) exam.  1 #468's clinical record was transferred to the hospital llowing nursing note was dent up for breakfast in jerri ed 25 % (percent) with NA (certified nursing assistant) Resident consumed se on duty without any a & O (Oriented) the (sic.) Inswer questions but ponse (per normal baseline). Se station per normal doing desident noted by nurse and of not responding to verbal or NP (nurse practitioner) on floor dent and gave verbal to send to tom) (Resident has her eyes	F 622			
	no response, pupil however resident is (sic) 02 (oxygen) s	low persons with her eyes but reactive to light, not talking a making a snoring like noise) tarted at 2l (liters)/min (minute) HOB (Head of bed) in upright				

Facility ID: VA0083

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		IDENTIFICATION NUMBER:	1'''	DING		(X3) DATE SURVEY COMPLETED	
		495299	B. WING	J	1 04	C / <b>27/2018</b>	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 622	writers fingers who not grasps on con (capillary) refill to to touch, WNL (wiskin tone color. El Technician) arrive being called and to Review of Resider revealed that she to unspecified asp. There was no evic information; Resident #468's cohospital for the fact 3/16/18.	moving hands and grasping en hand was rubbed but would mand), + (positive) cap hands (sic) skin warm and dry thin normal limits) of baseline MT (emergency Medical d within 3 mins (minutes) of book over from there."  Int #468's hospital record had expired in the hospital due biration pneumonia.  Idence that all the required lent #468's advanced directives contact information, and are plan was provided to the cility-initiated transfer on		522			
	conducted with LF the unit manager, a resident is sent stated the nurses to make him awar doctor wants the r the nurses would and/or emergency documents are se transfer to the hos face sheet, physic sheet would be se asked if the care p LPN #4 stated tha care plan. When a note regarding the with the resident f	D p.m., an interview was PN (licensed practical nurse) #4 regarding the nurse's role wher out to the hospital. LPN #4 should call the medical doctor e of the situation, and if the esident sent out to the hospital, then call the power of attorney contact. When asked what int with the resident for a spital, LPN #4 stated that the lian orders, and the transferent with the residents. When plan is ever sent with residents', at the nurses do not send the asked if the nurses document a documentation that was sent or a transfer, LPN #4 stated, mally document paper work sen					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C 04/27/2018
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB	,	STREET ADDRESS, CITY, STAT 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	E, ZIP CODE	04/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIAT	1 1
F 622	with them.  On 4/26/18 at 5:09 staff member) #1 the DON (Director of the above concerns	p.m., ASM (administrative ne administrator, and ASM #2, of Nursing) were made aware		622		
	not eating or drinki of) pain but his me not his baseline\	ng much. No c/o (complaints ntal status and functioning is Will send patient out to ER for evaluation and treatment".				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C 04/27/2018	
	PROVIDER OR SUPPLIER TH ADAM CRUMP HI	EALTH AND REHAB	I	3	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	<u>, 047</u>	2772010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 622	F 622 Continued From page 61		F	322			
	documented in part	ated 03/09/18 at 2:28 p.m. ;, "N.O. (new order) received or evaluation and treatment. rty) notified."					
	nurse) #14, on 04/2 was asked if care president upon transstated they do not send the Resident's record (MAR) and the send the send the record (MAR)	with LPN (licensed practical 26/18 at 2:56 p.m., LPN #14 plan goals were sent with a fer to the hospital. LPN #14 pend care plans, but they do a medication administration reatment administration the has treatment information pals".					
		nt #142's MAR/TAR failed to tion of care plan goals.					
	member) #2, the di 3:20 p.m., ASM #2 documentation that transfer to the hosp the MD (medical do sheet, recent labs, about [Resident's] care plan or	with ASM (administrative staff rector of nursing, on 4/26/18 at was asked to describe the is sent with a resident upon oital. ASM #2 stated, "We send octor) orders, the transfer and any pertinent information condition". When asked if the lan goals are sent with the stated "It might be on the SM #2 stated she would check cumentation that care plan the Resident upon transfer. istrator, and ASM #2 were above findings on 4/26/18 at ion was obtained prior to exit.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495299	B. WING				C <b>27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB	· <b>\</b>	3600	EET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN ROAD EN ALLEN, VA 23060	1 0-11	21723.0
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	(1) This information following website: https://medlineplus (2) This information following website: https://medlineplus 6. The facility staff facility a copy of Reformation for a facility initiated. Resident # 318 was 02/28/17 with a readingnoses that incluperipheral vascular diabetes without confide gastroesophageal in hypertension (5).  Resident # 318's middata set), an annual (assessment reference Resident # 318 as interview for mentaling extensive member for activities. The nurse's "Prografor Resident # 318" informed by staff rupon entering the reference open but not a droopiness noted to assessment. V/S (resident document (medical doctor) urgent in the staff rupon entering the reference open but not a droopiness noted to assessment. V/S (resident document (medical doctor) urgent in the staff rupon entering the reference open but not a droopiness noted to assessment. V/S (resident document (medical doctor) urgent in the programment of the progra	n was obtained from the  .gov/ency/article/000521.htm  n was obtained from the  .gov/ency/article/000479.htm failed to provide the receiving esident # 318's care plan goals d transfer.  s admitted to the facility on dmission of 04/24/18 with uded but were not limited to disease (1), type 2(two) emplication (2), epilepsy (3) reflux disease (4), and  nost recent MDS (minimum all assessment with an ARD ence date) of 01/28/18, coded scoring a 15 on the brief I status (BIMS) of a score of 0 nitively intact for making daily int # 318 was coded as assistance of one staff		522			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			04/3	27/ <b>201</b> 8
	PROVIDER OR SUPPLIER	EALTH AND REHAB		36	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 0472	21/2010
(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 CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	informed writer to the facility) to an acute evaluation r/t (relate Family aware, resident Hospital) per prefer family."  The nurse's "Prografor Resident # 318 Change of Conditions."	f member) # 4, physician] ransport resident OOF (out of care setting for further ed to) change in status. dent transported to (Name of rential request of patient and ess Notes," dated 04/08/2018 documented, "11:24 a.m. on. Situation: Resident was	F	522			
	room) evaluation pormember) # 4, physiconfusion and weal side of body as well of resident's mouth pressure) 156/94, F	of Hospital) for ER (emergency er [ASM (administrative staff ician] due to increased kness noted to resident's right II as droop noted to right side II. VS (vital signs: BP (blood P (pulse) - 95, O2 sats (oxygen ercent) Temp - (temperature) II)-17."					
	conducted with LPI 9, unit manager. W paperwork is sent v initiated transfer or "We send the resid information, physic diagnoses, social s information, facility condition, vitals, cu and history and physend the resident's receiving facility what resident to the ho	O p.m., an interview was N (licensed practical nurse) # When asked to describe what with the resident upon a facility discharge LPN # 9 stated, lent's emergency contact ian contact information, recurity number, insurance information, resident's errent physician order sheet ysical." When asked if they care plan goals to the nen transferring or discharging ospital, LPN # 9 stated, "No."					
	(administrative staf						

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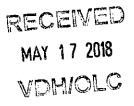
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C 4/27/2018
	PROVIDER DR SUPPLIER	EALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			12112010
(X4) ID PREFIX TAG			ID PREFI TAG	X (EACH CORRECTION CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETION DATE
F 622	were made aware of No further information References: (1) The vascular sy blood vessels. It indicapillaries that carry Arteries can become called atheroscleror vessels and block is Weakened blood with bleeding inside the obtained from the white postained from the white postained from the white postained from the white postained from the without goal of treatment at blood glucose level prevent complication to treat and managactive and eating his was obtained from https://medlineplus.  (3) A brain disorder recurring seizures. clusters of nerve consend out the wrong strange sensations strangely. They may blood the sensations strangely.	stem is the body's network of cludes the arteries, veins and y blood to and from the heart. It is thick and stiff, a problem sis. Blood clots can clog blood flow to the heart or brain. It is easily blood. This information was vebsite: In gov/medlineplus/vasculardise is ein which the body cannot at of sugar in the blood. The it first is to lower your high. Long-term goals are to bons. The most important way the type 2 diabetes is by being the ealthy foods. This information the website: In gov/ency/article/000313.htm.  It that causes people to have that causes people to have that causes people may have and emotions or behave y have violent muscle spasms the sess. This information was vebsite:	F6	522		
		nts to leak back, or reflux, into irritate it. This information			,	

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

Event ID: TQ6711

Facility ID: VA0083

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION  NG	COMP	COMPLETED		
		495299	B. WING		Ł	7/2018	
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIES OF THE	JLD BE	(X5) COMPLETION DATE	
F 622	was obtained from https://www.nlm.nil (5) High blood presobtained from the v	the website: n.gov/medlineplus/gerd.html. ssure. This information was	F 6	22		e e e e e e e e e e e e e e e e e e e	
	facility a copy of Refor a facility initiated for a facility initiated Resident # 46 was 05/24/16 with a readiagnoses that includementia (1), femulobstructive pulmon and hypertension (Resident # 46's moset), a significant of ARD (assessment coded Resident # 4 the brief interview score of 0 - 15, 7 (impaired of cognition Resident # 46 was assistance of one daily living.  The nurse's "Prografor Resident # 46 of the companion of t	admitted to the facility on admission of 01/10/18 with uded but were not limited to a fracture (2), chronic ary disease (3) diabetes (4), 5).  Dest recent MDS (minimum data shange assessment with an reference date) of 01/17/18, 46 as scoring a 7 (seven) on for mental status (BIMS) of a seven) - being severely on for making daily decisions. Coded as requiring extensive staff member for activities of decumented, "dated 01/07/2018 documented, "13:26 (1:26)					
	p.m., Nurse on dut indicated a right fe (new order obtaine	y received x-ray results which moral neck fracture. NOO ed) from on call MD (medical transported via (by) (Name of				• · · · · · · · · · · · · · · · · · · ·	

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		495299	B. WING		l l	C / <b>27/2018</b>
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION OATE
F 622	Ambulance Service 1330 (1:30, p.m.). doctor/responsible On 04/26/18 at 3:5 conducted with LPI 9, unit manager. V paperwork is sent vinitiated transfer or "We send the resic information, physic diagnoses, social sinformation, facility condition, vitals, cuand history and physend the resident's resident is transfer stated, "No." On 04/27/18 at approximation (administrative stated administrator and Awere made aware No further information References: (1) A loss of brain of diseases. It affects judgment, and behobtained from the https://medlineplus (2) You had a fract leg. It is also called needed surgery to had surgery called fixation. In this surgery called fixation. In this surgery called fixation.	and 2 (two) attendants at On call MD/RP (medical party) made aware of event."  O p.m., an interview was N (licensed practical nurse) # When asked to describe what with the resident upon a facility discharge, LPN # 9 stated, lent's emergency contact ian contact information, security number, insurance information, resident's irrent physician order sheet ysical." When asked if they care plan goals when the red or discharged, LPN # 9  Proximately 11:30 a.m. ASM ff member) # 1, the ASM # 2, director of nursing of the findings.  Ition was provided prior to exit.		522		

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	NG		COMPLETED	
		495299	B. WING		l l	C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		27/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 623	(3) Disease that macan lead to shortne was obtained from https://www.nlm.nih (4) A chronic disease regulate the amour information was obhttps://www.nlm.nih 001214.htm. (5) High blood presobtained from the whitps://www.nlm.nih essure.html. Notice Requiremer CFR(s): 483.15(c)( §483.15(c)(3) Notice Requiremer CFR(s): 483.15(c)(1) for the facility trainers of the facility must send a representative of the Long-Term Care Of (ii) Record the reast discharge in the reaccordance with pand	website: gov/ency/patientinstructions/0  akes it difficult to breath that ss of breath). This information the website: a.gov/medlineplus/copd.html.  se in which the body cannot at of sugar in the blood. This tained from the website: a.gov/medlineplus/ency/article/  sure. This information was website: a.gov/medlineplus/highbloodpr  ats Before Transfer/Discharge 3)-(6)(8)  se before transfer. asfers or discharges a a must- and the resident's f the transfer or discharge and move in writing and in a aner they understand. The a copy of the notice to a ane Office of the State mbudsman. sons for the transfer or sident's medical record in aragraph (c)(2) of this section; otice the items described in	F 6:	1. Facility will provide writte notification to the resident a representative for a facility i transfer. 2. Each residents has the pobeing affected. 3. Medical Record staff and Admission staff will be re-ed on providing written notificathe resident and represental facility initiated transfer.	nitiated tential of lucated ation to	5/29/18

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495299	B. WING			04/2	; 27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			1 0-112	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		) BE	(X5) COMPLETION DATE	
F 623	§483.15(c)(4) Timin (i) Except as specific)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or (A) The safety of in be endangered und this section; (B) The health of in be endangered, under paragraph (C) The resident's allow a more immedunder paragraph (C) An immediate required by the resunder paragraph (C) A resident has days.  §483.15(c)(5) Commotice specified in must include the form (ii) The effective days.  §483.15(c)(5) Commotice specified in must include the form (iii) The location to transferred or discovered in the control of the control	ing of the notice.  fied in paragraphs (c)(4)(ii) and in, the notice of transfer or under this section must be at least 30 days before the red or discharged.  made as soon as practicable discharge when-individuals in the facility would der paragraph (c)(1)(i)(C) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility would der paragraph (c)(1)(i)(D) of individuals in the facility for 30 dident's urgent medical needs, c)(1)(i)(A) of this section; or not resided in the facility for 30 dients of the notice. The written paragraph (c)(3) of this section following: transfer or discharge; ate of transfer or discharge; which the resident is	F	623	4. Audits will be conducted to en written notification to the reside and representative for a facility initiated transfer has been completed weekly for four week then monthly for three months. Results of the audits will be revie at the monthly QAPI meeting for three months to ensure complia	nt s ewed	

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

Event ID: TQ6711

Facility ID: VA0083

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED			
		495299	B. WING			04/27/2018		
	ROVIDER OR SUPPLIEF	HEALTH AND REHAB		3600	ET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN ROAD N ALLEN, VA 23060	1 0-172		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION OATE	
	telephone number Long-Term Care (vi) For nursing far and developmental disabilities, the matelephone number the protection and developmental dis C of the Developmental disorder or related email address and agency responsibility advocacy of indivices ablished under for Mentally III Individual for Mentally III Indi	dress (mailing and email) and of the Office of the State Ombudsman; cility residents with intellectual al disabilities or related ailing and email address and of the agency responsible for advocacy of individuals with abilities established under Part mental Disabilities Assistance Act of 2000 (Pub. L. 106-402, .C. 15001 et seq.); and acility residents with a mental disabilities, the mailing and disabilities, the mailing and disabilities, the mailing and disabilities and disabilities, the mailing and disabilities, and acility residents with a mental disorder of the Protection and Advocacy ividuals Act.  Anges to the notice.  In the notice changes prior to offer or discharge, the facility ecipients of the notice as soon be the updated information		523				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495299	B. WING		1	C
NAME OF P	ROVIDER OR SUPPLIER	495299	D. WING	STREET ADDRESS, CITY, STATE, ZIP C		/27/2018
ELIZABE	TH ADAM CRUMP H	EALTH AND REHAB		3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		:
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFICIENCY)		(X5) COMPLETION DATE
	review, and clinical determined that fac written notification for facility initiated is seven out of 42 res Resident #157, 110  1. For Resident #157, 110  1. For Resident #157, 110  1. For Resident #157, 110  2. For Resident #157 written notification for a facility-initiate  3. For Resident #157 written notification for a facility-initiate  4. For Resident #157 written notification for a facility-initiate  4. For Resident #157 written notification for a facility staff to the resident/resp Resident #142's for the resident #142's for facility initiated transpital on 3/9/18.  6. The facility staff notification to the refacility initiated transpital on 4/8/18.  7. The facility staff for facility staff notification to the refacility initiated transpital on 4/8/18.	age 70 erview, facility document record review, it was cility staff failed to provide to the resident representative transfers to the hospital for sidents in the survey sample, 0, 81, 468, 142, 318, and 46.  57, facility staff failed to fication to the resident a facility-initiated transfer on  10, facility staff failed to provide to the resident representative d transfer on 2/21/18.  31, facility staff failed to provide to the resident representative d transfer on 12/28/18.  68, facility staff failed to fication to the resident a facility-initiated transfer on  failed to provide written notice consible representative for facility initiated transfer to the  failed to provide written esponsible party (RP) for the failed to provide written esponsible party (RP) for the failed to provide written esponsible party (RP) for the	F	623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C /27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	<del></del>	2712010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 623	hospital on 1/7/201. The findings included 1. Resident #157 w 3/23/18 with diagnor limited to Non-Alzhe encephalopathy, mweakness. Reside (minimum data set) assessment with ardate) of 3/30/18. Resident impaired in conthe BIMS (Brief Interexam).  Review of Resident revealed that she hhospital on 4/6/18. was documented: "and clammy. Tempor climbingResident Cannot hold self up continuing to go up Pupils not dilated. In Respirations even a 110/48,-102.7-117 (percent) (oxygen).  Further review of the Resident #157 was on 4/11/18 with a dilated revidence that the Ferrica with the self-self-self-self-self-self-self-self-	as admitted to the facility on uses that included but were not eimer's dementia, depression, and disorder and muscle int #157's most recent MDS was an admission ARD (assessment reference esident #157 was coded as a cognitive function scoring 99 on erview for Mental Status  if #157's clinical record ad been transferred to the The following nursing note Resident Lethargic. Skin hot (temperature) 102.7 and more lethargic than usual. oright. Temp is elevated and in Responsive to questions. Lung sounds clear. and unlabored. VS (vital signs) (pulse)-18 (respirations) - 93% in the clinical record revealed that admitted back to the facility		523		
ı	On 4/26/18 at 2:20	p.m., an interview was				

		IDENTIFICATION NUMBER:	1, ,	NG	COMPLETED		
		495299	B. WING		1	C / <b>27/2018</b>	
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION OATE	
F 623	conducted with LF the unit manager. resident represent resident transfer to that the nurses did documentation to On 4/26/18 at 5:00 staff member) #1 the DON (Director of the above conducted that a stage renails of the above conducted to the stage renails of the above conducted to the above conduct	PN (licensed practical nurse) #4, LPN #4 stated that the tative was notified verbally of a to the hospital. LPN #4 stated d not provide written the resident representative. P.p.m., ASM (administrative the administrator, and ASM #2, or of Nursing) were made aware		23			

AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY
	495299	B. WING			04/2	; 7/2018
NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEA	LTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			, , ,	
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION OATE
(liters) of oxygen via Noted of bead) elevate Resident encouraged her nose and out her opening). Resident her breath) noted but doe refused all intervention notified, ordered to see 4.45 (sic) am resident (Name of ambulance) (responsible party) can be returned from the Resident #110 was accorded and the review of the Resident #110 was accorded and the revidence that the RP notified in writing for the 2/21/18.  On 4/26/18 at 2:20 purconducted with LPN (the unit manager. LP resident representative resident transfer to the that the nurses did not documentation to the On 4/26/18 at 5:09 purconducted with that the nurses did not documentation to the On 4/26/18 at 5:09 purconducted with the DON (Director of of the above concerning the side of the above concerning the side of the side of the above concerning the side of the side of the above concerning the side of	ration) was 81 with 4 lit N/C (nasal cannula). HOB ed to assist with breathing. to breath in deep through mouth (with lips and small as no SOB (shortness of s have some anxiety and ns. Response: On call end out. (sic) Around (sic) it was transported through to (Name of Hospital). RP elled and notified."  clinical record revealed that dmitted back to the facility gnosis of shortness of  110's clinical record failed to (responsible party) was ner reason for transfer on  m., an interview was licensed practical nurse) #4, PN #4 stated that the rewas notified verbally of a le hospital. LPN #4 stated of provide written resident representative.  m., ASM (administrative administrator, and ASM #2, Nursing) were made aware	F	523			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED	
		495299	B. WING				27/2018
	ROVIUER OR SUPPLIER	EALTH AND REHAB	:	3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) 1D PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 623	Continued From pa	age <b>74</b>	F	323			
	written notification for a facility-initiate	11, facility staff failed to provide to the resident representative d transfer on 12/28/18.					
	11/18/16 with diagr not limited to high t disorder, arthritis, o dementia, depress Resident #81's mo	admitted to the facility on noses that included but were blood pressure, thyroid esteoporosis, Non-Alzheimer's ion, and muscle weakness. st recent MDS (minimum data as a significant change					
	assessment with a date) of 2/19/18. Feeling severely imp	n ARD (assessment reference Resident #81 was coded as aired in cognitive function ossible 15 on the BIMS (Brief					
	that he had been to 12/28/18. The folk "Resident has dark left side of jaw and (status/post) fall dato right and left ma (centimeters) x 3.5 on left side 1.5 cm 3.5 cm. Resident has suspicion of an any with minimal separ (Name of hospital) doctor/RP (responsible)	t #81's clinical record revealed ransferred to the hospital on owing nursing note was written: a purple bruising to right and left elbowResident is S/P ay 2 noted dark purple bruising andible right side bruise is 2 cm (centimeters) and bruise by 1.5 cm. left elbow 2 cm by had X Ray that showed high terior right mandibular fracture ration. Resident sent out to for CT scan. MD (medical sible party) made aware."					
	Resident #81 arriv	he clinical record revealed that ed back to the facility on agnosis of a mandibular					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
		495299	B. WING	)		C 04/27/2018	
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, Z 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	<u> </u>	27/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	1X5) COMPLETION DATE	
F 623	Review of Resider evidence that the notified in writing for 12/28/18.  On 4/26/18 at 2:20 conducted with LF the unit manager. resident represent resident transfer to that the nurses did documentation to 12/26/18 at 5:00 staff member) #1 the DON (Director of the above conducted in the policy of the staff member) #1	nt #81's clinical record failed to RP (responsible party) was for his reason for transfer on D p.m., an interview was PN (licensed practical nurse) #4, LPN #4 stated that the tative was notified verbally of a to the hospital. LPN #4 stated d not provide written the resident representative.  D p.m., ASM (administrative the administrator, and ASM #2, of Nursing) were made aware	F	623			
	provide written no representative for 3/16/18.  Resident #468 wa 10/5/06 and readi that included but dementia, muscle blood pressure, a #468's most receive assessment was ARD (assessment Resident #468 was impaired in cognit	468, facility staff failed to tification to the resident a facility-initiated transfer on as admitted to the facility on mitted on 5/1/12 with diagnoses were not limited to unspecified weakness, anorexia, high and atrial fibrillation. Resident and MDS (minimum data set) a quarterly assessment with an at reference date) of 2/7/18. as coded as being severely tive function scoring 99 on the view for Mental Status) exam.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILI		E CDNSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		495299	B. WING	;			7/2018
	PROVIDER OR SUPPLIER	IEALTH AND REHAB	1	3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 04/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1D PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 623	Review of Resider revealed that she on 3/16/18. The form of the consumed 2 from CNA (certified liquids). Resident nurse on duty with (Oriented) the (sich questions but incomormal baseline), per normal doing in noted by nurse and responding to vert (nurse practitioner resident and gave (emergency room opened and will form or response, pupil however resident (sich) 02 (oxygen) sivia non rebreather position, Resident writers fingers when the grasps on component (capillary) refill to the color. Effective of Resider Review of Resider	age 76  Int #468's clinical record was transferred to the hospital billowing nursing note was sident up for breakfast in jerri 5 % (percent) with assistance d nursing assistant) (drank all consumed medication per out any difficulties. A (alert) & O) confusion able to answer herent with response (per Resident up at nurse station normal activities. Resident d aide @145pm of not bal or tactile stimuli (sic) NP o) on floor and assessed verbal to send to ER (Resident has her eyes allow persons with her eyes but a reactive to light, not talking as making a snoring like noise) started at 2l (liters)/min (minute) of, HOB (Head of bed) in upright moving hands and grasping en hand was rubbed but would mand), + (positive) cap hands (sic) skin warm and dry thin normal limits) of baseline MT (emergency Medical d within 3 mins (minutes) of book over from there."		623		3	
	Review of Resider	viration pneumonia. Int #468's clinical record failed to RP (responsible party) was For her reason for transfer on					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDI	ING		COMPLETED	
		495299	B. WING		04	C /27/2018
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	3/16/18.  On 4/26/18 at 2:2 conducted with Let the unit manager. resident represen resident transfer that the nurses didocumentation to On 4/26/18 at 5:0 staff member) #1 the DON (Directo of the above conducted to the above conducted to the staff member) #1 the DON (Directo of the above conducted the above conducted the above conducted the staff member) #1 the DON (Directo of the above conducted the staff member) #1 the DON (Directo of the above conducted the staff member) #1 the facility state or resident/responsitiated transfer to 3/09/18.  Resident #142 was 08/30/17 with received the urinary trade and kidneys) (1), level in the blood) low back pain.  The most recent assessment, a 14 with an assessment, a 14 with an assessment (brief interview for the staff interview for the unit manager.	0 p.m., an interview was PN (licensed practical nurse) #4, LPN #4 stated that the tative was notified verbally of a to the hospital. LPN #4 stated d not provide written the resident representative.  9 p.m., ASM (administrative the administrator, and ASM #2, or of Nursing) were made aware		23		

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED C	CONSTRUCTION :	, ,	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		
04/27/2018	·	B. WING	495299		
,	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060		EALTH AND REHAB	PROVIDER OR SUPPLIER	
D BE COMPLÉTIO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ID PREFIX TAG	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(EACH DEFICIENC)	(X4) ID PREFIX TAG
		F 62	oner Progress Note" dated m., documented in part, "Still ng much. No c/o (complaints ntal status and functioning is	The "Nurse Practiti 03/09/18 at 1:06 p. not eating or drinking	F 623
			Will send patient out to ER for evaluation and treatment".  ated 03/09/18 at 2:28 p.m. t, "N.O (new order) received to evaluation and treatment. RP notified."  dated 03/09/18 at 4:53 p.m. t, "Resident left facility via	not his baseline\ (emergency room)  The nurse's note documented in parsent [sic] to ER for (responsible party)  The nurse's notes of	
			onducted with LPN (licensed 5 on 04/26/18 at 1:14 p.m. d how the resident/responsible notified of a transfer to the stated that the "Charge nurse ly know that the resident is '. When asked if this is to the resident/responsible N #15 stated "No".	practical nurse) #18 LPN #15 was aske representative was hospital. LPN #15 calls to let the fami getting transferred	
			M #2 stated "No".	member) #2, the di 3:20 p.m., ASM #2 resident/responsible about transfer to the the staff, "Call the di notification in the newritten notification provided to the rese representative, AS	
			evaluation and treatment. RP notified."  dated 03/09/18 at 4:53 p.m. t, "Resident left facility via ware".  onducted with LPN (licensed 5 on 04/26/18 at 1:14 p.m. d how the resident/responsible notified of a transfer to the stated that the "Charge nurse ly know that the resident is '. When asked if this is to the resident/responsible N #15 stated "No".  with ASM (administrative staff irector of nursing, on 4/26/18 at was asked how the le representative is notified the hospital. ASM #2 stated that family and document the urse's notes". When asked if of the transfer to the hospital is ident/responsible	sent [sic] to ER for (responsible party)  The nurse's notes of documented in part stretcherRP is at An interview was contractical nurse) #1 LPN #15 was asked representative was hospital. LPN #15 calls to let the faming getting transferred provided in writing representative, LPI During an interview member) #2, the did 3:20 p.m., ASM #2 resident/responsible about transfer to the staff, "Call the finotification in the newritten notification provided to the response of the staff, and the staff, a	

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

Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 79 of 211



AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COMPLETED			
		405000	B MINO			C	
	PROVIDER OR SUPPLIER	495299 EALTH AND REHAB	B. WING	S 3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	04/2	7/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION OATE
F 623	made aware of the 5:15 p.m.  No further information of the side of	above findings on 4/26/18 at son was obtained prior to exit. On was obtained from the agov/ency/article/000521.htm on was obtained from the agov/ency/article/000479.htm failed to provide written asponsible party (RP) for the sfer of Resident # 318 to the admitted to the facility on admission of 04/24/18 with aded but were not limited to a disease (1), type 2(two) amplication (2), epilepsy (3) reflux disease (4), and assessment with an ARD ence date) of 01/28/18, coded scoring a 15 on the brief all status (BIMS) of a score of 0 nittively intact for making daily ess Notes," dated 04/08/2018 documented, "8:19 a.m., resident was not 'looking good' from, resident noted to have everbally coherent. Some of R (right) side of face on (vital signs) obtained on		523			

AND PLAN OF CORRECTION (X1) PROVIDERSOPPLIER CLIA  IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		495299	B. WING			C / <b>27/2018</b>
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	1X5) COMPLETION DATE
F 623	resident document (medical doctor) 114 on nurse asset (administrative stainformed writer to facility) to an acute evaluation r/t (rela Family aware, rest Hospital) per preferamily."  The nurse's "Progfor Resident # 318 Change of Condition sent out to (Nameroom) evaluation member) # 4, phy confusion and we side of body as worderessure) 156/94, saturation) 97% (p98.6, R (respiration) 97% (p98.6, R (respiration) 97% (pontify the RP (respiration) 9	ted and reported to MD upon calling, also blood sugars essment, MD phoned, [ASM aff member) # 4, physician] transport resident OOF (out of e care setting for further ted to) change in status. ident transported to (Name of erential request of patient and  aress Notes," dated 04/08/2018 documented, "11:24 a.m. ion. Situation: Resident was e of Hospital) for ER (emergency per [ASM (administrative staff sician] due to increased akness noted to resident's right ell as droop noted to right side th. VS (vital signs: BP (blood P (pulse) - 95, O2 sats (oxygen percent) Temp - (temperature) ion)-17."  50 p.m., an interview was PN (licensed practical nurse) # regarding how the facility staff ponsible party) of a facility f a resident to the hospital. LPN otify the RP or family by phone." written notification is provided to LPN #9 stated, "No."		523		

	OF CORRECTION	IDENTIFICATION NUMBER:	l ` '	G	COV	APLETED
		495299	B. WING_			C / <b>27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		21,20.0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	References: (1) The vascular sy blood vessels. It ind capillaries that carr Arteries can become called atherosclero vessels and block it. Weakened blood vessels and block it. Weakened blood vessels and blood vessels. It indicates the contained from the vessels. It is indicated to treat and managactive and eating heart was obtained from https://medlineplus.  (3) A brain disorder recurring seizures. clusters of nerve cessend out the wrong strange sensations strangely. They may or lose conscious obtained from the vessels that the vessels are contained from the vessels and blook in the vessels are contained from the vessels are contained	stem is the body's network of cludes the arteries, veins and y blood to and from the heart. It is thick and stiff, a problem sis. Blood clots can clog blood flow to the heart or brain. It is information was vebsite: In gov/medlineplus/vasculardise is in which the body cannot at of sugar in the blood. The triest is to lower your high. Long-term goals are to ons. The most important way the type 2 diabetes is by being ealthy foods. This information the website: Ingov/ency/article/000313.htm.  If that causes people to have that causes people to have and emotions or behave y have violent muscle spasms ess. This information was vebsite: Ingov/epilepsy.html.	F 62	23		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED		
		495299	B. WING	<u></u>		04/2	: 27/ <b>201</b> 8
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		3600	ET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN ROAD N ALLEN, VA 23060	1 0412	2772010
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F 623	obtained from the	essure. This information was	F	523			
	notification to the	off failed to provide written responsible party (RP) for the cansfer of Resident # 46 to the 118.					
	05/24/16 with a re diagnoses that in dementia (1), fen	es admitted to the facility on eadmission of 01/10/18 with cluded but were not limited to nur fracture (2), chronic onary disease (3) diabetes (4), (5).	1	Í			1
	set), a significant ARD (assessmer coded Resident # the brief interview score of 0 - 15, 7	nost recent MDS (minimum data change assessment with an it reference date) of 01/17/18, 446 as scoring a 7 (seven) on v for mental status (BIMS) of a (seven) - being severely tion for making daily decisions.					
	for Resident # 46 p.m., Nurse on di indicated a right to (new order obtain doctor). Residen Ambulance Servi 1330 (1:30, p.m.)	gress Notes," dated 01/07/2018 documented, "13:26 (1:26) uty received x-ray results which femoral neck fracture. NOO ned) from on call MD (medical it transported via (by) (Name of ce) and 2 (two) attendants at it. On call MD/RP (medical le party) made aware of event."					
	conducted with L	:50 p.m., an interview was PN (licensed practical nurse) # regarding how the facility staff					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDING			COMPLETED	
		495299	B. WING			C 04/27/2018	
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB			ESS, CITY, STATE, ZIP CODE AIN ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACI	ROVIDER'S PLAN OF CORREC H CORRECTIVE ACTION SHO -REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5] COMPLETION OATE
F 623	initated transfer o # 9 stated, "We n When asked if a wathe RP or family, On 04/27/18 at ap (administrative standard administrator and were made aware) No further information of the standard from the https://medlineplu.  (2) You had a fract leg. It is also called needed surgery to had surgery called fixation. In this sucut to open your sobtained from the https://medlineplu.  (3) Disease that in can lead to shorted was obtained from the https://www.nlm.r.  (4) A chronic disease.	ponsible party) of a facility f a resident to the hospital. LPN otify the RP or family by phone." written notification is provided to LPN #9 stated, "No." proximately 11:30 a.m. ASM aff member) # 1, the ASM # 2, director of nursing of the findings. The findings of the findings of the findings. The function that occurs with certain is memory, thinking, language, thavior. This information was exebsite: Its.gov/ency/article/000739.htm. The femurin your ed the thigh bone. You may have to repair the bone. You may have to repair the bone. You may have to repair the bone are cut on internal regery, your surgeon will make a fracture. This information was exebsite: Its.gov/ency/patientinstructions/0 makes it difficult to breath that these of breath). This information in the website: Inih.gov/medlineplus/copd.html.		523			
	information was	unt of sugar in the blood. This obtained from the website: nih.gov/medlineplus/ency/article/					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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		495299	B. WING			04/2	27/2018
	PROVIDER OR SUPPLIER TH ADAM CRUMP H	EALTH AND REHAB		36	TREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625 SS=D	obtained from the watter sure.html. Notice of Bed Hold CFR(s): 483.15(d)(Section 1988). 15(d) Notice of Section 1988. 15(d)(1) Notice of Section 1988. 15(d)(2) Bedden 1988. 15(	sure. This information was vebsite: n.gov/medlineplus/highbloodpr  Policy Before/Upon Trnsfr 1)(2)  of bed-hold policy and returnate before transfer. Before a sfers a resident to a hospital or on therapeutic leave, the st provide written information to dent representative that the state bed-hold policy, if the resident is permitted to residence in the nursing dipayment policy in the state 40 of this chapter, if any; cility's policies regarding which must be consistent with this section, permitting a land on specified in paragraph (e)(1)  -hold notice upon transfer. At		625	F625  1. Facility will provide notice of bhold policy upon transfer to resident/responsible representate.  2. Each residents has the potentibeing affected.  3. Licensed nurses, Medical Reconstant Admission Staff will be educated on providing notice of hold policy upon transfer to resident/responsible representate.  4. Audits will be conducted to enducte of bed hold policy upon transfer to resident/ responsible representative have been complete weekly for four weeks then more for three months. Results of the visits will be reviewed at the mode.  QAPI meeting for three months ensure compliance.	al of ords re- bed tive. asure eleted othly elementally	5/29/18
	described in parag	ion of the bed-hold policy raph (d)(1) of this section. NT is not met as evidenced					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` '	PLE CONSTRUCTION		COMPLETED		
		495299	B. WING_		04	C /27/2018	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 625	by: Based on staff intereview and clinical determined the fact written bed hold not resident/responsib transfer or within the residents in the sur #318, and #46.  1. The facility staff hold notification/poresident/responsib residents transfer to the sur and the findings included the fi	erview, facility documentation record review, it was ility staff failed to provide a stification/policy to be representative at the time of venty four hours for 3 of 42 revey sample, Residents #142, failed to provide a written bed licy to Resident #142's be representative upon the so hospital on 03/09/18.  If failed to provide a written bed licy to Resident #318's be representative upon the so hospital on 04/08/18.  If failed to provide a written bed so hospital on 04/08/18.  If failed to provide a written bed so hospital on 04/08/18.		25			

ANO PLAN OF CORRECTION  (X1) PROVIDER SUPPLIER CLIA IOENTIFICATION NUMBER:		IOENTIFICATION NUMBER:	1 '		CONSTRUCTION	COMPLETEO		
		495299	B. WING			04/2	; 27/2018	
	PROVIOER OR SUPPLIEF	HEALTH AND REHAB	STREET AOORESS, CITY, STATE, ZIP COO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			DE .		
(X4) IO PREFIX TAG	(EACH OEFICIENG	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREF TAG	1	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROPOLICIENCY)	O BE	(X5) COMPLETION DATE	
F 625	Iow back pain.  The most recent Massessment, a 14 with an assessme coded the residen (brief interview for had severe cognit making.  The "Nurse Practi 03/09/18 at 1:06 protesting or drink of) pain but his monot his baseline (emergency room  The nurse's notest documented in pasent [sic] to ER for (responsible party)  The nurse's notest documented in pasent [sic] to ER for (responsible party)  The nurse's notest documented in pasent [sic] to ER for (responsible party)  The nurse's notest documented in pasent [sic] to ER for (responsible party)  The nurse's notest documented in pasent [sic] to ER for (responsible for protection pasent [sic] to ER for protection (sic) and interview member) #10, a second pasent [sic] to ER for protection (sic) and interview member (sic) and interview director, on 04/26 they currently do manager, so at the second pasent [sic] to ER for (responsible for protection (sic) and interview director, on 04/26 they currently do manager, so at the second pasent [sic] to ER for (responsible for protection (sic) and (sic	MDS (minimum data set) day Medicare assessment, ent reference date of 04/02/18, et as scoring a "3" on the BIMS mental status), indicating he ive impairment of daily decision  tioner Progress Note" dated o.m., documented in part, "Still ting much. No c/o (complaints ental status and functioning is ental status and fu		625				

		IDENTIFICATION NUMBER:	l , ,	DING		COMPLETED		
		495299	B. WING		04	C /27/2018		
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	IX5) COMPLETION OATE		
F 625	resident/responsit holds. OSM #11 shold information owhen a Resident in During an interview member) #2, the consident/responsit stated she would documentation the ASM #1, the adminate aware of the 5:15 p.m.  On 4/27/18 at 7:30 copy of the "Notic review of the documentation the was nowher resident/responsit acknowledgementation."  During an interview 9:15 a.m., the "Notic review of the documentation the was nowher resident/responsitional acknowledgementation."  During an interview 9:15 a.m., the "Notic review of the documentation to the following and interview of the contraction of the following and interview of the modern to the following and interview of the following and	ole representative about bed stated, "There is not any bed urrently in writing that is sent is transferred".  w with ASM (administrative staff director of nursing, on 4/26/18 at 2 was asked if written ed hold was provided to ole representative, ASM #2 check to see what bed hold e facility provides.  Inistrator, and ASM #2 were e above findings on 4/26/18 at 0 a.m., the facility provided a e of Bed Hold Policy". Upon umentation, it was noted that e on the document for the ole representative to sign to f the bed hold.  w with OSM #11 on 04/27/18 at olice of Bed Hold Policy" was e stated that the notice the her is part of the packet that a ole representative receives upor facility. She confirmed that it int a bed hold notification and facility does not provide any in to the resident/responsible garding a bed hold when a		625				
	   (1) This informat	tion was obtained from the						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ICATION NUMBER.		2) MULTIPLE CONSTRUCTION BUILDING		
		495299	B. WING			I	C / <b>27/2018</b>
	PROVIDER OR SUPPLIER	I		3 <b>600 M</b>	FADDRESS, CITY, STATE, ZIP COL OUNTAIN ROAD ALLEN, VA 23060		2772010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 625	following website: https://medlineplus (2) This informati following website: https://medlineplus 2. The facility staff 318's representati hold policy when to the hospital on 04.  Resident # 318 was 02/28/17 with a rediagnoses that incomperipheral vascular diabetes without orgastroesophageal hypertension (5).  Resident # 318's redata set), an annual (assessment reference) Resident # 318 as interview for mention 15, 15- being condecisions.  The nurse's "Progfor Resident # 318" "Informed by staff upon entering the eyes open but not droopiness noted assessment. V/S resident document (medical doctor) 114 on nurse asses (administrative staffully interview staffully interview for mention of the eyes open but not droopiness noted assessment. V/S resident document (medical doctor) 114 on nurse asses (administrative staffully interview staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffully interview for medical doctor) 114 on nurse asses (administrative staffull	s.gov/ency/article/000521.htm ion was obtained from the s.gov/ency/article/000479.htm failed to provide Resident # ve written notification of the bed he resident was discharged to	F	325			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILC		COMPLETED		
	495299	B. WING	ì		04/2	27/ <b>2018</b>
NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEA		1	ST 3 <b>6</b>	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	1 04/2	.772016
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
evaluation r/t (related Family aware, resided Hospital) per prefere family."  The nurse's "Progres for Resident # 318 d Change of Condition sent out to (Name of room) evaluation per member) # 4, physic confusion and weaks side of body as well of resident's mouth. pressure) 156/94, P saturation) 97% (per 98.6, R (respiration).  Further review of Refailed to reveal the fainformation regarding Resident #318"s rep  During an interview 9:15 a.m., the "Notice shown to her. She se surveyor showed heresident/responsible admission to the fact does not represent at that currently the fact written notification to representative regar transfer to the hospit on 04/27/18 at apprecadministrative staff.	care setting for further d to) change in status.  ent transported to (Name of ential request of patient and ential request of patient and ess Notes," dated 04/08/2018 occumented, "11:24 a.m.  a. Situation: Resident was f Hospital) for ER (emergency r [ASM (administrative staff cian] due to increased ness noted to resident's right as droop noted to right side VS (vital signs: BP (blood (pulse) - 95, O2 sats (oxygen cent) Temp - (temperature) -17."  esident #318's clinical record escility staff provided written g the bed hold policy to be a feel Hold Policy" was estated that the notice the r is part of the packet that a representative receives upon ility. She confirmed that it is a bed hold notification and cility does not provide any of the resident/responsible ding a bed hold when a tal occurs.		625			

		IDENTIFICATION NUMBER:	l'''	ING	COMPLETED		
		495299	B. WING		1	C / <b>27/2018</b>	
	PROVIDER OR SUPPLIER	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION OATE	
F 625	were made aware  No further information  References: (1) The vascular sign of the vascular si	of the findings.  Ation was provided prior to exit.  Asystem is the body's network of includes the arteries, veins and irry blood to and from the heart.  The thick and stiff, a problem cosis. Blood clots can clog blood flow to the heart or brain. It is information was website:  The signar in the blood. The at first is to lower your high cell. Long-term goals are to ions. The most important way ge type 2 diabetes is by being the healthy foods. This information in the website:  The seizures happen when cells, or neurons, in the brain in gisignals. People may have	F	325			
	strangely. They m or lose conscious obtained from the https://medlineplu (4) Stomach conte	s and emotions or behave ay have violent muscle spasms ness. This information was website: s.gov/epilepsy.html. ents to leak back, or reflux, into ad irritate it. This information					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B. WING				1
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	04/2	27/2018
ELIZABE	ETH ADAM CRUMP H	IEALTH AND REHAB			000 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	(5) High blood predobtained from the https://www.nlm.ni essure.html.  3. The facility staff 46's representative hold policy when the hospital on 01/2 Resident # 46 was 05/24/16 with a readiagnoses that incidementia (1), femobstructive pulmor and hypertension (2) Resident # 46's meset), a significant of ARD (assessment coded Resident # the brief interview score of 0 - 15, 7 (impaired of cogniti Resident # 46 was assistance of one daily living.  The nurse's "Progressident # 46 op.m., Nurse on dufindicated a right fee (new order obtained doctor). Resident	the website: h.gov/medlineplus/gerd.html. ssure. This information was website: h.gov/medlineplus/highbloodpr  failed to provide Resident # e written notification of the bed he resident was discharged to 107/18.  admitted to the facility on admission of 01/10/18 with luded but were not limited to ur fracture (2), chronic hary disease (3) diabetes (4),	F	325			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		i ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495299	B. WING		04	C /27/2018	
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE	
F 625	1330 (1:30, p.m.). doctor/responsible  Further review of R failed to reveal the information regardi Resident # 46"s reputation of the information regardi Resident # 46"s reputation of the information of	On call MD/RP (medical party) made aware of event."  esident #46's clinical record facility staff provided written ing the bed hold policy to presentative.  with OSM #11 on 04/27/18 at ice of Bed Hold Policy" was stated that the notice the er is part of the packet that a e representative receives upon cility. She confirmed that it is a bed hold notification and incility does not provide any to the resident/responsible arding a bed hold when a poital occurs.  proximately 11:30 a.m. ASM if member) # 1, the ASM # 2, director of nursing of the findings.  Identical memory is incomed that occurs with certain memory, thinking, language, avior. This information was		525			

NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, 2P CODE 3800 MOUNTAIN ROAD GLEN ALLEN, VA 23080  (W.4) DI SUMMENY STATEMENT OF DEPTENDENCES (PROVIDER SPLANDE CORRECTION)  FRESULATORY OR LSC DENTEYING INFORMATION)  F 625  Continued From page 93 cut to open your fracture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.  (3) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.  (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 001214.htm.  (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/ 001214.htm.  (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.  F 645 PASARR Screening for MD & ID CFR(s): 483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3); (i) of this section, unless the State mental health authority, has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority in the tuthority, prior to admission, (A) That, because of the physical and mental evaluation performed by a person or entity other than the State mental health authority in the tuthority, prior to admission, (A) That, because of the physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental evaluati		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, ZIP CODE 3800 MOUNTAIN ROAD GLEAN ALLER, VA 23080   SUMMARY STATEMENT OF DEPICENCIES   SUMMARY STATEMENT OF DEPICENCY   SUMMARY STATEMENT OF DEPICE			495299			<del> </del>		
F 625 Continued From page 93 cut to open your fracture. This information was obtained from the website: https://mww.nlm.nih.gov/medlineplus/copd.html.  (3) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.  (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.  (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.  (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.  F 645 PSS=E  F 647 SS=E  F 648 SQ(k) Preadmission Screening for individuals with intellectual disability.  §483.20(k) Preadmission Screening for individuals with intellectual disability.  §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than t					S1 36	600 MOUNTAIN ROAD	1 04/2	
cut to open your fracture. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00166.htm.  (3) Disease that makes it difficult to breath that can lead to shortness of breath). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.  (4) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.  (5) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.  F645 PASARR Screening for MD & ID SEE CFR(s): 483.20(k)(1)-(3)  §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with a mental disorder and individuals with intellectual disability.  §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3) (i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental evaluation of PASARRs on residents.  3. Admissions staff will be reducated on obtaining PASARR screening prior to residents	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	- 1	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
	F 645	cut to open your frobtained from the https://medlineplus 00166.htm.  (3) Disease that mean lead to shorth was obtained from https://www.nlm.ni  (4) A chronic disease regulate the amount information was obtained from the https://www.nlm.ni 001214.htm.  (5) High blood preobtained from the https://www.nlm.ni essure.html. PASARR Screenin CFR(s): 483.20(k) §483.20(k) Preadmindividuals with a with intellectual disease with a light intellectual disease with a light independent phys performed by a perstate mental healt (A) That, because	acture. This information was website: s.gov/ency/patientinstructions/0 takes it difficult to breath that ess of breath). This information the website: h.gov/medlineplus/copd.html. ase in which the body cannot not of sugar in the blood. This otained from the website: h.gov/medlineplus/ency/article/ssure. This information was website: h.gov/medlineplus/highbloodpring for MD & ID (1)-(3) mission Screening for mental disorder and individuals sability.  Lursing facility must not admit, on 1989, any new residents with: as defined in paragraph (k)(3) unless the State mental health rmined, based on an ical and mental evaluation erson or entity other than the th authority, prior to admission, of the physical and mental	F		1. Facility will obtain PASARR screening prior to residents admitting to the facility. PASARRS have been completed on resident #90, #20, #60 and #53  2. A review of residents will be conducted to initiate the comple of PASARRs on residents.  3. Admissions staff will be reeducated on obtaining PASARR	ts	5/29/18
i la companya da managaran da ma						screening prior to residents		

AND PLAN OF CORRECTION  (Xt) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILE		(X3) DATE SURVEY COMPLETED			
		495299	B. WING			1	C 27/2018
	PROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD ILEN ALLEN, VA 23060		21/2010
(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 SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETION DATE
F 645	and (B) If the individual services, whether is specialized services (ii) Intellectual disas (k)(3)(ii) of this section intellectual disability authority has deter (A) That, because condition of the incompact of the individual services, whether is specialized services (B) If the individual services, whether is specialized services (ii) The preadmission for determinations to a nursing facility being admitted to the transferred for care (ii) The State may preadmission screep aragraph (k)(1) of to a nursing facility (A) Who is admitted hospital after recein hospital, (B) Who requires recondition for which the hospital, and (C) Whose attendibefore admission to	requires such level of the individual requires es; or bility, as defined in paragraph etion, unless the State ey or developmental disability emined prior to admission-of the physical and mental dividual, the individual requires es provided by a nursing facility; requires such level of the individual requires es for intellectual disability. Estimate the properties of the emission of an individual who, after the nursing facility, was even in a hospital. Choose not to apply the ening program under this section to the admission of the individual who, after the section to the admission of this section to the admission of the individual who.		345	admitting to the facility. PASARR be completed  4. Audits will be conducted to en PASARR screenings have been obtained prior to residents admit to the facility weekly for four we then monthly for three months. Results of the audits will be revie at the monthly QAPI meeting for three months to ensure compliant.	sure tting eks ewed	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		405000	B. WING			C	l	
NAME OF I	DOMEST OF STIPPLIED	495299	D. WING		TREET ADDRESS OUTV STATE 71D OODE	04/2	7/2018	
	PROVIDER OR SUPPLIER  TH ADAM CRUMP H	EALTH AND REHAB		3	ETREET ADDRESS, CITY, STATE, ZIP CODE 1600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 645	Continued From pa	age 95	F	645				
	section- (i) An individual is of disorder if the individual is of disorder defined in (ii) An individual is intellectual disabilit or is a person with described in 435.10 This REQUIREME by:  Based on staff into and clinical record facility staff failed to (Preadmission Scriwas completed for	considered to have an y if the individual has an y as defined in §483.102(b)(3) a related condition as						
	#90's PASARR wa resident was evalu services in the mos appropriate for the  2. The facility staff PASARR (preadmireview) was compl	failed to ensure Resident s completed to ensure the ated and receiving care and st integrated setting resident's needs.  failed to ensure Resident #20's ssion screening and resident ete to ensure the resident was siving care and services in the						
	most integrated se resident's needs.  3. The facility staff PASARR (preadmi review) was compl evaluated and rece	failed to ensure Resident #60's ssion screening and resident ete to ensure the resident was eiving care and services in the tting appropriate for the						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION ING	COM	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB	•	STREET ADDRESS, CITY, STATE, ZO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	_ `	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 645		failed to complete the ening and resident review dent #53.	Fe	545			
	#90's PASARR was resident was evaluated services in the most appropriate for the Resident # 90 was 11/08/13. Resident were not limited to (2), dementia without the resident without the resident without the resident without the resident was a serviced without the resident without the resident was a serviced with the resident was a serviced was a serviced with the resident was evaluated as a serviced was appropriate for the resident was evaluated was evaluated was evaluated as a serviced was appropriate for the resident was evaluated was appropriate for the resident was evaluated was appropriate for the resident was evaluated with the resident was evaluated with the resident was evaluated with the resident was a serviced was a serviced with the resident was a serviced was						
	set), a quarterly assessment reference the resident as cognitive resident as cognitive reveal the resident. Resident #90's congrevision date of 02/documentation regulation on 04/25/18 at apprequest was made member) # 1, admit PASARR. On 04/2	t #90's clinical record failed to					

	F CORRECTION	IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		MPLETED
		495299	B. WING		1	04	C /27/2018
	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060 ;		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 645	entitled "Medicaid Service Authorizadated 11/08/13.  On 4/26/18 at 11: conducted with O (social worker) ar OSM #7 stated the level two PASARI Tennessee but he one PASARRs ar When asked if the residents' PASAR stated, "No. We asked who was re PASARRs are collected back to you?  On 4/26/18 at 11:	Funded Long Term Care tion Form" for Resident # 90  32 a.m., an interview was SM (other staff member) #7 and OSM #10 (social worker). The facility staff usually obtains responsible from the hospital ey check to make sure term of the sure that the completed, OSM #10 that have not been checking." When the esponsible for ensuring mpleted, OSM #10 stated, "Can	F6	445			
	PASARRs.  On 4/26/18 at 2:1 conducted with O who was employed approximately on for ensuring PAS, stated, "When we system, the referred clinical information manager at the hassessment instresometimes that in over with the resiour outside liaisout wo and we get the confirmed the absence of the system.	3 p.m., an interview was SM #11 (the admissions director ed at the facility for e month) regarding the process ARRs are completed. OSM #11 e get a referral through our ral is then checked for the n and I contact the case ospital for the UAI (uniform ument) and PASARR. Information doesn't always come dent at the time of admission but in follows up with that in a day or see information." OSM #11 ove letter entitled "Medicaid im Care Service Authorization int #90 dated 11/08/13 provided					

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE (X7			(X3) DATE SURVEY COMPLETED		
		495299	B. WING		1	C / <b>27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	IEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		2172010
(X4) ID PREFI <b>X</b> TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
F 645	was not a PASARI weeks ago our cor call with the social manager and adm what they are and were told that the do them in house. two weeks ago."  On 4/26/18 at 5:32 administrator) and nursing) were made on 4/27/18 at 8:14 facility did not have On 04/27/18 at ap (administrative state administrator and were made aware No further information was of https://www.nlm.ni 001214.htm.  (2) A brain disorder mood, energy, act carry out day-to-day obtained from the https://www.nimh.i. order/index.shtml.  (3) A loss of brain diseases. It affects	R. OSM #11 stated, "About two porate office had a conference workers, business office issions regarding PASARRs, why they are needed and we social worker in a rare case can That is the new process as of 2 p.m., ASM #1, (the ASM #2 (the director of de aware of the above findings. A.m., ASM #1 stated the era policy regarding PASARRs. proximately 11:30 a.m. ASM ff member) #1, the ASM #2, director of nursing of the findings. It is the body cannot are in which the body cannot are	F	45		

	OF DEFICIENCIES OF CORRECTION	(X1). PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		/27/2018
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F 645	obtained from the whttps://medlineplus  (4) Fear. This info website: https://www.nlm.nil #summary.  (5) Depression mablue, unhappy, mis Most of us feel this short periods. Clindisorder in which for frustration interfor more. This inforwebsite: https://medlineplus 2. The facility staff PASARR (preadmireview) was complevaluated and recemost integrated seresident's needs.  Resident #20 was 5/20/17. Resident were not limited to pressure), urinary disorder (1). Resident were not limited to pressure), urinary disorder (1). Resident Review of Resident Review of Resident Review of Resident reveal the resident On 4/25/18 at approximate of the resident On 4/25/18 at approximate of the resident of the re	website: a.gov/ency/article/000739.htm. rmation was obtained from the h.gov/medlineplus/anxiety.html  by be described as feeling sad, serable, or down in the dumps. It was at one time or another for a mode deelings of sadness, loss, anger, ere with everyday life for weeks rmation was obtained from the sagov/ency/article/003213.htm. failed to ensure Resident #20's assion screening and resident ete to ensure the resident was eliving care and services in the admitted to the facility on #20's diagnoses included but hypotension (low blood tract infection and bipolar dent #20's most recent MDS c), a quarterly assessment with ent reference date) of 1/24/18, as being cognitively intact.	F	545		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
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F 645	signed by Resider facility. The letter company and doc letter is to confirm Long Term Care of On 4/26/18 at 11:3 conducted with Os (social worker) an OSM #7 stated the level two PASARF Tennessee but he one PASARRs are When asked if the residents' PASAR stated, "No. We hasked who was re PASARRs are corliget back to you? On 4/26/18 at 11:3 admissions depar PASARRs.  On 4/26/18 at 2:1 conducted with Owho was employed approximately one for ensuring PASAR stated, "When we system, the referr clinical information manager at the hoassessment instru	sented a letter dated 12/28/16, int #20's physician at another was addressed to an insurance umented, "The purpose of this (name of Resident #20) meets riteria."  32 a.m., an interview was SM (other staff member) #7 d OSM #10 (social worker). It is from a company based in runderstanding was that level to obtained from the hospital. It is even to make sure Rs are completed, OSM #10 have not been checking." When it is ponsible for ensuring mpleted, OSM #10 stated, "Can"  52 a.m., OSM #10 stated the timent was responsible for		645			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COMF	E SURVEY PLETED
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	PROVIDER OR SUPPLIER ET <b>H ADAM CRUM</b> P H		1	360	EET ADDRESS, CITY, STATE, ZIP CODE 0 MOUNTAIN ROAD EN ALLEN, VA 23060	1	
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 645	confirmed the abornot a PASARR. O weeks ago our corcall with the social manager and adm what they are and were told that the social manager and adm what they are and were told that the social manager and adm what they are and were told that the social manager and administrator) and nursing) were made on 4/26/18 at 5:32 administrator) and nursing) were made on 4/27/18 at 8:14 facility did not have longer who have it changes. They go active to very sadinactive, and then normal moods in the called mania. The This information white control of the called mania. The This information white control of the called mania. The This information white control of the called mania. The This information white control of the called mania. The This information white control of the called mania. The This information white called mania and called mania and called mania and called mania. The This information white called mania and cal	rege 101  ve letter that was provided was SM #11 stated, "About two porate office had a conference workers, business office issions regarding PASARRs, why they are needed and we social worker in a rare case can That is the new process as of the aware of the above findings. It a.m., ASM #1, (the ASM #2 (the director of the aware of the above findings. It a.m., ASM #1 stated the et a policy regarding PASARRs. It ion was provided prior to exit. It is a serious mental illness. It go through unusual mood of from very happy, "up," and and hopeless, "down," and back again. They often have between. The up feeling is down feeling is depression." It is a sobtained from the website: In.nih.gov/vivisimo/cgi-bin/query-t=medlineplus&v%3Asources=e&query=bipolar+disorder&_ga 65706.1525089773-139120270.  If alled to ensure Resident #60's ission screening and resident lete to ensure the resident was eliving care and services in the etting appropriate for the		645			

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:	i ' '	TIPLE CONSTRUCTION  ING		(X3) DATE COMF	SURVEY PLETED
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F 645	resident's needs.  Resident #60 was a 4/18/12. Resident were not limited to disorder (2) and ch Resident #60's mos set), a quarterly ass (assessment refere the resident as bein Review of Resident reveal the resident'  On 4/25/18 at approsurveyor's request ASM (administrator) presurveyor's request ASM (administrator) presur	admitted to the facility on #60's diagnoses included but schizophrenia (1), bipolar ronic pain syndrome. st recent MDS (minimum data sessment with an ARD ence date) of 2/13/18, codeding cognitively intact.	F	545			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`′		E CONSTRUCTION		PLETED	
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	AME OF PROVIDER OR SUPPLIER  LIZABETH ADAM CRUMP HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 645	On 4/26/18 at 2:13 conducted with OS who was employed approximately one for ensuring PASA stated, "When we system, the referraclinical information manager at the hot assessment instru Sometimes that in over with the residiour outside liaison two and we get the confirmed the abocare service author PASARR. OSM # ago our corporate with the social wor and admissions reare and why they at that the social wor in house. That is tweeks ago."  On 4/26/18 at 5:32 and ASM #2 (the caware of the abova.m., ASM #1 stat policy regarding P. No further information of the social worth the social work in house. They may the folious the social work in house. They may the social work in house. They may the folious regarding P. No further information of the social work in the social work in house. They may the folious regarding P. No further information. They may the folious the social work in the social work in house. They may the folious the social work in house. They may the folious the social work in the social work in house. They may the folious the social work in the social work in house. They may the folious the social work in house.	B p.m., an interview was SM #11 (the admissions director d at the facility for month) regarding the process RRs are completed. OSM #11 get a referral through our all is then checked for the and I contact the case spital for the UAI (uniform ment) and PASARR. formation doesn't always come ent at the time of admission but follows up with that in a day or entry information." OSM #11 ve Medicaid funded long-term orization form was not a 11 stated, "About two weeks office had a conference call there, business office manager garding PASARRs, what they are needed and we were told ker in a rare case can do them the new process as of two 2 p.m., ASM #1, (administrator) director of nursing) were made e findings. On 4/27/18 at 8:14 ed the facility did not have a		645				

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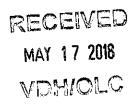
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		ONSTRUCTION	COM	E SURVEY APLETED
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	PROVIDER OR SUPPLIE	R HEALTH AND REHAB		3600	EET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN ROAD N ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 645	This information of https://vsearch.nl meta?v%3Aproje medlineplus-bund (2) "Bipolar disord People who have changes. They gactive to very sadinactive, and ther normal moods in called mania. The This information of https://vsearch.nl meta?v%3Aproje medlineplus-bund=2.1717494.67191477942321  4. The facility star pre-admission so Resident #53.  Resident #53 was 9/3/13 and readmithat included but disorder (1), demurinary tract infection of the most recent annual assessment reference date) of moderately impair was coded as de of daily living.  Review of the clirical residual control of the clirical resident was coded as de of daily living.	was obtained from the website: m.nih.gov/vivisimo/cgi-bin/query- ct=medlineplus&v%3Asources= fle&query=schizophrenia  der is a serious mental illness. it go through unusual mood o from very happy, "up," and and hopeless, "down," and hoback again. They often have between. The up feeling is down feeling is depression." was obtained from the website: m.nih.gov/vivisimo/cgi-bin/query- ct=medlineplus&v%3Asources= fle&query=bipolar+disorder&_ga fle5706.1525089773-139120270.  If failed to complete the reening and resident review for admitted to the facility on hitted on 11/8/17 with diagnoses were not limited to: bipolar entia, difficulty swallowing and tions.  MDS (minimum data set), an ent, with an ARD (assessment f 2/1/18 coded the resident as red cognitively. The resident pendent on staff for all activities	F	645			
		reening and Resident Review een completed for Resident #53.					

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

Event ID: TQ6711

Facility ID: VA0083

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PRINTED: 05/08/2018 FORM **A**PPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	EALTH AND REHAB	<b>1</b>	STREET ADDRESS, CITY, STATE, ZI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		,
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F 645	On 4/26/18 at 11:3 conducted with OS (social worker) and OSM #7 stated the level two PASARR Tennessee but her one PASARRs are When asked if the residents' PASARR stated, "No. We hasked who was re PASARRs are con I get back to you?'  On 4/26/18 at 11:5 admissions depart PASARRs.  On 4/26/18 at 2:13 conducted with OS who was employed approximately one for ensuring PASA stated, "When we system, the referraclinical information manager at the hoassessment instru Sometimes that in over with the resid our outside liaison two and we get the stated, "About two had a conference business office maregarding PASARR are needed and we conference and we get and we conference and median and we get the stated, "About two had a conference business office maregarding PASARR are needed and we conference and we con	32 a.m., an interview was SM (other staff member) #7 d OSM #10 (social worker). It is from a company based in a runderstanding was that level to obtained from the hospital. It is are completed, OSM #10 ave not been checking." When sponsible for ensuring appleted, OSM #10 stated, "Can".  32 a.m., OSM #10 stated the sment was responsible for ensuring appleted. The sponsible for ensuring appleted of the sment was responsible for ensuring appleted.		645		

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

Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 106 of 211



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE	SURVEY PLETED
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NAME OF E	PROVIDER OR SUPPLIER	<u> </u>		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0-1/2	E772010
FI IZARE	TH ADAM CRUMP H	EALTH AND REHAR		36	00 MOUNTAIN ROAD		ļ
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F 645	· · · · · · · · · · · · · · · · · ·		F 6	645			
	is the new process	as of two weeks ago."					
•	and the facility's po	y of Resident #53's PASAAR licy on PASARR was made on of ASM (administrative staff dministrator.					
	PASAAR) but I don one." ASM #1 retur	a.m. ASM #1, the d, "They're looking for it (the 't think she (Resident #53) has ned at 9:00 a.m. and stated have a PASAAR completed.					
	facility did not have	a.m., ASM #1 stated the a policy regarding PASARRs. ion was provided prior to exit.					
F 656	1. Bipolar disorder mental illness. Peo unusual mood char happy, "up," and ac "down," and inactiv often have normal feeling is called ma depression. This in https://medlineplus Develop/Implement	Bipolar disorder is a serious ple who have it go through nges. They go from very stive to very sad and hopeless, e, and then back again. They moods in between. The up nia. The down feeling is formation was obtained from: .gov/bipolardisorder.html t Comprehensive Care Plan	F	656	F656		5/29/18
SS=E	§483.21(b) Compres §483.21(b)(1) The implement a compresare plan for each resident rights set f §483.10(c)(3), that objectives and time	ehensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable eframes to meet a resident's and mental and psychosocial			1. Resident #95's care plan has be revised to reflect resident's choice height of bed; Residents #88, #6 : #35, #81 care plans are being followed.	e on	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED -
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	PROVIDER OR SUPPLIER ETH A <b>DAM CRUMP</b> H	HEALTH AND REHAB		36	FREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD LEN ALLEN, VA 23060		
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F 656	needs that are ide assessment. The describe the follow (i) The services the or maintain the resphysical, mental, a required under §44 (ii) Any services the under §483.24, §4 provided due to the under §483.10, incommendations findings of the PAS rationale in the rescommendations findings of the PAS rationale in the rescommendation resident's represe (A) The resident's desired outcomes (B) The resident's future discharge. I whether the residence community was as local contact agenentities, for this purities, for this purit	ntified in the comprehensive comprehensive care plan must ving - at are to be furnished to attain sident's highest practicable and psychosocial well-being as 83.24, §483.25 or §483.40; and att would otherwise be required 83.25 or §483.40 but are not e resident's exercise of rights cluding the right to refuse 483.10(c)(6). d services or specialized ces the nursing facility will to PASARR. If a facility disagrees with the SARR, it must indicate its sident's medical record. with the resident and the ntative(s)-goals for admission and preference and potential for Facilities must document ent's desire to return to the essessed and any referrals to access and/or other appropriate arpose. In the comprehensive care ate, in accordance with the forth in paragraph (c) of this entity is not met as evidenced ation, resident interview, staff document review and clinical was determined the facility staff		356	2. A review of residents care plan with bed in low position, lids on containing hot liquids, administrator of blood pressure medication per physician orders, catheter care an activities was conducted to ensure the care plan is implemented and followed.  3. Nursing staff and Activity Direct will be re-educated on implementant following comprehensive care plans for bed in low position, lids cups containing hot liquids, administration for blood pressure medication per physician orders, catheter care and activities.  4. Audits will be conducted to entimplementing and following comprehensive care plans for bed low position, lids on cups contain hot liquids, administration of bid pressure medication per physicial orders, catheter care and activities weekly for four weeks then more for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	eups action and re d ctor ating re s on e aning pod an ies athly e	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 656	#35 and #81.  1. The facility staff the comprehensiving the low position.  2. The facility staff the comprehensiving on the hot liquid comprehensiving on the hot liquid comprehensiving the comprehensiving the comprehensiving the facility staff Resident #20's conditional resident #35's concatheter care.  5. The facility staff Resident #35's concatheter care.  6. The facility staff the comprehensiving the low position.  The findings incluing the findings incluing the low position.  Resident #95 was 2/12/18 with diagrilimited to multiple depression and president pression and president pression and president pression.	failed to implement and follow e care plan to maintain the bed for Resident #95.  failed to implement and follow e care plan to ensure a lid was up for Resident #88.  failed to implement and follow e care plan to ensure a lid was up for Resident #88.  failed to implement and follow e care plan to ensure a lid was up for Resident #6.  failed to implement and follow imprehensive care plan for the plan of pressure medication per failed to implement and follow imprehensive care plan for the plan of care for Resident #81.  de:  failed to implement and follow imprehensive care plan for Resident #81.  de:  failed to implement and follow imprehensive care for Resident #81.  de:  failed to implement and follow imprehensive care plan to maintain the bed for Resident #95.  admitted to the facility on moses that included but were not sclerosis (1), anemia, and		556			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	l · ·	TIPLE CONSTRUCTION ING	(X:	3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	) J	04/21/2016
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F 656	significant change a (assessment references resident as having BIMS (brief interview the resident was condecisions. The residependent on staff An observation was of Resident #95. The bed. The bed's heigh approximately 42 in An observation was of Resident #95. The and conversant. The level or approximate An observation was of Resident #95. The sleeping. The bed's approximately 42 in Review of the reside 2/12/18 scored the risk score of three.  Review of the reside 3/1/18 documented related to: New environment. Interversident's nurse. We care plans, LPN #1 their needs and taken was considered to the resident's nurse. We care plans, LPN #1 their needs and taken was considered to the resident's nurse.	assessment, with an ARD ence date) of 3/8/18 coded the scored a 14 out of 15 on the w for mental status) indicating agnitively intact to make daily dent was coded as being for all activities of daily living.  Is made on 4/24/18 at 3:15 p.m. he resident was lying in the ght was at waist level or aches.  Is made on 4/25/18 at 3:50 p.m. he resident was in bed, awake he bed's height was at waist ely 42 inches.  Is made on 4/26/18 at 8:15 a.m. he resident was in bed height was at waist level or aches.  Is made on 4/26/18 at 8:15 a.m. he resident was in bed height was at waist level or aches.  Is made on 4/26/18 at 8:15 a.m. he resident was in bed height was at waist level or aches.  Is made on 4/26/18 at 8:15 a.m. he resident was in bed height was at waist level or aches.  Is made on 4/26/18 at 8:15 a.m. he resident was in bed height was at waist level or aches.  Is made on 4/26/18 at 8:15 a.m. he resident was in bed height was at waist level or aches.  Is made on 4/26/18 at 8:15 a.m. he resident was in bed height was at waist level or aches.  Is made on 4/26/18 at 8:15 a.m. he resident was in bed height was at waist level or aches.  Is made on 4/26/18 at 8:15 a.m. he resident was in bed height was at waist level or aches.	F6	56		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		ATE SURVEY DMPLETED  C
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F 656	"The nurses, or the of nursing or social on them as well." Well plan, LPN #13 states the care plan was to followed, LPN #13 when a care plan we stated, "If whatever doesn't apply to the asked what height? LPN #13 gestured believel or approximate that was the low powhen made aware comprehensive care position, LPN #13 seneed to change that why residents had be "Basically they have of what they have a asked who used the "The nurses. Basic When asked if staff care plan, LPN #4 made aware of the stated, "The reside height." When asked LPN #4 stated the of the stated of the s	unit manager or the director worker or MDS nurse works When asked who used the care ed, "All of us." When asked if to be implemented and stated, "Yes." When asked would not be followed, LPN #13 we had doesn't work or it at resident anymore." When Resident #95's bed was at, with her hand to above waist ely 42 inches. When asked if sitton, LPN #13 stated, "No." of the intervention on the e plan to keep the bed in low stated, "I didn't know that. We		656		

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	l ` ′	NG		MPLETED
	• •	495299	B. WING		04	C /27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(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 CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
F 656	On 4/27/18 at 8:45	a.m., ASM #2 was asked what hree indicated, ASM #2 stated	F6	56		
	PREPARATION" didirects the patient's to discharge. Their nursing diagnoses after reviewing ass	ty's policy titled, "CARE PLAN ocumented, "A care plan is nursing care from admission written action plan is based on that have been formulated essment findings, and it ponents of the nursing		·		
	According to Funda Williams and Wilking documented, "A wrommunication too members that help careThe nursing information about tand goals. It conta achieving the goals and is used to directly there are changes with new orders"	` ,				
	& Wilkins 2007 Lip pages 65-77.  Basic Nursing, Ess (Potter and Perry, reference for care a written guideline	of Nursing Lippincott Williams pincott Company Philadelphia sentials for Practice, 6th edition, 2007, pages 119-127), was a plans. "A nursing care plan is for coordinating nursing care, ty of care and listing outcome				

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	DING	COV	E SURVEY MPLETED
		495299	B. WING	)	1	C /27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	criteria to be used i care. The written of nursing care prioriti professionals. The coordinates resourcare. A correctly for easy to continue call the patient's statunursing diagnosis and longer appropriation. An out of data compromises the quantum system distant spinal cord. It of the material that surnerve cells. This data messages between leading to the symptows obtained from:	n the evaluation of nursing rare plan communicates les to other health care care plan also identifies and ces used to deliver nursing rmulated care plan makes it are from one nurse to another as has changed and the and related interventions are ate, modify the nursing care e or incorrect care plan uality of nursing care."  s Multiple sclerosis (MS) is a sease that affects your brain damages the myelin sheath, irrounds and protects your amage slows down or blocks in your brain and your body, otoms of MS. This information		656		
	, -	failed to implement and follow care plan to ensure a lid was p for Resident #88.				
	3/15/13 with diagnor limited to: muscle who blood pressure, parand stroke. The rest contractured so that the right and rested	admitted to the facility on oses that included but were not veakness, dementia, high ralysis of the left arm and leg sident's neck was severely at her head was always bent to don her shoulder.  DS (minimum data set), a				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION DING	(X3	OMPLETED
		495299	B. WING	I		C <b>04/27/2018</b>
	PROVIDER OR SUPPLIER	HEALTH AND REHAB	l . <u>.</u>	STREET ADDRESS, CITY 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23	)	0-1/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTED CROSS-REFEREI	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION OATE
F 656	quarterly assessmereference date) of having scored a 1 interview for ment was cognitively into The resident was from staff for all and eating which the resident was a.m., of Resident in her wheelchair half-full cup of coff resident's table. The Review of the hot 2/6/18 documented the resident is at redinking hot liquid following apply to the resident was altered ROM (of joint(s) to domin cause difficulty in Shoulder (was checked yes, indicating place to enhance (rehabilitation) sor or other adaptive while handling and Interventions. Professional and interview was a strength of the resident in place to enhance (rehabilitation) sor or other adaptive while handling and Interventions. Professional and interview was a strength of the resident was a strength of the resid	age 113  eent, with an ARD (assessment 2/28/18 coded the resident as 3 out of 15 on the BIMS (brief al status) indicating the resident act to make daily decisions. coded as requiring assistance ctivities of daily living except for esident could perform er the tray was set up.  as made on 4/25/18 at 9:15 #88. The resident was sitting up eating breakfast. There was a fee with a straw in it on the here was no lid on the cup.  liquid safety evaluation dated d, "This assessment identifies if isk for injury while handling and s. Place a check mark if the the resident being assessed: range of motion) or contracture than side of (blank line) which handling regular cup or glass. 1. ecked). 11. If any boxes are cate which interim measures put be safety while rehabitive en is pending: 1. Cup with lid cup (was checked)."  dent's care plan initiated on end, "Focus. Resident has been as been identified for risk of injury did drinking hot beverages. Wide cup with lid or other conducted on 4/26/18 at 1:05 ensed practical nurse) #4 the		656		

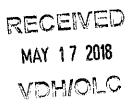
PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUI A. BUILD		СОМ	(X3) DATE SURVEY COMPLETED C		
		495299	B. WING				27/2018	
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		360	EET ADDRESS, CITY, STATE, ZIP CODE 0 MOUNTAIN ROAD EN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION OATE	
F 656	unit manager. When care plans, LPN # care plans to make and put into place care plans, LPN # everyone does as were expected to plan, LPN #4 state aware of the findion of the resident's coffee put milk and sugaresident had a specoffee cup, CNA it." When asked to on their hot liquid spill." When asked to on their hot liquid spill." When asked that a resident was CNA #14 stated, question." When the CNA's care concept Review of Resider "lid on cup for how on 4/26/18 at 5:1 member) #1, the director of nursing findings.  No further informatical care in the control of the cont	then asked why residents had the stated, "Basically they have the us aware of what they have the us aware of what they have the the stated, "The nurses. Basically citually." When asked if staff implement and follow the care the the theorem and follow the care the theorem and the time.  Conducted on 4/26/18 at 2:45 the tiffied nursing assistant) #14, the the was served, CNA #14 stated, "I ar in it." When asked if the the the ecial cup or had a lid on her the		656				
		ff failed to implement and follow ve care plan to ensure a lid was						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 115 of 211



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' <i>'</i>		CONSTRUCTION	1	PLETED
		495299	B. WING			04/3	27/2018
	ROVIDER OR SUPPLIER	EALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	1 0 772	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	11/3/17 and readmidiagnoses that includementia, cancer to weakness, depress. The most recent MI quarterly assessment ference date) of 1 having scored a founterview for mental was severely impair was coded as requiall activities of daily. An observation was a.m., of Resident # having breakfast. Ton the table without Review of the residevaluation dated, 2 assessment identificingly while handling Place a check marker resident being assessment or drown resident's perception in the table without the resident was checked and safety minited to: altered compairment (was checked). 11. If any indicate which interview in the counterpression of the resident is checked). 11. If any indicate which interview which counterpression is the checked.	dmitted to the facility on ted on 12/27/18 with uded but were not limited to: o left side of face, muscle ion and anxiety.  DS (minimum data set), a ent, with an ARD (assessment 1/15/18 coded the resident as ir out of 15 on the BIMS (brief I status) indicating the resident red cognitively. The resident iring assistance from staff for living.  Is made on 4/25/18 at 9:00  6. The resident was in bed here was a cup of hot coffee		\$56			

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	ING	COMPLETED	Y
		495299	B. WING		C 04/27/2018	8
	PROVIDER OR SUPPLIER	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE  (EACH CORRECTIVE ACTION SH  CROSS-REFERENCED TO THE API  DEFICIENCY)	OULD BE COMPLÉ	TION
F 656	adaptive cup4. T (were checked)."  Review of the residence 2/8/18 documente evaluated and has while handling and Interventions. Provadaptive cup."  An interview was op.m. with LPN (lice unit manager. Who care plans, LPN # care plans to mak and put into place care plans, LPN # everyone does act were expected to stated, "Yes." LPN findings at that time.  An interview was op.m. with CNA (cethe resident's coffee wout the cup on the #6 had a lid on he "I've never seen hare sident would he CNA #14 stated," how staff were managed have lid on their hedon't know. That's if the information of CNA #14 stated,"	dent's care plan initiated on: d, "Focus. Resident has been been identified for risk of injury drinking hot beverages. vide cup with lid or other  conducted on 4/26/18 at 1:05 ensed practical nurse) #4, the en asked why residents had 4 stated, "Basically they have e us aware of what they have "When asked who used the 4 stated, "The nurses. Basically tually." When asked if staff follow the care plan, LPN #4 I #4 was made aware of the le.  conducted on 4/26/18 at 2:45 rtified nursing assistant) #14, le. When asked how the vas served, CNA #14 stated, "I table." When asked if Resident r coffee cup, CNA #14 stated, er with one." When asked why have a lid on their hot liquids, So it doesn't spill." When asked ade aware that a resident was to ot liquids, CNA #14 stated, "I a good question." When asked was on the CNA's care card, No."  Int #6's care card documented, Int was to continue the continu		556		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING			LETED
		495299	B. WING	)		04/2	7/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB	-	STREET ADDRESS, CITY, STATE, ZI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	P CODE	V 1/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD I HE APPROPR	BE	(X5) COMPLETION DATE
F 656	member) #1, the a director of nursing findings.  No further informa  4. The facility staff Resident #20's coradministration of big physician's order.  Resident #20 was 5/20/17. Resident were not limited to pressure), urinary disorder (1). Resident were not limited to pressure), urinary disorder (1). Resident were not limited to pressure), urinary disorder (1). Resident were not limited to pressure), urinary disorder (1). Resident were not limited to pressure), urinary disorder (1). Resident was an ARD (assessm coded the resident endication for a side than 100 or a diast than 100 or a diast than 90. Review of MAR (medication in the resident was a following dates (as and nurses' initials systolic blood pressured in the resident was a following blood pressured in the resident was a following dates (as and nurses' initials systolic blood pressured in the resident was a followed blood pressured blood pressured in the resident was a followed blood pressured blood press	age 117  p.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the stion was provided prior to exit.  failed to implement and follow mprehensive care plan for the lood pressure medication per admitted to the facility on #20's diagnoses included but hypotension (low blood tract infection and bipolar dent #20's most recent MDS t), a quarterly assessment with ent reference date) of 1/24/18, as being cognitively intact.  In #20's clinical record revealed a dated 2/6/18 for Midodrine (2) time a day and to hold the hystolic blood pressure greater for Resident #20's April 2018 administration record) revealed dministered Midodrine on the sevidenced by a check mark b) although the resident's sture was greater than 100 or sesure was greater than 90:	F	656	*)		
	- 4/1/18- blood pre - 4/2/18- blood pre - 4/10/18- blood pr - 4/14/18- blood pr	ssure 122/55 essure 124/74					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		PLETED
		495299	B. WING	i		04/2	; !7/2018
	PROVIDER DR SUPPLIEI	HEALTH AND REHAB	L	3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 0-112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	1X5  COMPLETION DATE
F 656	- 4/22/18- blood p  Resident #20's co 9/12/17 documen status related to: ordered by physic effectiveness"  On 4/26/18 at 10: conducted with LF (Resident #20's u asked what is me nurses' initials on means it was don #20's physician of what should be do blood pressure is blood pressure is stated, "It (Midodi should contact the you need to find of LPN #9 was mad Midodrine was ini above dates and blood pressures of was asked if the r held on those dat medication should should have been nurses who admit above dates may he said to give the there was no doc	•	F	356			
	conducted with LI purpose of the ca keep everybody k	PN #9. LPN #9 was asked the tree plan. LPN #9 stated, "To knowledgeable about what's patient and why. Information					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	СОМ	PLETED			
		495299	B. WING							
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		3600	ET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN ROAD N ALLEN, VA 23060	ECTION (X5 HOULD BE COMPLE		CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION OATE			
F 656	of the patient. The purposes. Also so the work of the nurses who in to Resident #20 of 4/22/18 were not at the exact number legend. I don't know t	to the next person taking care ere are a lot of different o we can take care of them." rses are supposed to follow the		556						

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		IDENTIFICATION NUMBER:				COMPLETED		
		495299	B. WING		04	C / <b>27/2018</b>		
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHORT CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 656	documented, "A canursing care from a written action plan that have been form assessment finding components of the diagnosis, planning evaluation."  No further informat  (1) "Bipolar disorder People who have it changes. They go active to very sad a inactive, and then the normal moods in becalled mania. The called mania in the medline plus-bundle = 2.1717494.67196 1477942321  (2) "Midodrine is us hypotension (sudder occurs when a persposition). Midodrin called alpha-adrenic causing blood vessiblood pressure." Trom the website: https://medlineplustml	re plan directs the patient's admission to discharge. This is based on nursing diagnoses nulated after reviewing is, and it embodies the nursing process: assessment, in implementation, and ion was provided prior to exit.  If is a serious mental illness, go through unusual mood from very happy, "up," and and hopeless, "down," and back again. They often have etween. The up feeling is down feeling is depression." as obtained from the website: .nih.gov/vivisimo/cgi-bin/query=medlineplus&v%3Asources=e&query=bipolar+disorder&_ga 5706.1525089773-139120270.  It is do treat orthostatic en fall in blood pressure that son assumes a standing e is in a class of medications ergic agonists. It works by sels to tighten, which increases his information was obtained .gov/druginfo/meds/a616030.h		56				
		failed to implement and follow nprehensive care plan for						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED	
		495299	B. WING		<sub>04</sub>	C / <b>27/2018</b>	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP I	HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	,	I SHOULD BE	(X5) COMPLETION DATE	
F 656	Resident #35 was 10/1/16. Resident were not limited to weakness and ma Resident #35's mode set), a quarterly as (assessment refer resident's cognitive decision-making a Section G coded flextensive assistar mobility and requir or more staff with resident as having Review of Resider a physician's orded diagnosis of urinar comprehensive cadocumented, "Alter and bladder and a tract infections) r/t Indwelling Urinary RetentionKeep of the level of the blad observed sitting in tubing was observed on 4/25/18 at 7:45 observed lying in Indrainage bag was On 4/26/18 at 9:55 conducted with LF conducted with	admitted to the facility on the #35's diagnoses included but to difficulty swallowing, muscle also depressive disorder. On the end of 2/2/18, coded the end of the end		556			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l'''	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 04/27/2018	
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		12772010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE	
F 656	tubing and drainag LPN #5 stated, "B if the bag and tubi #5 stated, "No." V stated, "Contamin On 4/26/18 at 10:2 conducted with LF where a resident's bag should be in a dighooked to the bed When asked if the touch the floor, LF On 4/26/18 at 2:2 conducted with LF purpose of the carkeep everybody k going on with the that can be given of the patient. The purposes. Also so When asked if nu care plan, LPN #9 On 4/27/18 at 7:4 staff member) #1 (the director of nu above concern.  The facility documdocumented, "A conursing care from written action plar that have been for assessment findir components of the	ge bag should be positioned. elow waste level." When asked ng should touch the floor, LPN When asked why, LPN #5 ation."  27 a.m., an interview was PN #9. LPN #9 was asked a catheter tubing and drainage sitioned. LPN #9 stated, "It nity bag and the bag should be and lower than the waist." a tubing or drainage bag should PN #9 stated, "No."  3 p.m., another interview was PN #9. LPN #9 was asked the re plan. LPN #9 stated, "To nowledgeable about what's patient and why. Information to the next person taking care are are a lot of different of we can take care of them." reses are supposed to follow the	F	656			

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		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED		
		495299	B. WING			04/2	; ?7/2018	
	PROVIDER OR SUPPLIER			360	REET ADDRESS, CITY, STATE, ZIP CODE 10 MOUNTAIN ROAD EN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION OATE	
F 656	evaluation."  No further information of the todrain and collection of the the comprehensive of the comprehensive of the comprehensive of the today of	eter is a tube placed in the body turine from the bladder." This stained from the website: a gov/ency/article/003981.htm  failed to provide activities per explan of care for Resident #81.  admitted to the facility on moses that included but were blood pressure, thyroid osteoporosis, Non-Alzheimer's ion, and muscle weakness. The recent MDS (minimum data was a significant change in ARD (assessment reference Resident #81 was coded as paired in cognitive function to be solved to the BIMS (Brief all Status) exam. Resident #81 on B (Hearing, Speech and understanding others and erstood by others. Section Foundary Activities) is was very important for ave newspapers, books, and the countries. It was the was somewhat important for the outside to get fresh air when cood.		556				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1'''	NG	COMPLETED
	495299	B. WING		C 04/27/2018
			STREET ADDRESS, CITY, STATE, ZIP COU 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	
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Continued From page 124			556	
On 4/25/18 at 8:24 a.m., an observation was made of Resident #81. He was awake lying in bed watching television.				
1				
On 4/26/18 at 10:36 a.m., wound care observation was conducted with the wound care nurse. The wound care nurse stated that the resident hadn't been out of bed yet that day.				
conducted with R bed. The television the ceiling. When anyone had offer week, Resident #	esident #81. He was lying in on was on but he was looking at n Resident #81 was asked if ed him to do any activities that '81 stated, "No." Resident #81			
10/20/17 docume independent activifamily rather than participate in one	ented the following: "I prefer vities or spending time with my a doing things in groupsI will independent activity a			
come and visit wi activity programs me to join at my of participation level with me to ensure high level with no	th me, Invite me to "sit in" during you think I might enjoy, allowing own comfort level, Monitor my I in my independent activities a that I can still participate at a signs of decline, Offer me			
	SUMMARY S (EACH DEFICIEN REGULATORY OF  Continued From p On 4/25/18 at 8:2 made of Resident bed watching tele On 4/25/18 at 10: made of Resident eating lunch.  On 4/26/18 at 10: observation was onurse. The wound resident hadn't be On 4/26/18 at 12: conducted with R bed. The television the ceiling. When anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo  Review of Resident anyone had offer week, Resident # stated that he wo	PROVIDER OR SUPPLIER  TH ADAM CRUMP HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 124  On 4/25/18 at 8:24 a.m., an observation was made of Resident #81. He was awake lying in bed watching television.  On 4/25/18 at 10:47 a.m., an observation was made of Resident #81. He was sleeping in bed.  On 4/25/18 at 12:50 p.m., an observation was made of Resident #81. He was lying up in bed eating lunch.  On 4/26/18 at 10:36 a.m., wound care observation was conducted with the wound care nurse. The wound care nurse stated that the resident hadn't been out of bed yet that day.  On 4/26/18 at 12:49 p.m., an interview was conducted with Resident #81. He was lying in bed. The television was on but he was looking at the ceiling. When Resident #81 was asked if anyone had offered him to do any activities that week, Resident #81 stated, "No." Resident #81 stated that he would like to do more.  Review of Resident #81's activity care plan dated 10/20/17 documented the following: "I prefer independent activities or spending time with my family rather than doing things in groupsI will participate in one independent activity adayInvite clergy or people from my church to come and visit with me, Invite me to "sit in" during activity programs you think I might enjoy, allowing me to join at my own comfort level, Monitor my participation level in my independent activities with me to ensure that I can still participate at a high level with no signs of decline, Offer me activities and supplies for things I can do in my	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 124  Con 4/25/18 at 8:24 a.m., an observation was made of Resident #81. He was awake lying in bed watching television.  On 4/25/18 at 10:47 a.m., an observation was made of Resident #81. He was leeping in bed.  On 4/25/18 at 12:50 p.m., an observation was made of Resident #81. He was lying up in bed eating lunch.  On 4/26/18 at 10:36 a.m., wound care observation was conducted with the wound care nurse. The wound care nurse stated that the resident hadn't been out of bed yet that day.  On 4/26/18 at 12:49 p.m., an interview was conducted with Resident #81. He was lying in bed. The television was on but he was looking at the ceiling. When Resident #81 was asked if anyone had offered him to do any activities that week, Resident #81 stated, "No." Resident #81 stated that he would like to do more.  Review of Resident #81's activity care plan dated 10/20/17 documented the following: "I prefer independent activities or spending time with my family rather than doing things in groupsI will participate in one independent activity a dayInvite clergy or people from my church to come and visit with me, Invite me to "sit in" during activity programs you think I might enjoy, allowing me to join at my own comfort level, Monitor my participation level in my independent activities with me to ensure that I can still participate at a high level with no signs of decline, Offer me	THE CORRECTION    10ENTIFICATION NUMBER:   A BUILDING

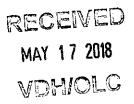
PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

_ ,	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B. WING			04/2	; 7/2018
	PROVIDER OR SUPPLIER		·		REET ADDRESS, CITY, STATE, ZIP CODE	1 0 1,2	1720 (0
ELIZABETH ADAM CRUMP HEALTH AND REHAB			G	LEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 656	paper, Please assis favorite activities at sitting outside and of the activities directed are made aware of facility, OSM #20 streceive a large printheir room. OSM # offered to go to an personally asks event of attend an activity would expect nursing department by assion OSM #20 stated the staff for the building other staff know whactivities, OSM #20 documented on the assessment. When liked to do for activitied to do for activitied to read the paweek from his hom when it is warm out outside. When asked day, OSM #20 agrestated that Resider times per week. We Resident #81 did the she took him his mif he wanted to get said no." OSM #20	ge 125 st me in participating in my my highest level, such as reading the newspaper."  p.m., an interview was M (other staff member) #20, or. When asked how residents activities going on in the stated that each resident will t activity calendar to put up in 20 stated that all residents are activity. When asked if she ery single resident if they want of, OSM #20 stated that she ng staff to help the activities sting residents to the activity. at there were only two activity g. When asked how she or not a resident likes to do for of stated that it should be sir care plan or activities on asked what Resident #81 lities, OSM #20 stated that he oper that he receives once a e-town. OSM #20 stated that tiside, Resident #81 liked to sit and if it was warm outside that the difficulty it was the stated of that all osm #20 stated that all osm #20 stated that ail. OSM #20 stated that ail. OSM #20 stated that ail. OSM #20 stated, "I asked up and do something and he ocould not remember when at #81 when he wanted to get	F	856			
	up. When asked if anywhere, OSM #2 accompanied OSM	she documented his refusal to stated, no. This writer then #20 to the activities Resident #81's activity log for					

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Facility ID: VA0083

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	PLETED
		495299	B. WING			1	, 27/2018
	PROVIDER OR SUPPLIER	HEALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTID (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION OATE
F 656	completely blank. activity she is sup done immediately activities she did where her notes where any notes of the above conditions and the state of the state of the state of the state of the above conditions are supplied to the state of	ent #81's April activity log was OSM # 20 stated that after an posed to document what was OSM #20 stated that the with Resident #81 must have I in her notes. When asked were located, OSM #20 stated, "I s."  Int #81's clinical record failed to be for the activities department.  In p.m., further interview was esident #81. Resident #81 staff took him outside later that ent #81 stated, "I feel so much ent #81 stated, "I feel so much ent #81 stated, and ASM #2, of Nursing) were made aware	F				
	exit. Care Plan Timing CFR(s): 483.21(b) §483.21(b)(2) A c be- (i) Developed with the comprehensiv (ii) Prepared by a includes but is no (A) The attending	and Revision )(2)(i)-(iii) rehensive Care Plans omprehensive care plan must in 7 days after completion of re assessment. In interdisciplinary team, that t limited to—	F	657	1. Resident #150 care plan has bupdated to address two incident resident to resident sexual abus.  2. No other residents affected.  3. Social Services staff will be reeducated to updated care plans residents involved in resident to resident altercations.	ts of e. - for	5/29/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		495299	B. WING			1	C <b>27/2018</b>
	PROVIDER OR SUPPLIER TH ADAM CRUMP H	EALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			V-121/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 657	resident. (D) A member of fi (E) To the extent p the resident and th An explanation mu medical record if th and their resident not practicable for resident's care pla (F) Other appropri disciplines as dete or as requested by (iii)Reviewed and the team after each as comprehensive an assessments. This REQUIREME by: Based on staff int and clinical record facility staff failed to comprehensive cat in the survey samp Resident #150 was resident-to-resident the facility staff fail address these incomprehensive cat in the survey samp Resident #150 was re	ood and nutrition services staff. racticable, the participation of the resident's representative(s). The participation of the resident's the participation of the resident representative is determined the development of the the resident. The vised by the interdisciplinary the resident, including both the the development of the the resident. The vised by the interdisciplinary the resident including both the the development as evidenced the review, facility document review the review, it was determined the the review and revise the the plan for one of 42 residents to the resident #150. The sinvolved in two the results and the to update her care plan to the dents.		557	4. Audits will be conducted to encare plans are updated for resident involved in resident to resident altercations weekly for four weethen monthly for three months. Results of the audits will be revient the monthly QAPI meeting for three months to ensure compliant.	ent ks ewed	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495299	B. WING_		l	C /27/2018	
NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HE	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP O 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		2772010	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
of 11/7/17, coded the on the BIMS (brief in score, indicating shomake daily cognitive was coded as wand the look back period having behaviors not to three days during Resident #150 was assistance of one of her activities of daily.  The Facility Reported 11/12/17 documented Allegation of abused incident: It was reported and the time of the part of the p	n assessment reference date be resident as scoring a zero interview for mental status) e was severely impaired to be decisions. Resident #150 dering one to three days during down the resident was coded as not directed toward others one in the look back period. In coded as requiring extensive or more staff members for all of a living.  The resident was coded as not directed toward others one in the look back period. In		57			

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Event ID: TQ6711

Facility ID: VA0083

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING	CON	TE SURVEY MPLETED	
		495299	B. WING	i	1	C / <b>2</b> 7/ <b>2018</b>	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE	
F 657	intact to make dail was coded as requested moving in the bed hygiene. He was do of one staff memborif the unit and toil independent for eas having restriction one side of his one Review of Resider plan dated 11/5/15 to evidence any do 11/12/17.  The Facility Report 12/9/17 document Resident to Resident AT approximately Administrator receives assessed and (Resident #269) with investigation has be received (Resident #269) with the resident #269 was 9/28/17 with diagral limited to: high blood disease (a slowly disorder character gait, stooped post fingers, drooling a sometimes with entraumatic brain inj MDS (minimum declosest to the incide assessment reference in the staff of	y decisions. Resident #268 uiring extensive assistance for , dressing, and personal coded as requiring supervision er for transfers, moving on and leting. The resident was ating. Resident #268 was coded ons in his range of motion on e arm and one leg.  Int #150's comprehensive care of and revised on 3/8/17, failed ocumentation of the incident on  Ited Incident (FRI) dated led in part, "Incident Type - ent Abuse. Describe Incident: 4:15 p.m. on this date, the levived a call that a nurse aide int #269)'s hand down (Resident led dining room. (Resident #150) d no injury was observed. Vas placed on 1:1. Our		657			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C / <b>2</b> 7/ <b>2018</b>
	PROVIDER OR SUPPLIER	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 657	interview for ment resident was capa decisions. The resilimited assistance member for all of Section E - Behave not having any be period.  Review of Resider plan dated 11/5/15 to evidence any decision to evidence any deci	ral status) score, indicating the able of making cognitive daily sident was coded as requiring a or supervisions of one staff his activities of daily living. In vior, the resident was coded as haviors during the look back of the state of t	F6	57		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION ING	(X3) DATE SU CDMPLE		
		495299	B. WING		04/27/	2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		OULD BE CO	(X5) DMPLETION DATE
F 657	ASM #2 stated, "Ye An interview was conformer administrated When asked if the end should have been usexual abuse, ASM worker to follow up informed the care puthese incidents. AS worker should have plan."  The facility policy, "documented in part the plan throughout document becomes record."  The administrator as made aware of the 5:15 p.m.	ge 131 s, it should be updated."  onducted with ASM #3, the or, on 4/26/18 at 3:10 p.m. care plan of Resident #150 updated after both allegation of #3 stated, "I asked the social on this." ASM #3 was ulan was not updated with M #3 stated, "The social enderessed that in the care  Care Plan Preparation" s, "Nurses update and revise the patient's stay and the part of the permanent patient and director of nursing were above findings on 4/26/18 at fon was provided prior to exit.	F6			
F 658 SS=D	Non-Medical Reader Chapman, page 13 (2) Barron's Diction Non-Medical Reader Chapman, page 43 Services Provided I CFR(s): 483.21(b)(3) Communication The Servic	ary of Medical Terms for the er, 5th edition, Rothenberg and 7. Meet Professional Standards	F 6	F658  1. Resident #94 order for a speen discontinued. Therapy has been obtained.	plint has	5/29/18

STATEMENT OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	СОМ	E SURVEY IPLETED
		495299	B. WING			1	C <b>27/2018</b>
	OVIDER OR SUPPLIER	EALTH AND REHAB		30	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD BLEN ALLEN, VA 23060	1 04/	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
(i) Tilby Edd w for of #8 Tipl Til R 8 w coble tr: R a de le R 2 for for the results of the resu	his REQUIREME y: Based on observa ocument review a vas determined tha ollow professional f 42 residents in the 94.  he facility staff fai hysician order for he findings includ tesident #94 was a /3/16. Resident # vere not limited to ontracture of mus lood pressure. Re minimum data set in ARD (assessme oded the resident rection G coded R ependent on one eing totally depen ansfers.  teview of Residen physician's order ocumented, "Resi oft forearm to prev tesident #94's con /2/17 failed to doo orearm splint.	al standards of quality.  NT is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff failed to standards of practice for one ne survey sample, Resident led to clarify Resident #94's a splint.	F	558	<ol> <li>A review of residents receiving splints was conducted to ensure orders reflect the current care or plan ordered by the physician.</li> <li>Licensed Nurse will be re-educated on ensuring resident receiving streflect the current plan of care ordered by the physician.</li> <li>Audits will be conducted on ensuring resident receiving splin reflect the current plan of care ordered by the physician weekly four weeks then monthly for the months. Results of the audits wereviewed at the monthly QAPI meeting for three months to encompliance.</li> </ol>	f cated plints ats for ree rill be	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
		495299	B. WING		1	C /27/2018	
	PROVIDER OR SUPPLIER ET <b>H ADAM CRUMP H</b> I	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		727/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	_ *	N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE	
F 658	forearm.  On 4/26/18 at 2:28 conducted with LPN (unit manager). LP splints with Velcro of Velcro splints. LPN wrote the physician splint was no longe #9 stated she had rasked if the physicic clarified, LPN #9 stand somehow I mis  On 4/26/18 at 5:32 staff member) #1 (to (the director of nursabove concern. We practice the facility the facility staff follows ASM #2 were asked standard of practice physician's orders.  The facility docume "NON-CONTROLL documented," 3. Collarifying orders as No further information of the collision of	p.m., an interview was N (licensed practical nurse) #9 PN #9 stated the facility had closures but did not have I #9 stated the nurse that I's order for Resident #94's or employed at the facility. LPN not seen the splint. When an's order should have been ated, "I look through orders it."  p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the hen asked what standard of staff follows, ASM #2 stated ows Lippincott. ASM #1 and d to provide the facility e regarding the clarification of ent titled, ED MEDICATION ORDERS" omplete documentation by			· · · · · · · · · · · · · · · · · · ·		
	surrounds and prot damage slows dow between your brain	ects your nerve cells. This on or blocks messages and your body, leading to the This information was					

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Event ID: TQ6711

Facility ID: VA0083

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	OF CORRECTION	iDENTIFICATION NUMBER:	l''		CONSTRUCTION	COMF	PLETED		
		495299	B. WING						
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H			360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	DDRESS, CITY, STATE, ZIP CODE UNTAIN ROAD LLEN, VA 23060  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Activities are being offered, cumented and provided to meet sident #81 needs. Each resident who prefers ependent activities has the tential of being affected. Activity staff will be re-educated ensuring activities are being fered and provided to meet each sidents' needs who prefers dependent activities.  Audits will be conducted to			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION OATE		
	obtained from the https://vsearch.nlmmeta?v%3Aprojecmedlineplus-bundle	website: a.nih.gov/vivisimo/cgi-bin/query- t=medlineplus&v%3Asources= e&query=multiple+sclerosis erest/Needs Each Resident		658 679	F679		r /20 /49		
SS=D	the comprehensive and the preference program to support activities, both facilindividual activities designed to meet to physical, mental, a each resident, end and interaction in the This REQUIREME by:  Based on observation in the record review, facility directord review, it was failed to provide activities were offer Resident #81.  The facility staff factivities were offer Resident #81's new (2018).  The findings including Resident #81 was 11/18/16 with diagont limited to high	facility must provide, based on a assessment and care plan as of each resident, an ongoing tresidents in their choice of lity-sponsored group and and independent activities, the interests of and support the and psychosocial well-being of ouraging both independence he community. ENT is not met as evidenced ation, resident interview, staff ocument review and clinical as determined that facility staff ctivities to meet the residents' residents in the survey sample, alled to provide evidence that ared and provided to meet eds for the month of April			<ol> <li>Activities are being offered, documented and provided to mee Resident #81 needs.</li> <li>Each resident who prefers independent activities has the potential of being affected.</li> <li>Activity staff will be re-educate on ensuring activities are being offered and provided to meet each residents' needs who prefers independent activities.</li> <li>Audits will be conducted to ensure residents' needs are met prefers independent activities we for four weeks then monthly for three months. Results of the aud will be reviewed at the monthly meeting for three months to ensure compliance.</li> </ol>	ed ch who eekly its QAPI	5/29/18		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			04/2	27/2018
	PROVIDER OR SUPPLIER			S 3	STREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 04/2	.772018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 679	Resident #81's moset) assessment with a date) of 2/19/18. It being severely improved for Mental was coded in section as usually usually being under (Preferences for Codocumented that is Resident #81 to hat magazines to read participate in religit documented that is	sion, and muscle weakness. In the street of	F	679			
	made of Resident bed watching telev On 4/25/18 at 8:24	60 a.m., an observation was #81. He was awake lying in vision. 4 a.m., an observation was #81. He was awake lying in	,				
	On 4/25/18 at 10:4 made of Resident On 4/25/18 at 12:5						
	On 4/26/18 at 10:3 observation was c nurse. The wound	36 a.m., wound care onducted with the wound care care nurse stated that the en out of bed yet that day.					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER SUPPLIER (CLA

	OF DEFICIENCIES  F CORRECTION	IDENTIFICATION NUMBER:	l ' '	NG	CON	MPLETED
		495299	B. WING		1	C /27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 679	conducted with Rebed. The television the ceiling. When had offered him to Resident #81 state that he would like  Review of Resident 10/20/17 documer independent activities and participate in one dayInvite clergy come and visit with activity programs me to join at my oparticipation level with me to ensure high level with no activities and supproom, such as the paper, Please assisting outside and On 4/26/18 at 2:00 conducted with Othe activities direct are made aware of facility, OSM #20 receive a large protheir room. OSM offered to go to ar personally asks et to attend an activity would expect nurse.	49 p.m., an interview was esident #81. He was lying in was on but he was looking at asked Resident #81 if anyone do any activities that week, ed, "No." Resident #81 stated	F 6	79		

NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  3600 MOUNTAIN ROAD  GLEN ALLEN, VA 23060  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCT			TE SURVEY MPLETED
NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEALTH AND REHAB  (X4) ID PREFIX TAG  CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 679  Continued From page 137  When asked if residents ever get missed and are not able to attend an activity, OSM #20 stated, "I am not going to say that is not going to happen, if something comes up it could happen." OSM #20 stated that there were only two activity staff for the building. When asked how she or other staff know what a resident likes to do for activities, OSM #20 stated that it should be documented on their care plan or activities assessment. When asked what Resident #81 liked to do for activities, OSM #20 stated that he liked to read the paper			495299	B. WING			04	l
F 679  Continued From page 137  When asked if residents ever get missed and are not able to attend an activity, OSM #20 stated, "I am not going to say that is not going to happen, if something comes up it could happen." OSM #20 stated that there were only two activity staff for the building. When asked how she or other staff know what a resident likes to do for activities, OSM #20 stated that it should be documented on their care plan or activities assessment. When asked what Resident #81 liked to do for activities, OSM #20 stated that he liked to read the paper					3600 MOUNTAII	N ROAD		
When asked if residents ever get missed and are not able to attend an activity, OSM #20 stated, "I am not going to say that is not going to happen, if something comes up it could happen." OSM #20 stated that there were only two activity staff for the building. When asked how she or other staff know what a resident likes to do for activities, OSM #20 stated that it should be documented on their care plan or activities assessment. When asked what Resident #81 liked to do for activities, OSM #20 stated that he liked to read the paper	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	X (EACH	CORRECTIVE ACTION SH REFERENCED TO THE API	OULD BE	(X5) COMPLETION DATE
home-town. OSM #20 stated that when it is warm outside, Resident #81 liked to sit outside. When asked if it was warm outside that day, OSM #20 agreed that it was. OSM #20 stated that Resident #81's family also visited 2-3 times per week. When asked what activities Resident #81 did that week, OSM #20 stated that she took him his mail. OSM #20 stated, "I asked if he wanted to get up and do something and he said no." OSM #20 could not remember when she asked Resident #31 when he wanted to get up. When asked if she documented his refusal anywhere, OSM #20 stated, no. This writer then followed OSM #20 to the activities department to view Resident #81's activity log for April 2018. Resident #81's April activity log was completely blank. OSM #20 stated that after an activity she is supposed to document what was done immediately. OSM #20 stated that the activities she did with Resident #81 must have been documented in her notes. When asked where her notes were, OSM #20 stated, "I can't find my notes."  Review of Resident #81's clinical record failed to evidence any notes for the activities department.	F 679	When asked if res not able to attend am not going to sa something comes stated that there we the building. Whe know what a reside OSM #20 stated the their care plan or a asked what Reside OSM #20 stated the that he receives on home-town. OSM warm outside, Resident #81 per week. When asked if it wosm #20 agreed that Resident #81 per week. When a #81 did that week, him his mail. OSM wanted to get up a no." OSM #20 con asked Resident #8 When asked if she anywhere, OSM # followed OSM #20 view Resident #81 Resident #81's Ap blank. OSM # 20 is supposed to do immediately. OSM she did with Resident were, OSM notes."	idents ever get missed and are an activity, OSM #20 stated, "I by that is not going to happen, if up it could happen." OSM #20 were only two activity staff for a sked how she or other staff ent likes to do for activities, nat it should be documented on activities assessment. When ent #81 liked to do for activities, nat he liked to read the paper nace a week from his #20 stated that when it is sident #81 liked to sit outside. Was warm outside that day, that it was. OSM #20 stated is family also visited 2-3 times asked what activities Resident OSM #20 stated that she took of #20 stated, "I asked if he and do something and he said all do not remember when she at when he wanted to get up. It is documented his refusal 20 stated, no. This writer then it to the activities department to "s activity log for April 2018. It is activity log was completely stated that after an activity she cument what was done of #20 stated that the activities lent #81 must have been refusal must have been refusal activity and have been refusal must have been refusal mus		779			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	I ' '	NG	COMPLETED
		495299	B. WING		C 0 <b>4/27/2018</b>
	PROVIDER OR SUPPLIER  TH ADAM CRUMP H	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOTE) CROSS-REFERENCED TO THE APPIDEFICIENCY)	OULD BE COMPLETION
F 679	conducted with Res stated that facility s afternoon. Resider better."  On 4/26/18 at 5:09 staff member) #1 the the DON (Director of the above conce	p.m., further interview was sident #81. Resident #81 taff took him outside later that at #81 stated, "I feel so much p.m., ASM (administrative ne administrator, and ASM #2, of Nursing) were made aware	F6	79	5/29/18
F 684 SS≃D	S 483.25 Quality of Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a rethat residents received accordance with properties, the compression of the compression of the practice, and the second and clinical record facility staff failed to in accordance with practice and the cocare plan for one of sample, Resident #	fundamental principle that tent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered residents' choices.  NT is not met as evidenced erview, facility document review review, it was determined the provide treatments and care professional standard of emprehensive person-centered 42 residents in the survey	F 6	1. Resident #95's ibuprofen we clarified and administered per physicians orders.  2. A review of resident receive ibuprofen was conducted to administered per physician's  3. Licensed nurse will be reed on administering ibuprofen physician's orders.  4. Audits will be conducted of ensuring resident receiving it is administered per physician orders weekly for four weeks monthly for three months. If the audits will be reviewed a monthly QAPI meeting for the months to ensure compliance.	vas ing ensure order. ducated per ouprofen o's s then Results of t the oree

AND DUAN OF CODDECTION INDESTRUCTION NUMBERS		A. BUILC		(X3) DATE SURVEY COMPLETED			
		495299	B. WING	I	·	04/	2 <b>7/2018</b>
	PROVIDER OR SUPPLIER	HEALTH AND REHAB	<b>I</b>	36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	1 04/2	2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 684	Resident #95 was 2/12/18 with diagn limited to: multiple depression and pr The most recent in significant change (assessment refer resident as having BIMS (brief intervite resident was a decisions. The resident on staff Review of the resident on staff Elevated temp (ten Administer Pain (significant change) (assessment refer resident as having BIMS (brief intervite resident was a decisions. The resident on staff Review of the April (significant pain (significant) by more for Fever. Start data Review of the April administration record administration record as a needed if The medication with the resident in the staff pain (significant pain is the staff pain in the staff pain in the staff pain is the staff pain in the staff pa	admitted to the facility on oses that included but were not sclerosis (1), anemia, essure ulcers.  MDS (minimum data set), a assessment, with an ARD rence date) of 3/8/18 coded the scored a 14 out of 15 on the ew for mental status) indicating ognitively intact to make daily sident was coded as being for all activities of daily living.  dent's comprehensive care plan documented, "Focus. mperature). Interventions. sic) medication as ordered."  I 2018 physician's orders profen Table 400 MG outh every 8 hours as needed		584			
	98.4. An interview was of p.m. with LPN (lice unit manager. Wh	5:48 a.m. for a temperature of conducted on 4/26/18 at 1:05 ensed practical nurse) #4, the en asked what was considered ated, "I'd say a hundred plus is					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY IPLETED
		495299	B. WING			1	C 27/2018
	PROVIDER OR SUPPLIE	REALTH AND REHAB	<b>.</b>	360	REET ADDRESS, CITY, STATE, ZIP COD 10 MOUNTAIN ROAD EN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION OATE
F 684	a fever." LPN #4 w #95's April 2018 M had followed the p the ibuprofen for a LPN #4 stated the An interview was p.m. with RN (reg who gave the ibup what was conside hundred point fou considered 98.7 t "No." When asked w that time, RN #3 sthe physician and it."  On 4/26/18 at 5:1 member) #1, the director of nursing findings. A request policy for following that time. No police No further informational that is nerve cells. This is messages between leading to the syn was obtained from	was asked to review Resident MAR. When asked if the staff ohysician order when they gave a temperature of 98.7 and 98.4, by had not.  conducted on 4/26/18 at 1:30 istered nurse) #3, the nurse orofen on 4/17/18. When asked tred a fever, RN #3 stated, "One r." When asked if she to be a fever. RN #3 stated, at the review the April 2018 MAR RN #3 stated, "She asked me for what she should have done at stated, "I should have contacted see if I could get an order for the stated aware of the grade was received.  O p.m. ASM (administrative staff administrator and ASM #2, the grade was received.  Attorn was provided prior to exit.  The sist of the states of the states. The sist of the states of the stat		684			
F 685		es to Maintain Hearing/Vision	F	685			

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

Event ID:TQ6711

Facility ID: VA0083

If continuation sheet Page 141 of 211



# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		MPLETED
		495299	B. WING			04	C / <b>27/2018</b>
	PROVIDER OR SUPPLIER	HEALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	_1	12112010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (PROPRIES OF THE APPROPRIES OF THE APPROPRI	DBE	(X5) COMPLETION DATE
F 685 SS=D	§483.25(a) Vision To ensure that res and assistive devidence in assist the resident §483.25(a)(1) In m §483.25(a)(2) By and from the office the treatment of vithe office of a profice of a	and hearing sidents receive proper treatment ces to maintain vision and he facility must, if necessary, the naking appointments, and tarranging for transportation to be of a practitioner specializing in the facility side or hearing impairment or fessional specializing in the for hearing assistive devices. ENT is not met as evidenced that facility staff failed at treatment and services for one the survey sample, Resident facilied to follow up on Resident hearing aids.		685	1. An appointment has been scheduled with the audiologist in Resident #110.  2. A review of residents needing treatment for hearing and vision conducted to ensure proper assistance was received.  3. Social service staff will be reeducated on assisting residents receiving proper treatment and assistive devices to maintain he and vision.  4. Audits will be conducted to e residents receive assistance in receiving proper treatment and assistive devices to maintain he and vision weekly for four week then monthly for three months Results of the audits will be revat the monthly QAPI meeting for three months to ensure complish	in aring ari	5/29/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495299	B. WING		04	C /27/2018
	PROVIDER OR SUPPLIER ETH ADAM CRUMP I	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION OATE
F 685	cognitive function on the BIMS (Brie exam. Section B documented Resi hearing.  On 4/24/18 at 3:0 conducted with Rehad some concern questions were be to ask "what?" on could not hear this that the social wo hearing aids. Resi hearing test done ENT (Ear, Nose at the test." When a hearing test, Resi ago. It may have stated that the social work that the social that the s	scoring 15 out of possible 15 f Interview for Mental Status) (Hearing, Speech and Vision) dent #110 as having adequate  3 p.m., an interview was esident #110. Resident #110 his regarding her hearing. While eing asked, Resident #110 had several occasions because she is writer. Resident #110 stated riker was aware of her need for ident #110 stated, "I had a and no one followed up on it. and Throat) stated that I failed isked how long ago she had her dent #110 stated, "Six months been longer." Resident #110 cial worker was made aware time of the hearing test.  the clinical record ance of her hearing test.  the clinical record failed to both the social worker regarding	F6	685		

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION		PLETED
		495299	B. WING	i		04/2	C 27/2018
ELIZABETH ADAM CRUMP HEALTH AND REHAB  (X4) ID PREFIX TAG  F 685  Continued From page 143 and direct communication to promote understanding."  On 4/26/18 at 11:41 a.m., an interview was conducted with OSM (other staff member) #10, the social worker. When asked if she was awar of Resident #110's request for hearing aides, OSM #10 stated, "She (Resident #110) said that she had a hearing test done. I asked her when the test was		1	360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060			
PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG	I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 685	and direct commurunderstanding."  On 4/26/18 at 11:4 conducted with OS the social worker. of Resident #110's OSM #10 stated th stated, "She (Resident done." OSM #10 swhen the hearing to she still had to get another appointment stated that she was been trying to get in [Virginia Common OSM #10 could now #110 had initially resident to the property of	1 a.m., an interview was M (other staff member) #10, When asked if she was aware request for hearing aides, at she was aware. OSM #10 dent #110) said that she had a		685			
	staff member) #1 t	p.m., ASM (administrative he administrator, and ASM #2, of Nursing) were made aware erns.					
	Guidance," docum "Vision and hearing residents receive p (sic) devices to ma abilities, the facility resident- in making arranging for trans of a practitioner sp	itled, "Vision and Hearing ents in part, the following: g guidance to ensure that proper treatment and assistive aintain vision and hearing must, if necessary, assist the g appointments, and - By portation to and from the office ecializing in the treatment of appairment or the office of a					

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

Event ID: TQ6711

Facility ID: VA0083

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495299	B. WING			04/2	7/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	J	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		BE	(X5) COMPLETION OATE
F 685	or hearing assistive responsibility is to a representatives in I available resources program payment, offering items and free to the commun services the reside be actively involved resources and coordinical team."	age 144 alizing in the provision of vision of devicesThe facility's assist residents and their ocating and utilizing any is (e.g. Medicare or Medicaid local health organizations services which are available nity) for the provision of the ints needsSocial services will it with providing these redinating efforts with the	F6	85			
F 686 SS=D	exit. Treatment/Svcs to CFR(s): 483.25(b)( §483.25(b)(1) Pres Based on the compresident, the facility (i) A resident receive professional standard pressure ulcers and ulcers unless the irredemonstrates that (ii) A resident with professional standard pressure ulcers and ulcers unless the irredemonstrates that (ii) A resident with professional standard pressure ulcers and ulcers unless the irredemonstrates that (ii) A resident with professional standard promote healing, promote h	Prevent/Heal Pressure Ulcer 1)(i)(ii)  egrity sure ulcers. brehensive assessment of a rmust ensure thates care, consistent with ards of practice, to prevent d does not develop pressure advidual's clinical condition they were unavoidable; and pressure ulcers receives and services, consistent trandards of practice, to revent infection and prevent	F6	686	1. Resident #157 right heel pressists ore is healed.  2. A review of residents identified with pressure sore was conducted and all areas have treatment ordered.  3. Licensed Nurse will be re-educted on ensuring any resident identified with pressure sore receive treatment orders immediately.  4. Audits will be conducted to entresident identified with pressure sores receive treatment immediately weekly for four weeks then month for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	d d ers. ated ed nent sure	5/29/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION ING	COV	(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C / <b>27/2018</b>
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		ALTINO IO
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		HOULD BE	(X5] COMPLETION DATE
F 686	a pressure sore for survey sample, Resident #157 was heel unstageable in Treatment orders after the wound had treatment was not right heel pressure after the wound had the findings included Resident #157 was 3/23/18 with diagnal limited to Non-Alze encephalopathy, in weakness. Reside (minimum data se assessment with a date) of 3/30/18. It being impaired in the BIMS (Brief Intexam). Resident extensive assistant members with ADI Review of Resident (On admission). To "Date first observed Stage: UTS (unstage: UTS (unstage: uts of Resident centimeters) 2, We Drainage: none	r one of 42 residents in the esident #157.  sidentified as having a right pressure sore (1) on 3/23/18, were not obtained and provided to Resident #157's esore until 3/36/18 (three days ad been identified).  de: sadmitted to the facility on oses that included but were not neimer's dementia, depression, mod disorder and muscle ent #157's most recent MDS to was an admission of ARD (assessment reference Resident #157 was coded as cognitive function scoring 99 on the following the following was documented: (Activities of Daily Living).  at #157's initial pressure injury at an unstageable pressure ified to her right heel on 3/23/18. The following was documented: ad: 3/23/18, Location: right heel, ageable), Length in CM obescribe treatment plan: skin out #157's baseline care plan following: R (right) heel red and	F 6	86		

	OF DEF(C(ENC(ES OF CORRECT(ON	(X1) PROVIDER/SUPPL(ER/CL/A (DENT(FICATION NUMBER:	1 ' '		STRUCT(ON		E SURVEY PLETED
		495299	B. W(NG			1	27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		3600 M	ADDRESS, C(TY, STATE, Z(P CODE OUNTA(N ROAD ALLEN, VA 23060		
(X4) (D PREF(X TAG	(EACH DEF(C(ENC)	ATEMENT OF DEF(C(ENC(ES Y MUST BE PRECEDED BY FULL SC (DENT(FY(NG (NFORMAT(ON)	(D PREF TAG		PROV(DER'S PLAN OF CORRECT (EACH CORRECT(VE ACT(ON SHOU CROSS-REFERENCED TO THE APPRO DEF(C(ENCY)	ILD BE	(X5) COMPLETION DATE
F 686	Review of Residen	t #157's physician order sheet	F	686		:	
		rder for skin prep was not 18 (three days after the wound			·		
	(treatment adminis the order for skin p	t #157's March 2018 TAR tration record) revealed that rep was not initiated untiles after the wound was found).					
	Review of Resident #157's clinical record documented the unstagebale to her right heel as healed on 4/17/18.						
	conducted with LPI the wound care nu should be in place "Yes, if we are app an order." LPN #6 #157's unstageable #6 stated that the value 3/23/18. When as treatment was initial physician order should be order was written of asked to provide e (skin prep) to Residual physician order.	p.m., an interview was N (licensed practical nurse) #6, rse. When asked if an order for skin prep, LPN #6 stated, lying skin prep, there should be was asked when Resident e wound was identified. LPN wound was identified on ked when the skin prepated, LPN #6 looked at the eet and confirmed that the on 3/26/18. LPN #6 was then vidence that the treatment dent #157's heel was /18 through 3/25/18.					
	conducted LPN #6 not find evidence t on 3/23/18 through treatment to the pr there is no evidence	i p.m., further interview was 5. LPN #6 stated that she could hat the skin prep was applied a 3/25/18. LPN #6 was asked it essure wound was delayed if the the skin prep was applied PN #6 stated, "If that's what					

	STATEMENT OF DEFICIENCIES (X	IDENTIFICATION NUMBER:	1 ' '	ING		COMPLETED		
		495299	B. WING		04	C / <b>27/2018</b>		
	PROVIDER OR SUPPLIER	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		,2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION OATE		
F 686	observation was obilateral heels. Reconcerns to her he concerns to he concerns the conc	proximately 4:00 p.m., conducted of Resident #157's esident #157 had no skin eels.  9 p.m., ASM (administrative the administrator, and ASM #2, of Nursing) were made aware erns.  ation was presented prior to er is an inflammation or sore on any prominence (e.g., shoulder buttocks, or heel), resulting essure on the area, usually ed to bed. Most frequently seen nobilized persons, decubitus evented by frequently change of bulation, cleanliness, and use of d a water or air mattress. Also Pressure sores. Barron's ical Terms for the Non Medical el A. Rothenberg, M.D. and		686				
	intact without eryt	hema or fluctuance) eschar on as "the body's natural						

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	495299	B. WING_		04/2	7/2018
			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	, ,,,,	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	D BE	[X5] COMPLETION DATE
(biological) cover" This information w Pressure Ulcer Ad http://www.npuap.c	and should not be removed. as obtained from National visory Panel website at org/pr2.htm.				
S483.25(d) Accide The facility must e §483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observa document review, facility staff failed to one of two oxygen failed to ensure as accidents were im the survey sample and Resident #8.  1. The facility staff tanks were stored oxygen storage ro 2. The facility staff a lid was on Resid liquids to prevent a handling and drink resident's assessr plan.	nts. nsure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent ENT is not met as evidenced ation, staff interview and facility it was determined that the o ensure a safe environment in storage rooms, Wing C; and sistance devices to prevent plemented for two residents in of 42 residents, Resident #88  failed to ensure two oxygen in a secure manner in the om on Wing C.  failed to implement and ensure ent #88's cup containing hot accidents and injury while ing hot beverages, per the nent and comprehensive care		manner on Wing C. Lids remain of cups containing hot liquids per the resident assessment and comprehensive care plan for Resident #88 and Resident #6.  2. A review of oxygen tanks storated will be completed to ensure oxyget is stored in a secure manner. A review of resident needing lids or cups containing hot liquids per the resident assessment and comprehensive care plan was conducted to ensure the lids remained on ensuring oxygen is stored in a secure manner. Nursing staff will be re-educated on ensuring lids remain on cups containing hot liquids	ge en nee aains	5/29/18
	PROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENCE REGULATORY OR I  Continued From pa (biological) cover" This information w Pressure Ulcer Adi http://www.npuap.of Free of Accident H CFR(s): 483.25(d)  §483.25(d) Accide The facility must e §483.25(d)(1) The as free of accident  §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on observat document review, facility staff failed to one of two oxygen failed to ensure as accidents were im the survey sample and Resident #8.  1. The facility staff tanks were stored oxygen storage row 2. The facility staff a lid was on Resid liquids to prevent a handling and drink resident's assessin plan.	PROVIDER OR SUPPLIER  TH ADAM CRUMP HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 148 (biological) cover" and should not be removed. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure a safe environment in one of two oxygen storage rooms, Wing C; and failed to ensure assistance devices to prevent accidents were implemented for two residents in the survey sample of 42 residents, Resident #88 and Resident #8.  1. The facility staff failed to ensure two oxygen tanks were stored in a secure manner in the oxygen storage room on Wing C.  2. The facility staff failed to implement and ensure a lid was on Resident #88's cup containing hot liquids to prevent accidents and injury while handling and drinking hot beverages, per the resident's assessment and comprehensive care plan.	RECORRECTION ABSERTATION NUMBER  495299  B. WING_  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 148  (biological) cover" and should not be removed. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm.  Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  \$483.25(d) Accidents. The facility must ensure that - \$483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and \$483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by:  Based on observation, staff interview and facility document review, it was determined that the facility staff failed to ensure a safe environment in one of two oxygen storage rooms, Wing C; and failed to ensure assistance devices to prevent accidents were implemented for two residents in the survey sample of 42 residents, Resident #88 and Resident #8.  1. The facility staff failed to ensure two oxygen tanks were stored in a secure manner in the oxygen storage room on Wing C.  2. The facility staff failed to implement and ensure a lid was on Resident #88's cup containing hot liquids to prevent accidents and injury while handling and drinking hot beverages, per the resident's assessment and comprehensive care	THE ADAM CRUMP HEALTH AND REHAB  SITREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLAN ALLEN, VA 23060  SUMMARY STATEMENT OF DESCRETCIENCIES (EACH DEFICIENCY)  CANDIDATION OR LSC IDENTIFYING REFORMATION)  CONTINUED From page 148  F 686  F 686  F 689  1. Oxygen tanks are store in a secumanner on Wing C. Lids remain or cups containing hot liquids per th resident assessment and comprehensive care plan for Resident #88 and Resident #6.  2. A review of oxygen tanks storal will be completed to ensure oxyge is stored in a secure manner. A review of resident needing lids or cups containing hot liquids per thresident assessment and comprehensive care plan was conducted to ensure the lids remain on the cups with hot liquid.  3. Nursing staff will be re-educate on ensuring oxygen is stored in a secure manner in the oxygen storage room on Wing C.  2. The facility staff failed to implement and ensure alid was on Resident #88's cup containing hot liquids per thresident assessment and comprehensive care plan.	A BUILDING  495299  B WING  STREET ADDRESS. CITY, STATE, ZIP CODE 3800 MOUNTAIN ROD  GLEN ALLEN, VA 23060  SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MIST IES PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 148 (biological) cover* and should not be removed. This information was obtained from National Pressure Ulcer Advisory Panel website at http://www.npuap.org/pr2.htm. Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and \$483.25(d)(2) Each resident environment remains as free of accident hazards as is possible; and \$483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. The facility staff failed to ensure a safe environment in one of two oxygen storage rooms, Wing C; and failed to ensure as east environment in one of two oxygen storage rooms, Wing C; and failed to ensure a safe environment in one of two oxygen storage rooms, Wing C; and failed to ensure as self-and the ensure of the received and resident #8.  1. The facility staff failed to ensure two oxygen tanks were stored in a secure manner in the oxygen storage room on Wing C.  2. The facility staff failed to implement and ensure alid was on Resident #88's cup containing hot liquids to prevent accidents and injury while handling and drinking hot beverages, per the resident assessment and comprehensive care plan.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		TE SURVEY MPLETED
		495299	B. WING	·		04	C / <b>27/2018</b>
	PROVIDER OR SUPPLIEF ETH A <b>dam Crump</b> I	REALTH AND REHAB		36	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD BLEN ALLEN, VA 23060	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT REFIX (EACH CDRRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		D BE	(X5) COMPLETION DATE
F 689	a lid was on Resid liquid to prevent a handling and drink resident's assessinglan.  The findings included on 4/25/18 at 3:25 tank storage was medication storage freestanding oxyg standing in an uprother tanks that with the stanks should be positionare supposed to should be positionare supposed to sto clarify if the tank where they cannorack like this, where they cannorack like this, where they could stated, "No. They oxygen tanks show where they cannostated, "To avoid a how much oxygen."	lent #6's cup that contained hot coidents and injury while king hot beverages, per the ment and comprehensive care		689	4. Audits will be conducted to en oxygen is stored in a secure man weekly for four weeks then mon for three months. Audits will als conducted to ensure lids remain cups containing hot liquid per thresident assessment and comprehensive care plan weekly four weeks then month for three months. Results of the audits wireviewed at the monthly QAPI meeting for three months to en compliance.	ner thly o be on e for e	

		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
ELIZABETH ADAM CRUMP HEALTH AND REHAB  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 689  Continued From page 150  On 4/25/18 at 5:34 a.m., another interview was conducted with LPN #12. LPN #12 stated he was not aware of the freestanding oxygen tanks in the storage room prior to this surveyor's observation. LPN #12 stated the oxygen tanks were for a Hospice resident and the tanks had been placed in the storage room by Hospice staff. LPN #12 stated he placed the placed the placed the placed the tanks in a metal rack.  On 4/25/18 observation at approximately 6:45			495299	B. WING				
F 689  Continued From page 150  On 4/25/18 at 5:34 a.m., another interview was conducted with LPN #12. LPN #12 stated he was not aware of the freestanding oxygen tanks were for a Hospice resident and the tanks had been placed in the storage room by Hospice staff. LPN #12 stated he placed the tanks in a metal rack.  On 4/25/18 observation at approximately 6:45		,	EALTH AND REHAB		3600 MOUNTAIN ROAD			
On 4/25/18 at 5:34 a.m., another interview was conducted with LPN #12. LPN #12 stated he was not aware of the freestanding oxygen tanks in the storage room prior to this surveyor's observation. LPN #12 stated the oxygen tanks were for a Hospice resident and the tanks had been placed in the storage room by Hospice staff. LPN #12 stated he placed the tanks in a metal rack.  On 4/25/18 observation at approximately 6:45	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
On 4/26/18 at 5:32 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.  The facility document regarding oxygen tank storage documented, "1. Cylinders are: Stored upright with valve outlet seals and valve protection caps in place. Either individually chained OR inserted in metal 'racks"  No further information was presented prior to exit.  3. The facility staff failed to implement and ensure a lid was on Resident #6's cup that contained hot liquid to prevent accidents and injury while handling and drinking hot beverages, per the resident's assessment and comprehensive care plan.  Resident #88 was admitted to the facility on 3/15/13 with diagnoses that included but were not limited to: muscle weakness, dementia, high blood pressure, paralysis of the left arm and leg and stroke. The resident's neck was severely	F 689	On 4/25/18 at 5:34 conducted with LPI not aware of the frestorage room prior LPN #12 stated the Hospice resident a in the storage room stated he placed the On 4/25/18 observa.m., revealed the On 4/26/18 at 5:32 staff member) #1 ((the director of nurabove concern.  The facility docume storage documents upright with valve oprotection caps in protection ca	a.m., another interview was N #12. LPN #12 stated he was estanding oxygen tanks in the to this surveyor's observation. Coxygen tanks were for a and the tanks had been placed by Hospice staff. LPN #12 the tanks in a metal rack.  ation at approximately 6:45 toxygen tanks were secure.  p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the sent regarding oxygen tank and could be seals and valve to blace. Either individually and in metal 'racks'"  ation was presented prior to exit.  failed to implement and ensure the ent #6's cup that contained hot be contained hot be contained and injury while the ent and comprehensive care admitted to the facility on the contained but were not weakness, dementia, high ralysis of the left arm and leg		689			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		COMI	E SURVEY PLETED
		495299	B. WING			04/	C 27/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	E, ZIP CODE	<u>  U4/2</u>	2112U 10
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD O THE APPROPI	BE	(X5) COMPLETION DATE
F 689	contractured so that the right and rested. The most recent MI quarterly assessmereference date) of 2 having scored a 13 interview for mental was cognitively inta. The resident was cofrom staff for all acteating which the residently after. An observation was a.m., of Resident # in her wheelchair exhalf-full cup of cofferesident's table. The Review of the hot lie 2/6/18 documented the resident is at risdrinking hot liquids. following apply to the feeling was checked yes, indicating place to enhance (rehabilitation) screor other adaptive currently and the resident was checked yes, indicating place to enhance (rehabilitation) screor other adaptive currently and the resident was while handling and while handling and	ther head was always bent to on her shoulder.  DS (minimum data set), a ent, with an ARD (assessment 2/28/18 coded the resident as out of 15 on the BIMS (brief 1 status) indicating the resident ct to make daily decisions. Oded as requiring assistance ivities of daily living except for sident could perform the tray was set up.  Is made on 4/25/18 at 9:15 Is The resident was sitting up ating breakfast. There was a see with a straw in it on the ere was no lid on the cup.  In the tray was set up.  In the tray was set up		689			

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495299	B. WING				) 27/2018
	PROVIDER OR SLIPPLIE ET <b>H ADAM CRUMP I</b>	HEALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	1 04/2	1720 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILIENCY)	DBE	(X5) COMPLETION DATE
F 689	An interview was p.m. with CNA (cethe resident's coffee open milk and sugaresident had a specoffee cup, CNA #it." When asked won their hot liquids spill." When asked that a resident war CNA #14 stated, question." When a the CNA's care can resident war compared to the co	conducted on 4/26/18 at 2:45 crtified nursing assistant) #14, e. When asked how the was served, CNA #14 stated, "I r in it." When asked if the ecial cup or had a lid on her #14 stated, "No. She doesn't like why a resident would have a lid s, CNA #14 stated, "So it doesn't d how staff were made aware s to have lid on their hot liquids, I don't know. That's a good asked if the information was on ard, CNA #14 stated, "No."		689			

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

Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 153 of 211



	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	l'	3) DATE SURVEY COMPLETED
		495299	B. WING	·		C <b>04/27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB		STREET ADDRESS, CI 3600 MOUNTAIN ROA GLEN ALLEN, VA	AD	0.1.2.7.2.0.10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	
F 689	weakness, depress The most recent M quarterly assessme reference date) of having scored a for interview for menta was severely impair was coded as requiver all activities of daily.  An observation was a.m., of Resident # having breakfast. Ton the table without Review of the reside evaluation dated, 2 assessment identifinjury while handling Place a check marker esident being assessment or drown resident's perception liquids and safety marked to: altered of impairment (was of behavior which count while the resident is checked). 11. If any indicate which interto enhance safety was creen is pending, adaptive cup4. To (were checked)."	DS (minimum data set), a ent, with an ARD (assessment 1/15/18 coded the resident as ur out of 15 on the BIMS (brief I status) indicating the resident red cognitively. The resident iring assistance from staff for a living.  Is made on 4/25/18 at 9:00 for the resident was in bed there was a cup of hot coffee		689		
	2/8/18 documented	lencs care plan initiated on. I, "Focus. Resident has been been identified for risk of injury				

•	1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		495299	B. WING		1	C / <b>27/2018</b>
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 689	while handling and Interventions. Provadaptive cup."  An interview was cop.m. with LPN (lice unit manager. Whe care plans, LPN #4 care plans to make and put into place." care plans, LPN #4 everyone does actuwere expected to fostated, "Yes." LPN findings at that time. An interview was cop.m. with CNA (cert the resident's aide. resident's coffee waput the cup on the #6 had a lid on her "I've never seen he a resident would had CNA #14 stated, "Show staff were machave lid on their hod don't know. That's if the information we CNA #14 stated, "Neview of Resident" Iid on cup for hot limited.	drinking hot beverages. ide cup with lid or other  anducted on 4/26/18 at 1:05 ansed practical nurse) #4, the en asked why residents had stated, "Basically they have bus aware of what they have bus aware of the astated, "The nurses. Basically wally." When asked if staff collow the care plan, LPN #4 #4 was made aware of the expectation of the was served, CNA #14 stated, "I when asked how the eas served, CNA #14 stated, or with one." When asked why ave a lid on their hot liquids, for it doesn't spill." When asked de aware that a resident was to the tiquids, CNA #14 stated, "I a good question." When asked as on the CNA's care card, lo."  It #6's care card documented, iquids."		,		
	member) #1, the ad	p.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING		C 04/27/2018	
	PROVIDER OR SUPPLIER	EALTH AND REHAB	3	TREET ADDRESS, CITY, STATE, ZIP CODE 1600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	, 01,21,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	ų
F 690	Bowel/Bladder Inco CFR(s): 483.25(e)(  §483.25(e) Incontin §483.25(e)(1) The investment who is con- admission receives maintain continence condition is or becomot possible to main §483.25(e)(2)For an incontinence, based comprehensive assensure that— (i) A resident who end indwelling catheter resident's clinical continence in assessed for reman as possible unlessed demonstrates that and (iii) A resident who receives appropriate prevent urinary tracecontinence to the end service in the end of	ion was provided prior to exit. Intinence, Catheter, UTI 1)-(3) Inence. Ifacility must ensure that Itinent of bladder and bowel on Iservices and assistance to Ite unless his or her clinical Itinence is on the clinical Itinence is on the resident's Itinence is on the facility must Itinence is on the resident's Itinence is on the resident's Itinence is on the resident's is on the resident's interest the facility without an Itinence is one of the catheter is one	F 690		heter ping e ted or. nsure gs four	
	possible.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495299	B. WING				C / <b>27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB		3600	EET ADDRESS, CITY, STATE, ZIP CODE 0 MOUNTAIN ROAD EN ALLEN, VA 23060	1 04/	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TD THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 690	This REQUIREMENT by: Based on observator record review, it was staff failed to provid manner to prevent residents in the suresidents in the sure Resident #35's cath bag was observed.  The findings included Resident #35 was a 10/1/16. Resident were not limited to weakness and major Resident #35's most assessment with a resident's cognitive decision-making as Section G coded Resident as having a Review of Resident as having a Review of Resident as having a Review of Resident a physician's order diagnosis of urinary comprehensive cardocumented, "Alter and bladder and an tract infections) r/t (Indwelling Urinary CreatentionKeep do the level of the blad the review of the level of the blad the review of the level of the blad the review of the level of the blad the level of the blad the review of the level of the blad the review of the blad the level of the blad the review of the level of the blad the level of the blad the record review of the level of the blad the record review of the level of the blad the level of the blad the record review of the level of the blad the record review of the level of the blad the record review of the level of the blad the record review of the level of the blad the record record record review of the level of the blad the record	cion, staff interview and clinical is determined that the facility le catheter services in a infection for one of 42 vey sample, Resident #35.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage touching the floor.  The eter (1) tubing and drainage the floor.  The eter (1) tubing and draina	F	890			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	ING		COMPLETED	
		495299	B. WING		04	C I/ <b>27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 690	observed sitting in tubing was observed observed lying in be drainage bag was of the conducted with LPI LPN #5 was asked tubing and drainage LPN #5 stated, "Be if the bag and tubin #5 stated, "No." We stated, "Contaminated, "Contaminated, "Contaminated, "Contaminated, "Conducted with LPI where a resident's bag should be in a dign hooked to the bed when asked if the touch the floor, LPI On 4/26/18 at 5:32 staff member) #1 (If (the director of nursabove concern.)  The facility docume failed to reveal document failed to reveal do	a wheelchair. The catheter ed touching the floor.  a.m., Resident #35 was ed. The bottom of the catheter observed touching the floor.  a.m., an interview was N (licensed practical nurse) #5. where a resident's catheter e bag should be positioned. How waste level." When asked ug should touch the floor, LPN then asked why, LPN #5 wition."  7 a.m., an interview was N #9. LPN #9 was asked catheter tubing and drainage tioned. LPN #9 stated, "It ity bag and the bag should be and lower than the waist." tubing or drainage bag should		390		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B. WING		C 04/27/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CLIZADO	TH ADAM CRUMP HI	EALTH AND DEHAD		3600 MOUNTAIN ROAD	
CLIZADO	TH ADAM CRUMP H	EALTH AND KEHAB		GLEN ALLEN, VA 23060	
(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 SHOUL)  CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLÉTION
F 690	Continued From pa	<del></del>	F 690	F695	5/29/18
		gov/ency/article/003981.htm			,
F 695		ostomy Care and Suctioning	F 698	1	
SS=D	CFR(s): 483.25(i)			stored in a bag when not in use.	
	§ 483.25(i) Respira	tory care, including		Resident #110 is receiving oxyge	n per
		and tracheal suctioning.		physician's order.	
		sure that a resident who		2. A review of resident with oxyg	<sub>zen</sub>
		are, including tracheostomy uctioning, is provided such		was conducted to ensure nasal	,5,1
		h professional standards of		cannulas are in bags when not in	) IICO
		ehensive person-centered			i I
		ents' goals and preferences,		and the oxygen rate is administe	ileu
	and 483.65 of this			per physician's orders.	
	į This REQUIREMEI ¹ by:	NT is not met as evidenced		3. Nursing staff will be re-educa-	ted
		tion, staff interview and clinical		on ensuring oxygen nasal cannu	l l
	record review it was	s determined that the facility		stored in a bag when not in use.	1
		le respiratory services and		Licensed Nurses will be re-educa	1 1
	store respiratory ed	uipment in a sanitary manner.		on ensuring oxygen rate is	
	1. The facility staff t	failed to store Resident # 152's		administered per physician's	
	1	plastic bag when not in use.		ordered.	
		failed to follow physicians tered oxygen at the incorrect		4. An audit will be conducted to	
	rate to Resident #1			ensure oxygen nasal cannula ar	e
	Tato to reocidom in			stored in a bag when not in use	
	The findings includ	e:		weekly for four weeks then mo	nthly
	   4 Tl			for three months. An audit will	
	!	failed to store Resident # 152's plastic bag when not in use.		be conducted to ensure oxygen	İ
	Hasai Calliula III a	plastic bag which not in use.		is administered per physician's	
		s admitted to the facility on		orders weekly for four weeks th	nen
		noses that included but were		monthly for three months. Resi	
		ey disease (1), hypertension		the visits will be reviewed at th	
	(2), edema (3), hea	iit raiiure anu pain.		monthly QAPI meeting for thre	
	Resident # 152's m	ost recent comprehensive		months to ensure compliance.	
		•	ĺ	months to ensure compliance.	1

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
,	С
495299 B. WING	04/27/2018
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, Z  3600 MOUNTAIN ROAD  GLEN ALLEN, VA 23060	ZIP CODE
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT	TION SHOULD BE COMPLÉTION THE APPROPRIATE DATE
F 695  Continued From page 159  MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/03/18, coded Resident # 152 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Resident # 152 was coded as being independent to requiring supervision of one staff member for activities of daily living.  The POS (physician's order sheet) dated April 2018 for Resident # 152 documented, " O2 (oxygen) at 3LPM (three liters per minute) NC (nasal cannula) continuous every shift. Maintain sats (saturation) above 90. Start Date 09/20/2017."  An observation on 04/24/18 at approximately 12:06 p.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.  An observation on 04/25/18 at approximately 9:19 a.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.  An observation on 04/26/18 at approximately 7:55 a.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.  An observation on 04/26/18 at approximately 12:00 p.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.  An observation on 04/26/18 at approximately 12:00 p.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.  An observation on 04/26/18 at approximately 12:00 p.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.  An observation on 04/26/18 at approximately 12:07 p.m. revealed Resident #152's oxygen tubing wrapped around the front of the oxygen concentrator with the nasal cannula not in a bag.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			CON	(X3) DATE SURVEY COMPLETED	
		495299	B. WING				C / <b>27/2018</b>
	PROVIDER OR SUPPLIER		1	3600 MOUNT	RESS, CITY, STATE, ZIP CODE Fain Road En, Va. 23060	,	21,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF I TAG	X (EAC	ROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHO S-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	JX5) COMPLETION DATE
F 695	tubing wrapped are concentrator with to Observations of the revealed she was a portable oxygen cythe wheelchair and nasal cannula. The portable cylinder work on 04/26/18 at apwas asked to observation, oxyg LPN # 9 stated, "A should have been shift, this was over On 04/27/18 at appropriate of the concentrator and were made aware. No further information of the concentration and were made aware. No further information of the concentration and were made aware. (1) Most kidney distributed amage may remove wastes. Caproblems, injuries, higher risk of kidney high blood pressur with kidney diseased damages the nephother kidney problems and Infection obtained from the high silver in the control of the control o	bund the front of the oxygen he nasal cannula not in a bag. The resident on the above dates in her wheelchair, with a dinder attached on the back of a was receiving oxygen via the O2 (oxygen) from the reas set correctly.  Proximately 1:00 p.m., LPN # 9 three Resident # 152's oxygen the entubing and nasal cannulated bagged. It's checked every blooked."  Proximately 11:30 a.m. ASM off member) # 1, the the ASM # 2, director of nursing of the findings.  It ion was provided prior to exit.  Reases attack the nephrons are all the tubing and prior to exit.  Reases attack the nephrons of the findings.  It is the tubing and prior to exit.  Reases attack the nephrons are all the tubing and prior to exit.  Reases attack the nephrons.  Reases attack the nephrons are all the tubing and prior to exit.  Reases attack the nephrons or medicines. You have a set of a close family member are all the tubing and prior to exit.  Reases attack the nephrons.  Reases attack the nephrons are all the tubing and prior to exit.  Reases attack the nephrons.  Reases attack the nephrons are all the tubing and prior to exit.  Reases attack the nephrons.	695				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION	COV	(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C / <b>27/2018</b>
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION OATE
F 695	(3) A swelling causitissues. This informatissues. This informatissues. This informatissues. This informatissues. This informatis to the facility staff orders and administrate to Resident #1 Resident #110 was 2/17/17 and readmatisgues that incluend stage renal distinguismajor depressive direcent MDS (minimal quarterly assessment references the modern for the BIMS (Brieflexam).  Review of Resident for the facility of the Resident #110 was cognitive functions on the BIMS (Brieflexam).  Review of Resident for the facility of	vebsite: a.gov/medlineplus/highbloodpr  ed by fluid in your body's mation was obtained from the a.gov/medlineplus/edema.html. failed to follow physician's stered oxygen at the incorrect 10.  admitted to the facility on itted on 4/16/18 with uded but were not limited to ease with dependence on ation, high blood pressure, and isorder. Resident #110's most num data set assessment) was	F6	695		

	AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   (X2) MULTIPLE CONSTRUCTION   A. BUILDING   A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495299	B. WING	i		1	C <b>27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB		360	EET ADDRESS, CITY, STATE, ZIP CODE 0 MOUNTAIN ROAD EN ALLEN, VA 23060	1 041	2112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION OATE
F 695	made of Resident # flow rate was set al above the 5 liter maconcentrator.  Review of Resident dated 4/28/17 docut for Respiratory Dist (diagnoses) of acut CHF (congestive he apnea. Goal (Name adequate gas exchadventitious breath respiratory distress breath thru next revoxygen as ordered on room air and/or oxygen flow rate ar On 4/27/18 at 9:45 conducted with RN asked who change #110's oxygen, RN when I am here I dethe flow rate of Resconcentrator, RN # On 4/27/18 at 9:55 conducted with LPI the unit manager. Volanges her own 0 did not. LPN #4 co oxygen was not at 10 oxygen tank or con oxygen tank or con	#110. Resident #110's oxygen bove the red ring that was also ark on her oxygen  #110's Respiratory care plant mented the following: "At risk tress r/t (related to) Dx re/chronic respiratory failure, eart failure), Obstructive sleep to of Resident #110) will have ange as evidenced (sic) by no sounds, absence of and absence of shortness of view. Interventions: administer Monitor oxygen saturations oxygen as needed. Monitor and response."  a.m., an interview was (registered nurse) #5. When so the flow rate on Resident #5 stated, "Most of the time or." When RN #5 was shown sident #110's oxygen 5 stated, "No that is not right."  a.m., an interview was N (licensed practical nurse) #4, When asked if Resident #110 2 rate, LPN #4 stated that she infirmed that Resident #110's		695			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			СОМ	(X3) DATE SURVEY COMPLETED	
	•	495299	B. WING	,			C 27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		3600	ET ADDRESS, CITY, STATE, ZIP CODE MOUNTAIN ROAD N ALLEN, VA 23060	1 0-11	2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 725 SS=D	what it meant when above the 5 liter math than 5. I don't think above 5. You need above 5."  Review of the mandoxygen concentrate following: "Do not so RED ring. An oxygen Lymin will decrease on 4/27/18 at appreciation (administrative staff administrative staff sufficient Nursing SCFR(s): 483.35(a) Sufficient Provide nursing and resident safety and practicable physical well-being of each resident assessme and considering the diagnoses of the far accordance with that §483.70(e).  §483.35(a)(1) The	cal treatment. When asked the ball was on the red line ark, LPN #16 stated, 'It's more the concentrator can go a special concentrator to go a special concentrator for the or documented in part the et the flow rate above the en flow rate greater than 5 at the oxygen concentration."  Oximately 12:30 p.m., ASM f member) #1, the ASM #2, the DON (Director of e aware of the above dion was presented prior to exit. Staff 1)(2)		725	F725 PNC – No POC needed		
	by sufficient number	as or each of the following					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			04/2	; 27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		36	TREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD LEN ALLEN, VA 23060	1 0-1/2	172010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 725	types of personnel nursing care to all resident care plans (i) Except when wathis section, license (ii) Other nursing polimited to nurse aid §483.35(a)(2) Exceparagraph (e) of this designate a license nurse on each tour This REQUIREMED by:  Based on staff intereview, clinical recordate a complaint investigned the facility staff failed for one of 42 resident #41.  The facility staff failed for one of 42 resident #41.  The facility staff failed for one of 42 resident #41.  The facility staff failed for one of 42 resident #41.  The facility staff failed for one of 42 resident #41.  The facility staff failed for one of 42 resident #41.  The facility staff failed for one of 42 resident #41.  The findings including living assistant were not limited to urinary retention ar #41's most recent I quarterly assessment reference date) of 2 being cognitively in Resident #41 as recone-person physical mobility/transfers are one-person physical mobility/transfers are set in the plant of the plan	on a 24-hour basis to provide residents in accordance with initived under paragraph (e) of ed nurses; and ersonnel, including but not es.  The personnel includ	F 7	25	Past noncompliance: no plan of correction required.		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/SUA IDENTIFICATION NUMBER:		l · · ·	ING		COMPLETED		
		495299	B. WING		n4	C // <b>27/2018</b>	
	PROVIDER OR SUPPLIE	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 0 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		1 00272010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	JX5) COMPLETION DATE	
F 725	urinary catheter (2 comprehensive catheter) involuntary mover (diagnosis); Parki 1 person. Person person. Transfer (catheter) bag to a.m"  On 3/22/18, the Continuation of the catheter of	lent as having an indwelling (2). Resident #41's are plan dated 11/27/17 ave a physical functioning deficitly impairment, ROM (range of s., Self care impairment due to ments secondary to Dx nson'sDressing assistance of all Hygiene assistance of 1 assistance of 1 person. Foley be changed to leg bag every office of Licensure and ved a complaint regarding the complainant alleged the to provide ADL (activities of a timely manner on 3/18/18		725			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495299	B. WING_		ţ	C 04/27/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION OATE	
F 725	administrator to Re 3/19/18 documente everyone. I sincer yesterday. Upon re employees call out shift). We were so aides for that shift just was unexpected years and even du had that many call is not an excuse of know that I person day tracking call or once they reach the warrant a write up going through the apologize."  Review of the as w 3/18/18 revealed 1 assistants), 1 CNA orientee were sche 3/18/18. Further refour CNAs and the CNA was no call not documented two Cunit (a unit contain reported three CNAThe schedule also worked on day shift on 3/18/18). I remember what tin was changed on 3.	esident #41's family member on ed, "Good afternoon to ely regret this incident occurred eview, we had a total of six on 7-3 (7:00 a.m. to 3:00 p.m. sheduled to have 16 nurse so to have over a third call out ed. I have been here for 3.5 ring snow storms we have not out on one shift. I realize this nly an explanation. Please ally review attendance every uts and tardy's. I write up staff e number of infractions to and we do terminate staff disciplinary process. Again, I worked nursing schedule for 5 CNAs (certified nursing on light duty and 1 CNA eduled for the day shift on eview of the schedule revealed orientee called out and one on show. The schedule staff As worked Resident #41's ing 60 beds) although staff As worked the unit on that day revealed no CNAs who us night stayed over and	F 72	25			

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

Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 167 of 211



	OF DEFICIENCIES  DE CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495299	B. WING		N4	C / <b>27/2018</b>	
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		12112010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
F 725	resident's medicing she was doing. Lift she was not good When asked what stated maybe arout LPN #5 stated, "I taides who were will think we only had aides was prn (as many aides are typishift, LPN #5 stated but usually there is of day Resident #4 her catheter bag, I the way her daugh earlier in the morn CNAs on the unit to p.m. to 11:00 p.m. works a different us as needed. When affected resident and things and I have asked if the resident asked if the reside #5 stated, "I think On 4/26/18 at 2:40 conducted with CN that worked on Reshift on 3/18/18). describe any even occurred on 3/18/1 resident's family more short staffed CNAs on the unit to describe the amount of the state of the same of the	e and asked the resident how PN #5 stated the resident stated because she was still in bed. time this occurred, LPN #5 and 12:00 p.m. or 1:00 p.m. think it was afternoon. The orking weren't the usual aides. If three aides and one of the needed)." When asked how bically on the unit during day and, "There is supposed to be six as five." When asked what time 14 prefers to be assisted with LPN #5 stated, "Assuming by after reacted, I'm guessing ing." LPN #5 stated one of the chat day usually works the 3:00 shift, one of the CNAs usually anit and one of the CNAs works a asked if the lack of staff care, LPN #5 stated, "Yes thave the time to spend with they have to speed through to do more patient care." When ents' care needs were met, LPN	F 7	725			

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	NG		COMPLETED	
		495299	B. WING		n <sub>4</sub>	C / <b>27/2018</b>
	PROVIDER OR SUPPLIER	EALTH AND REHAB	\	STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		72172010
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
F 725	CNA #14 stated on together to care for specific resident as the time she saw R resident was comin stated the resident see a catheter. Will Resident #41, CNA what time but it was member came to the Resident #41 again getting off at 3:00 p. On 4/26/18 at 3:22 was conducted with member) #3 (the forwas asked to descrot 3/18/18 regardin stated on 3/18/18, out. ASM #3 stated covered but with the was not covered. A staff did not assist manner. ASM #3 s and he were not m 3/18/18 and some of should have called asked how many CResident #41's unit usually scheduled to 0n 4/26/18 at 3:29 conducted with OS (the staffing coordidid not think she w stated LPN #10 was that day. OSM #12	ever cared for the resident.  3/18/18 the CNAs worked residents and no one took a signment. CNA#14 said by desident #41 on 3/18/18, the lang down the hall. CNA#14 was dressed and she did not men asked what time she saw a#14 stated she did not know as before the resident's family me facility and she saw around the time she was bom.  p.m., a telephone interview of ASM (administrative staff former administrator). ASM #3 ribe the events that took place of Resident #41. ASM #3 about a third of the shift called do the shifts had originally been at many call outs, the schedule ASM #3 stated he was sure Resident #41 in a timely stated the director of nursing and aware of the staffing on one in the nursing department the director of nursing. When the same usually scheduled for it, ASM #3 stated six CNAs are	F 7	25		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495299	B. WING				C 27/2018
	PROVIDER OR SUPPLIER			360	REET ADDRESS, CITY, STATE, ZIP CODE 0 MOUNTAIN ROAD EN ALLEN, VA 23060	1 04	2172010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1D PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTIES OF THE A	D BE	(X5) COMPLETION OATE
F 725	stated, "They should supervisor should come in and ask 1 over to work." When shift supervisor on day on 3/18/18, Os and stated there we working that night working. OSM #12 could have manda called CNAs to corof the night shift Clover, OSM #12 stated gone when LPN #'  On 4/26/18 at 3:56 conducted with CN that worked on Reshift on 3/18/18). Othere CNAs worked the two female CN residents and he coresidents and he coresidents and he coresidents and sasistransfers. When a Resident #41 on 3 not think so. When usually work on ReCNA #15 stated not CNAs. When asked the care on 3/18/18 believe it did but uncontrol. We try to asked how the lack care that day, CNA couldn't get to ever three people, we depretty sure care waresidents were provinced.	Id mandate. The night shift have started calling in CNAs to 1 to 7 CNAs if they could stay en asked who was the night the night of 3/17/18 into the SM #12 reviewed her records as no night shift supervisor but there were four nurses as the county there were four nurses as the county that the county there were four nurses as the county the county of those nurses are decorated any of those nurses are decorated and the county of the	F	725			

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495299	B. WING			C / <b>2</b> 7/ <b>2018</b>		
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		121/2010		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE
F 725		page 170 nk so. With three people that is	F 725					
	On 4/26/18 at 4:0 conducted with C how many CNAs #14 stated there i CNAs on each unshe had ever bee CNAs. CNA #14 CNAs affected re #14 stated, "It wa in a timely manne out of bed, daily of the nurses did he On 4/26/18 at 4:2 conducted with R stated she could loccurred on 3/18/requires staff ass catheter bag over comfortably get dever had, a delay catheter bag chai "That happens. I When asked if the her catheter bag chai "That happens. I When asked if the her catheter bag is so much for evagainst any of the them to go around the th	2 p.m., another interview was NA #14. CNA #14 was asked are usually on each unit. CNA s usually between four and five alt and 3/18/18 was the first time in on a unit with only two other was asked how the lack of sident care on 3/18/18. CNA is hard for us to get to everyone early care." CNA #14 stated one of the panswer call lights.  3 p.m., an interview was esident #41. Resident #41 not specifically remember what #18. Resident #41 stated she istance with changing her into a leg bag so she can ressed. When asked if she has in assistance with getting her inged over, Resident #41 stated, Don't ask me what time or day." It delay in assistance with having changed over impacts her ability in the first of the room for daily in the first one is a delay in the first one. There is a delay in the first one is a delay in the first one is a delay in the first one. There is a delay in the first one	American Company					

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

Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 171 of 211

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MAY 17 2018
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· ·	TIPLE CONSTRUCTION  NG	COV	(X3) DATE SURVEY COMPLETED	
		495299	B. WING		04/27/2018	
	PROVIDER OR SUPPLIER	HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 725	stated, "If I keep pand keep hollering asked how this mastated, "It makes it that nobody wants."  On 4/26/18 at 4:43 was conducted winurse) #10 (the daLPN #10 was asked understaffed on 3), could not remembe stated, "We have often." LPN #10 wastaff call out for the "When I get the call have enough stated the next shift. I go and I go out on the who does this on the night shift sup what happens if the LPN #10 stated, "be able to mandate has been a time that."  On 4/26/18 at 5:33 administrator) and	r twice. The resident further bushing the button (call light) then they get it done." When takes her feel, Resident #41 me wonder if I am just someone	F7			
	ASM #2 confirmed aware of the staffi have come in to the been aware. ASM from the night shift and work during the #2 stated since 3/	d she was not called and made ng issue on 3/18/18 and would he facility to help if she had 1/2 also confirmed no CNAs twere mandated to stay over the day shift on 3/18/18. ASM 18/18, CNAs have to call the of nursing when they call out				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	IPLE CONSTRUCTION NG	(X	3) DATE SURVEY COMPLETED		
		495299	B. WING _			C 04/27/2018		
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	ODE	04/2//2010		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO			PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	OULD BE COMPLETION		
F 725	and nurses have to ASM #2 stated a m provided to staff affithe time clock, on the and remains on the and remains on the The memo referent multiple locations in clock during the sure 3/21/18 and docum (sic): All Employees before your shift. A out to (name of AS CNA's are required assistant director of All Employees that of the shift will be a consistent of the shift will be a co	call her when they call out. Itemo and an in-service was iter 3/18/18, and is posted at the staffing coordinator's door in nursing supervisor clipboard. Itemo and an in-service was iter 3/18/18, and is posted at the staffing coordinator's door in nursing supervisor clipboard. Itemo was observed in including the units and time rvey. The memo was dated itented, "Effective immediatley is are required to call 2 hours in all Nurses are required to call in to call out to (name of if nursing) 1st and the job 2nd. Itented the facility did not have a interpolation was presented prior to exit. Itented itented was presented prior to exit. Itented was presented was presented prior to exit. Itented was presented prior to exit. Itented was presented was presented and the proof of the prior was presented was presented was presented and the proof of the prior was presented was presented and the proof of the prior was presented and the proof of the proof of the prior was presented and the proof of the proof of the prior was presented and the proof of the prior was presented and the proof of the proof of the proof of the proof of t	F 72	25				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		SURVEY PLETED
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		495299	B. WING			04/2	27/2018
	(EACH DEFICIENC)	EALTH AND REHAB  TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	36 <b>G</b>	REET ADDRESS, CITY, STATE, ZIP CODE  500 MOUNTAIN ROAD  LEN ALLEN, VA 23060  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROGRAMMENT OF THE APPROPROPROGRAMMENT OF THE APPROPROPROGRAMMENT OF THE APPROPROPROFILE OF THE APPROPROPROGRAMMENT OF THE APPROPROPROFILE OF THE APPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROFILE OF THE APPROPROPROFILE OF THE APPROPROPROPROFILE OF THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE İ	(X5) COMPLETION DATE
<u> </u>					DEFICIENCY)		
F 730	to drain and collect information was ob https://medlineplus	ter is a tube placed in the body urine from the bladder." This tained from the website: gov/ency/article/003981.htm Review-12 hr/yr In-Service		725	F730 1. Performance reviews will be		5/29/18
	The facility must co of every nurse aide months, and must reducation based or reviews. In-service requirements of §4 This REQUIREMED by: Based on staff intereview, it was deterfailed to complete a CNAs (certified nur every 12 months.  The facility staff fail review within 12 moat the facility since The findings including Review of a list of crevealed 48 CNAs facility since before  On 4/26/18 at 5:32 staff member) #1 (In the director of nurse	rview and facility document mined that the facility staff a performance review for sing assistants) at least once ed to complete a performance onths for 48 CNAs employed before 4/24/17.  e: currently employed CNAs had been employed at the			completed on CNAs employed at facility since before 4/24/17.  2. No other concern was identified 3. Human Resources staff and the Director of Nursing will be reeducated on ensuring performance reviews are conducted on CNAs least once every 12 months.  4. An audit will be conducted to ensure performance reviews are conducted on CNAs at least once every 12 months weekly for four weeks then monthly for three months. Results of the audits we reviewed at the monthly QAPI meeting for three months to encompliance.	ed. e nce at e r	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495299	B. WING_		C 04/27/2018	
	PROVIDER OR SUPPLIER  TH ADAM CRUMP HI	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 745 SS=D	On 4/27/18 at 7:45 facility policy regard and stated the polic November 28. When had been complete don't think so." AS evaluations had not and ASM #2 was moncern.  The facility docume Evaluations" docume evaluation provides supervisor and the employee's overall developmental area employee's job des between employee managers is very in The facility docume documented, "The competencies will be annually by License or Certified Nursing No further information."	a.m., ASM #1 provided the ding performance evaluations by went into effect on en asked if the evaluations and for CNAs, ASM #1 stated, "I M #2 confirmed the the been completed. ASM #1 stated and aware this was a sent titled, "Performance and titled, "Performance and the employee to discuss the work performance and as as it relates to the coription. Communication as and supervisors or important"  The ent titled, "COMPETENCIES" attachments for Core one completed upon hire and and one of the completed upon hire and the completed upon hire a	F 7:		5/29/18	
	maintain the highes and psychosocial w This REQUIREMEN by:	ility must provide ocial services to attain or st practicable physical, mental vell-being of each resident.  NT is not met as evidenced interview,		resident #110 request for hea aids and provided documenta  2. Each residents has the pote being affected who has reque assistance with hearing device	ring tion. ential of ested	

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495299	B. WING				27/2018
	PROVIDER OR SUPPLIEF	HEALTH AND REHAB		3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 0417	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY)		DBE	(X5) COMPLETION DATE
F 745	review, it was dete provide medically- of 42 residents in #110.  The facility staff fa social services wa #110's request for The findings inclu  Resident #110 wa 2/17/17 and readr diagnoses that incend stage renal dialysis, atrial fibri major depressive recent MDS (mini a quarterly assess (assessment refer Resident #110 wa cognitive function on the BIMS (Brie exam. Section B documented Residenting.  On 4/24/18 at 3:0 conducted with Rehad some concer questions were be to ask "what?" on	review and clinical record ermined the facility staff failed to related social services for one the survey sample, Resident as following up on Resident hearing aides.  de:  s admitted to the facility on mitted on 4/16/18 with cluded but were not limited to isease with dependence on llation, high blood pressure, and disorder. Resident #110's most mum data set assessment) was sment with and ARD rence date) of 1/24/18. Is coded as being intact in scoring 15 out of possible 15 of Interview for Mental Status) (Hearing, Speech and Vision) dent #110 as having adequate  3 p.m., an interview was esident #110. Resident #110 ns regarding her hearing. While eing asked, Resident #110 had several occasions because she		745		nsure nen nce in aring s ewed	
	that the social wo hearing aides. Re hearing test done	s writer. Resident #110 stated rker was aware of her need for sident #110 stated, "I had a and no one followed up on it. and Throat) stated that I failed					

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

Event ID: TQ6711

Facility ID: VA0083

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MAY 17 2018

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			04	C /27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		3600 MC	ADDRESS, CITY, STATE, ZIP CODE DUNTAIN ROAD ALLEN, VA 23060		12112010
(X4) ID PREFIX TAG			ID PREFI TAG	_	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE	
F <b>7</b> 45	hearing test, Residence ago. It may have be stated that the sociaround the same to Review of Residence plan dated 4/28/17 following: "At risk (related to) Impaired Resident #110) will known daily thru nown	age 176 sked how long ago she had her lent #110 stated, "Six months een longer." Resident #110 ial worker was made aware ime of the hearing test.  at #110's communication care t, documented in part, the for impaired communication r/t ed hearing. Goal: (Name of I continue to make her needs ext review. Interventions: as needed and repeat as in eye contact if possible, etting, speak at appropriate e patient hearing, use simple nication to promote	F 7	745			
	revealed no evider Further review of the evidence notes from Resident #110's here On 4/26/18 at 11:4 conducted with Osthe social worker. of Resident #110's OSM #10 stated the stated, "She (Resident Hearing test done." OSM #10 when the hearing she still had to get another appointment.	th #110's clinical record face of her hearing test.  the clinical record failed to some the social worker regarding earing aides.  1 a.m., an interview was some some some some some some some som					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY CDMPLETED	
		495299	B. WING		04	C <b>//27/20</b> 18
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZII 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION)				ON SHOULD BE HE APPRDPRIATE	(X5) COMPLETION OATE
F 745	been trying to get in [Virginia Commonw OSM #10 could not #110 had initially re it had been some ti had no evidence or trying to get Reside VCU audiologist.  On 4/26/18 at 5:09 staff member) #1 the DON (Director of the above conce The facility policy ti Guidance," docume "Vision and hearing residents receive p (sic) devices to ma abilities, the facility resident- in making arranging for transport of a practitioner special special or hearing assistive responsibility is to a representatives in I available resources program payment, offering items and free to the communication of the communica	realth University]) audiologist. remember when Resident quested hearing aides but that me. OSM #10 stated that she documentation that she was ent #110 and appointment with p.m., ASM (administrative ne administrator, and ASM #2, of Nursing) were made aware	F 7			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED	
		495299	B. WING				C <b>/2</b> 7 <b>/2018</b>
	PROVIDER OR SUPPLIER	EALTH AND REHAB		36	FREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757 SS=E	CFR(s): 483.45(d)  §483.45(d) Unneces Each resident's dru unnecessary drugs drug when used-  §483.45(d)(1) In extended the second secon	essary Drugs-General.  ug regimen must be free from  s. An unnecessary drug is any  excessive dose (including rapy); or  excessive duration; or  nout adequate monitoring; or  nout adequate indications for its  ne presence of adverse ich indicate the dose should be tinued; or  combinations of the reasons hs (d)(1) through (5) of this  ENT is not met as evidenced  erview, facility document review review, it was determined that led to ensure a resident was sary medication for one of 42 livey sample, Resident #20.  illed to hold Resident #20's rine (1) per physician's order on pril 2018.		757	1. Resident #20 physician was notified of administering midodri when it should have been held perphysician's orders.  2. A review of residents on Midodrine will be conducted to ensure it is given as ordered by the physician.  3. Licensed staff will be re-education administering Midodrine as ordered by the physician.  4. Audits of residents who have Midodrine orders will be conducted weekly for four weeks then montifor three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance.	er he ted ted thly	5/29/18
	, Resident #20 was	admitted to the facility on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B, WING _			C / <b>27/2018</b>	
	PROVIDER OR SUPPLIER ETH A <b>DAM CRUMP</b> H			STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		727/2010	
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION OATE	
F 757	5/20/17. Resident were not limited to pressure), urinary disorder (2). Resident (2). Resident an ARD (assessme coded the resident Review of Resident a physician's order milligrams one time medication for a sythan 100 or a diast than 90. Review of MAR (medication at the resident was a following dates (as and nurses' initials systolic blood presidastolic blood president #20's cor 9/12/18 - blood president #20's cor 9/12/17 documente status related to: Hordered by physicial effectiveness"  On 4/26/18 at 10:2 conducted with LP (Resident #20's un asked what is meanurses' initials on timeans it was done	#20's diagnoses included but hypotension (low blood tract infection and bipolar dent #20's most recent MDS), a quarterly assessment with ent reference date) of 1/24/18, as being cognitively intact.  It #20's clinical record revealed dated 2/6/18 for Midodrine 2.5 a day, and to hold the estolic blood pressure greater olic blood pressure greater f Resident #20's April 2018 administration record) revealed dministered Midodrine on the evidenced by a check mark although the resident's sure was greater than 100 or sure was greater than 90: sure 122/55 essure 124/74 essure 106/68	F 75	7			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	CON	COMPLETED	
		495299	B. WING	i		/27/2018	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	IEALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP ( 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION OATE	
F 757	blood pressure is blood pressure is stated, "It should be the MD (medical of find out the next sinformed Resident as administered of made aware of Reson the above date medication should dates. LPN #9 states been held and the contacted. LPN # administered the may have contacted give the medication to	ne if the resident's systolic greater than 100 or diastolic greater than 90. LPN #9 be held and you should contact loctor) because you need to tep for orders." LPN #9 was at #20's Midodrine was initialed in the above dates and also esident #20's blood pressures is. LPN #9 was asked if the have been held on those ated the medication should have doctor should have been 9 stated the nurses who Midodrine on those above dates and the doctor and he said to in but confirmed there was no evidence this.		757			
	to Resident #20 of 4/22/18 were not a 4/22/18 were not a On 4/26/18 at 4:4: was conducted with initialed administra Midodrine on 4/2/should be docume medication is held the exact number, legend. I don't kn There is a little both and we write a not order for Midodrin LPN #10 was ask resident's systolic 100 or diastolic blue LPN #10 stated, "	nitialed Midodrine administration of 4/1/18, 4/10/18, 4/14/18 and available for interview.  By p.m., a telephone interview th LPN #10 (the nurse who ation of Resident #20's 18). LPN #10 was asked what ented on the MAR if a 1. LPN #10 stated, "I don't know. There is a number on the ow if it's a three or a seven. It is a three or a seven. It is a three or a seven was read to LPN #10 and the was read to LPN #10 and the what should be done if the blood pressure is greater than bood pressure is greater than 90 you will hold it." LPN #10 was the dever holding Resident #20's					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILE		COMPLETED				
		495299	B. WING	i			2 <b>7/2018</b>	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP I	HEALTH AND REHAB	1	36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	Ē		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 757	Midodrine. LPN # the medication on asked if she recal April 2018, LPN # consistently. I dor (name of Residen On 4/26/18 at 5:33 staff member) #1 (the director of nu above concern.  The facility docum administration documedication hasn't contraindications of the contraindications of the contraindications of the contraindications of the contraindications of the contraindications of the contraindications of the contraindications of the contraindications of the contraindications of the contraindications of the contraindications of the contraindications of the contraindication of	to stated she recalled holding several occasions. When led holding the medication in 10 stated, "I don't have her n't know the last time I had it #20) so I can't say for certain."  2 p.m., ASM (administrative (the administrator) and ASM #2 rsing) were made aware of the ment regarding medication cumented, "Verify that the expired and that no		75 <b>7</b>				

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	i ` ′	IG	COMPLETED	
		495299	B. WING _		04/2	27/2018
	PROVIDER OR SUPPLIER  ETH ADAM CRUMP HI	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CDDE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
F 761	medlineplus-bundle =2.1717494.67196.1477942321 Label/Store Drugs : CFR(s): 483.45(g)( §483.45(g) Labeline Drugs and biological labeled in accordar professional principal appropriate access instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In acceptant laws, the fabiologicals in locket temperature contropersonnel to have a §483.45(h)(2) The locked, permanently storage of controlled the Comprehensive Control Act of 1976 abuse, except whe package drug districtly detected This REQUIREMED by: Based on observations document review, if facility staff failed to	emedlineplus&v%3Asources= e&query=bipolar+disorder&_ga 5706.1525089773-139120270.  and Biologicals h)(1)(2)  g of Drugs and Biologicals els used in the facility must be nce with currently accepted bles, and include the ory and cautionary e expiration date when  e of Drugs and Biologicals ecordance with State and acility must store all drugs and d compartments under proper els, and permit only authorized eccess to the keys.  facility must provide separately y affixed compartments for ed drugs listed in Schedule II of the Drug Abuse Prevention and the facility uses single unit elbution systems in which the eninimal and a missing dose can		F761	d swere as will ations here ons when o d with d ded onthly the	5/29/18

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

Event ID:TQ6711

Facility ID: VA0083

If continuation sheet Page 183 of 211



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	COMP		
		495299	B. WING			04/2	; 27/2018
	PROVIDER OR SUPPLIER			30	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	:	
(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 SHOUL) CROSS-REFERENCED TO THE APPROFIDERICLENCY)	D BE	(X5) COMPLETION DATE
F <b>7</b> 61	storage rooms, Wi  1. The facility staff an open vial of PPI (1)) solution and an intensol, and failed suppositories in the room.  2. The facility staff medication, Loraze use.  The findings included.  1. The facility staff an open vial of PP bottle of lorazepand discard expired dialed wing C medication.  On 4/25/18 at 3:29 C medication storated by the containing the vial instructions docum 30 days should be oxidation and degree potency"  One open bottle of full) with no open box containing the vial instructions.	failed to label an open date on D (purified protein derivative n open bottle of lorazepam to discard expired diazepam e Wing C medication storage failed to ensure an expired epam (1) was not available for the contract of t		761			

	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	] ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING				C /27/2018	
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060	_	72772010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIOER'S PLAN OF CORRECTIVE ACTION SHOUNDS OF THE APPRICED TO THE APPRICED T	JLD BE	(X5) COMPLETION OATE	
F 761	documented, "Dischandwritten expirated An interview was commediately after the found. LPN #12 was when a medication "Write down the data As soon as you pick medication was operasked where the data stated the date shownedication lid or paragraph open date should be make sure it has be and to make sure at certain medications #12 was asked where the was days. LPN #12 corropen and not labeled #12 was shown the asked if the medicate. LPN #12 stated date. LPN #12 stated date on it." When I diazepam supposite expiration date was On 4/26/18 at 5:32 staff member) #1 (the director of nursabove concern.  The facility document MEDICATION" document of the director of nursabove concern.	ard after 12/27/17" and a ion date of 12/27/17.  Inducted with LPN #12 he above medications were as asked what should be done is opened. LPN #12 stated, the you open the medication. It is the induction when it is a point induction in the induct	F	761				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION	СОМ	E SURVEY PLETED
		495299	B. WING	i		04/2	C 27/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICLENCY)	DBE	(X5) COMPLETION DATE
F 761	No further information (1) Aplisol PPD solid of tuberculosis (a luwas obtained from https://dailymed.nlmm?setid=1e91a67c34  (2) Lorazepam inte This information was https://medlineplustml  (3) Diazepam is use spasms and seizure obtained from the whittps://medlineplustml  2. The facility staff medication, Loraze use in the medication A-wing.  On 04/25/18 at 3:20 storage room locate with LPN (licensed inspection of the remedication storage 30-milliliter bottle or	ion was presented prior to exit.  ution is used in the diagnosis ung disease). This information the website: n.nih.gov/dailymed/drugInfo.cf -1694-4523-9548-58f7a88711  nsol is used to relieve anxiety. as obtained from the website: .gov/druginfo/meds/a682053.h  ed to relieve anxiety, muscle es. This information was		761			
		scription" of Lorazepam t, 'Discard opened bottle after					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD		COMPLETED			
		495299	B. WING		····	1	27/ <b>201</b> 8
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H			360	EET ADDRESS, CITY, STATE, ZIP CODE O MOUNTAIN ROAD EN ALLEN, VA 23060		
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F 761	Continued From particles of the lorazepam sto A-wing medication available for use and discard date.  On 04/25/18 at 3:3 conducted with LP lorazepam was expended to the lorazepam was expe	age 186  age 186  ared the refrigerator in the storage room was observed and was 26 days past the  0 a.m., an interview was N # 2. When asked if the pired, LPN # 2 stated, "Yes. It discarded."  32 a.m., an interview was M (administrative staff ctor of nursing. When asked to ss for ensuring expired of available for use ASM # 2 audits of the medication carts oms are done at least monthly. Its are found they are disposed ack to pharmacy or destroyed. Orazepam stored the A-wing medication storage ked."  Droximately 11:30 a.m. ASM off member) # 1, the ASM # 2, director of nursing		761			
	Reference: (1) Used to relieve class of medication works by slowing a relaxation. This in the website:	anxiety. Lorazepam is in a as called benzodiazepines. It activity in the brain to allow for formation was obtained from s.gov/druginfo/meds/a682053.h		1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3			

		IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COMPLETED	
		495299	B. WING				C / <b>27/2018</b>
	(EACH DEFICIENC)	EALTH AND REHAB  ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	36 <b>G</b>	TREET ADDRESS, CITY, STATE, ZIP CODE  500 MOUNTAIN ROAD  LEN ALLEN, VA 23060  PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N O BE	(X5) COMPLETION DATE
	CFR(s): 483.60(i)(1) §483.60(i) Food sa The facility must - §483.60(i)(1) - Proc approved or considerate or local author (i) This may include from local producer and local laws or re (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for serve food in according serve food in according the serve food in according the serve food this REQUIREMED by:  Based on observate determined the fact a sanitary manner unit B.  The facility staff fait bread with their bar the Unit B dining room was CNA (certified nurs)	fety requirements.  cure food from sources lered satisfactory by federal, rities.  e food items obtained directly rs, subject to applicable State egulations.  oes not prohibit or prevent groduce grown in facility compliance with applicable bod-handling practices.  does not preclude residents ods not preclude residents ods not procured by the facility.  Te, prepare, distribute and redance with professional service safety.  NT is not met as evidenced tion and staff interview, it was ility staff failed to serve food in in one of three dining rooms, led touched the residents' re hands while serving food in form.		312	1. Staff will not touch bread with their bare hands. 2. Each resident has the potential be affected. 3. Nursing staff will be re-education not touch bread or any food it with their bare hands. 4. An audit will be conducted to ensure staff is not touching bread food items with their bare hands weekly for four weeks then mone for three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.	I to ed tem d or thly	5/29/18

PRINTED: 05/08/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
•		495299	B. WING			04/2	27/2018
	PROVIDER OR SUPPLIE T <b>H ADAM CRUMP</b> I	HEALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION OATE
F 812	and served it to a sanitize her hands bread to the reside another CNA (CN bread to a resider #13 did not sanitiz serving the bread On 4/25/18 at 2:5 conducted with C observation. CNA off the cart, put the drinks." When as handling the bread would take the brought top of the bag. Wit out of the bag. Wit out of the bag, Cuse her hands. V bare hands, CNA stated that she with while serving. CNA bag open." When bare hands was signot sanitary."	he then pulled out cornbread resident. CNA #14 did not a before or after serving the ent. On 4/24/18 at 1:39 p.m., A #13), was observed serving at with her bare hands. CNA we her hands before or after to the resident.  9 p.m., an interview was NA #13, regarding the above A #13 stated, "We take the tray e tray on the table, take lids off ked how staff should be d, CNA #13 stated that she ead out of the bag and lay it on hen asked how she would take CNA #13 stated that she would when asked if she would use her #13 stated, "Yes." CNA #13 as not supposed to wear gloves NA #13 stated, "I could turn the asked if serving bread with sanitary, CNA #13 stated, "No. It		312			
	the DON (Directo of the above cond		3	-			
	exit.	ation was presented prior to			F842		5/29/18
F 842 SS=D	CFR(s): 483.20(f)	s - Identifiable Information (5), 483.70(i)(1)-(5)	F	842	1. Resident #319 and Resident #40 no longer reside at the facility.	68	-7-3/10
		sident-identifiable information. ot release information that is	<b>,</b>	•	Resident #95 care plan was review for accuracy.	ved	

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

Event ID:TQ6711

Facility ID: VA0083

If continuation sheet Page 189 of 211

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B. WING				C <b>27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	·		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>,</b>	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 842	resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use of except to the extent to do so.  §483.70(i) Medical §483.70(i)(1) In acc professional standar must maintain med that are- (i) Complete; (ii) Accurately docu (iii) Readily access (iv) Systematically of systematically of systematically of systematically of linformation cont regardless of the for records, except wh (i) To the individual representative whe (ii) Required by Lav (iii) For treatment, poperations, as perr with 45 CFR 164 5i (iv) For public healt neglect, or domesti activities, judicial a law enforcement popurposes, research medical examiners a serious threat to by and in complian	e to the public. release information that is e to an agent only in contract under which the agent or disclose the information t the facility itself is permitted  records. cordance with accepted ards and practices, the facility lical records on each resident  mented; ible; and organized  acility must keep confidential ained in the resident's records, orm or storage method of the en release is- , or their resident are permitted by applicable law; w; payment, or health care mitted by and in compliance		42	<ol> <li>Any resident has the potential be affected.</li> <li>Licensed Nursing and social ser staff will be re-educated on ensur documentation is completed in the medical record to include but not limited to informing residents of results of an investigation of abuse monitoring residents for changes health conditions and maintainin accurate care plan.</li> <li>An audit will be conducted to ensure documentation is complete in the medical record to include not limited to informing resident the results of an investigation of abuse, monitoring residents for changes in health conditions and maintaining an accurate care plat weekly for four weeks then monfor three months. Results of the audits will be reviewed at the monthly QAPI meeting for three months to ensure compliance.</li> </ol>	rvice ring ne t the se, in g an ted but ts of	

			COMPLETED		
		495299	B. WING		C 04/27/2018
	A. BUILDING  B. WING  NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEALTH AND REHAB  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE  3600 MOUNTAIN ROAD  GLEN ALLEN, VA 23060  PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE A PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO				
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF1		N SHOULD BE COMPLETO E APPROPRIATE DATE
F 842	record information unauthorized use.  §483.70(i)(4) Media for- (i) The period of tin (ii) Five years from there is no requirer (iii) For a minor, 3 y legal age under State §483.70(i)(5) The results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of a state of the results of	against loss, destruction, or cal records must be retained the required by State law; or the date of discharge when ment in State law; or years after a resident reaches ate law.  Inedical record must containation to identify the resident; resident's assessments; resident's and officer and officer and officer licensed ress notes; and illicology and other diagnostic required under §483.50.  Note in the sevidenced review of a complaint investigation, it at the facility staff failed to the and accurate clinical record dents in the survey sample, a 468 and # 95.  If alled to document Resident # of the results of an		342	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495299	B. WING		· · · · · · · · · · · · · · · · · · ·	04/2	27/2018
	PROVIDER OR SUPPLIE	<u> </u>		31	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	1 04/2	27/2018
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 842	resident for any commercial states of the findings inclusion. The findings inclusion of the findings inclusion of the findings inclusion of the findings inclusion of the findings inclusion of the finding inclusion of the	failed to write an accurate care #95.  de:  ff failed to complete a facility er a reported allegation of that # 319.  as admitted to the facility on gnoses that included but were onic obstructive pulmonary entia (2), gastroesophageal, hypertension (4), atrial scular dystrophy (6), nagia (7), and post mastectomy	F	842			
	assessment with date) of 09/18/17, scoring a 15 on the status (BIMS) of a cognitively intact in Resident # 319 where assistance of one daily living.  The statement gives by OSM (other statement (Resident # 309/10) in the patient (Resident in the statement of th	ata set), an admission an ARD (assessment reference coded Resident # 319 as the brief interview for mental a score of 0 - 15, 15- being for making daily decisions. as coded as requiring extensive staff member for activities of the ven by Resident # 319 and taken aff member) # 10, the social 19/2017 documented, "Last sident # 319) reported to SS that she was having trouble used her call bell to ask for help. In and was pleasant and helped the bed. Patient stated she					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		405200	B. WING	-		C		
NAME OF I	PROVIDER OR SUPPLIER	495299	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	04/2	7/2018	
	TH ADAM CRUMP HI	EALTH AND REHAB		36	600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
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F 842	and helped again became in and made Patient stated that nurse came back in 5 (five) [one of ther with her. Patient stathrough [sic] her in the patient they we attack [sic] her. Or station she felt scarthey were giving he comfortable chair beshe put herself on Patient did stated to victim of abuse in the Patient did state to that she would sue did and the nurses.  Review of the facilit Resident # 319 and record failed to evid was informed of the On 04/26/18 at 3:0 was conducted with member) # 3, the fasked if Resident # findings of the inventage ASM # 3 stated, "Sfindings following the February (2018) are three weeks of each on the phone about his conversations we documented ASM # 3 stated  n and this time nurse came in ut the third time the nurse a noise and walked out. the nurse was mad. The nurse was mad. The nurse was also ated they grabbed her up and the wheelchair. According to re not gentle with her and nuce she was up at the nurse's red because of the nurse looks er. She asked for a more out nobody would help her so the floor to get comfortable. SS that she has been a he past (outside of this facility). SS that she told the nurses them because of what they	F	342					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l · · ·	TIPLE CONSTRUCTION ING	CON	(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C / <b>27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		12112010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG		I SHOULD BE	(X5) COMPLETION DATE
F 842	with ASM # 2, direct about the document conversations with results of the invest don't have anything.  On 04/27/18 at app (administrative staff administrator and Awere made aware of the No further information of the was obtained from the was	tor of nursing. When asked tation of ASM # 3's Resident # 319 regarding the igation ASM # 2 stated, "We documented."  roximately 11:30 a.m. ASM member) # 1, the SM # 2, director of nursing of the findings.  on was provided prior to exit.  elkes it difficult to breathe that as of breath). This information the website:  .gov/medlineplus/copd.html.  unction that occurs with certain memory, thinking, language, evior. This information was rebsite: gov/ency/article/000739.htm.  ets to leak back, or reflux, into irritate it. This information the website: .gov/medlineplus/gerd.html.	F 8	42		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495299	B. WING				27/2018
	PROVIDER OR SUPPLIER ETH ADAM CRUMP H	HEALTH AND REHAB		360	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD .EN ALLEN, VA 23060	, ,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5] COMPLETION DATE
F 842	2. The facility staff with Resident #46 and that facility staresident for any characteristics and that included but with dementia, muscle blood pressure, and #468's most recert assessment was a ARD (assessment Resident #468 was impaired in cognition BIMS (Brief Intervional Conducted with Resident #468 was impaired in cognition BIMS (Brief Intervional Conducted with Resident Head allegation that her the night before singled allegation that her mother in her mouth. The daughter state to go out that night stated that she was that her mother dican't say with cert responsible for her Review of Resider revealed that she on 3/16/18. The findocumented, "Resident Resider	failed to document a concern 8's health condition on 3/15/18 aff were going to monitor the nanges.  Is admitted to the facility on nitted on 5/1/12 with diagnoses were not limited to unspecified weakness, anorexia, high and atrial fibrillation. Resident at MDS (minimum data set) a quarterly assessment with an a reference date) of 2/7/18. Is coded as being severely we function scoring 99 on the liew for Mental Status) exam.  Is p.m., an interview was esident #468's responsible or. The daughter had made an mother was not acting herself are left for the hospital on the properties of the hospital on the left for the hospital on the series of the wanted her mother to the hospital, but the nurses as fine. The daughter stated and in the hospital on 3/16/18 but ainty that the facility was redeath.  In #468's clinical record was transferred to the hospital ollowing nursing note was sident up for breakfast in jerri		342			
	from CNA (certifie	5 % (percent) with assistance d nursing assistant) (drank all consumed medication per					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED C		
		495299	B. WING		04	/27/2018	
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIF 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION OATE	
F 842	nurse on duty without (oriented) the (sic) questions but incomported by incomported by nurse and responding to verb (nurse practitioner) resident and gave (emergency room) opened and will fol no response, pupil however resident is (sic) 02 (oxygen) s (minute) via non rein upright position, grasping writers find but would not grascap (capillary) refill dry to touch, WNL baseline skin tone Medical Techniciar (minutes) of being there."  Review of Resident revealed that she if 3/16/18 due to unsufficient and she if the condition of the clinic evidence and in the component of the clinic evidence and its condition of the clinic evidence and its condi	but any difficulties. A (alert) & O confusion able to answer herent with response (per Resident up at nurse station ormal activities. Resident di aide @145 pm (sic) of not al or tactile stimuli (sic) NP on floor and assessed verbal to send to ER (Resident has her eyes low persons with her eyes but reactive to light, not talking smaking a snoring like noise) tarted at 2 I (liters)/min breather, HOB (Head of bed) Resident moving hands and agers when hand was rubbed ps on command), + (positive) to hands (sic) skin warm and (within normal limits) of color. EMT (emergency n) arrived within 3 mins called and took over from the describing the events of daughter was worried about her and the clinical record that did a mouth full of food on when she had been		842			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION  NG	COV	(X3) DATE SURVEY COMPLETED	
	495299	B. WING_			C / <b>27/2018</b>	
NAME OF PROVIDER OR SUPPLED			STREET ADDRESS, CITY, STATE, ZIP CO 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		21,2010	
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SH <b>O</b> ULD BE	(X5) COMPLETION OATE	
conducted with #4 stated that seems the resident out asked what had she could not relooked like prio could recall that Resident #468 morning (3/16/2 resident appear baseline. LPN #4 at the nurses's #4 stated that seems in the dining row with some cuein assistant). LPN coughing or has stated that when hospital, there wairway. LPN #4 mouth was clear out to the hospital resident did not had arrived when out on the unit. #468 having isset that morning. We daughter's conducted that she not sure if it was recall what had 3-11 shift, the def #4) that she was condition. LPN room and notice.	t:13 p.m., an interview was LPN #4, the unit manager. LPN he was the nurse that had sent to the hospital on 3/16/18. When d happened, LPN #4 stated that emember what the resident had to ther being sent out. LPN #4 to the she remembered seeing up at the nurses' station that l8). LPN #4 stated that the red to look normal and within her f4 stated that Resident #468 was tation right after breakfast. LPN he had also seen Resident #468 om for breakfast feeding herself ing from a CNA (certified nursing f7 did not recall the resident ving difficulties eating. LPN #4 in the resident was sent out to the was no obvious blockage of her stated that Resident #468's ir on 4/16/18 when she was sent tal. LPN #4 stated that the eat lunch that day because EMT en lunch trays were being passed LPN #4 did not recall Resident sues swallowing her medications When asked if she could recall the tern about Resident #468's ition the night before, LPN #4 did. LPN #4 stated that she was s exactly the night before but did happened. LPN #4 stated that on aughter had told the nurse (LPN s concerned about her mother's #4 went down to the resident's ed that she was holding food in LPN #4 wiped out her mouth and	F 84	42			

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

Event ID: TQ6711

Facility ID: VA0083

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1,,	TIPLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			C 04/27	//2018
	PROVIDER OR SUPPLIER ETH A <b>DAM CRUMP HI</b>	EALTH AND REHAB		STREET ADDRESS, CITY, STATE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060	E, ZIP CODE	0-7/21	72010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD E TO THE APPROPRI	_ ,	(X5) COMPLETION OATE
F 842	then stated that the to her normal self (stated that at first the mom to be sent out that once the reside self, the daughter with monitoring her mot Resident #468's vit there was no other be sent out to the daughter that she with claim that she will be claimed out her modid not document the clinical record.  Review of the invest administration on 3 daughter had been condition on 3/15/1 Resident #468 as stollowing witness st LPN #4 on 3/19/18 of my office when I talking to (Name of state well there's (Nin my direction. (Nawalking towards with us to the room Resident's nurse) at that Res. (resident) appeared normal. It to note that Res was side of her mouth. I and was able to cled (Name of 3-11 CNA)	ge 197 Irresident appeared to be back alert and oriented x2). LPN #4 Irresident appeared to her back alert and oriented x2). LPN #4 Irresident was back to her normal was okay with the facility her. LPN #4 stated that al signs were normal and that indication that she needed to hospital. LPN #4 then told the would notify her if anything recalled the daughter feeding inkie right after LPN #4 Irresident and should have in stigations conducted by /19/18 revealed that the concerned with the resident's 8, 3-11 shift; the night before ent out to the hospital. The atement was documented by 10 moticed (Name of daughter) nurse) and heard (nurse) and heard (nurse) and heard (nurse) and heard (nurse) and heard (Name of get oget nurse on duty to come of the west to room and noticed was in her jerri chair and nowever (sic) writer was able as hoarding food to the right writer used a toothette (sic) and residents mouth out. CNA and RP (responsible party) at resident does this often.		342			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		495299	B. WING	i		1 .	27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		36	REET ADDRESS, CITY, STATE, ZIP CODE 00 MOUNTAIN ROAD LEN ALLEN, VA 23060		2172010
(X4) ID PREFIX <b>T</b> AG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 842	twinkie which she stirst approached by wanted to send Refood was cleaned she looked normal wanted her sent ou No she appears to she has any changaway."	e after (sic) RP gave resident a started eating. When writer was y (name of daughter), she is to ER however (sic) after out of her mouth, RP stated to me and writer asked if she at. (Name of daughter) stated be fine, just monitor her and if the please let me know right roxiamtely 1:00 p.m., ASM	F	342			
	administrator and A Nursing) were mad concerns. No furth prior to exit. 3. The facility staff plan for Resident # Resident #95 was 2/12/18 with diagnalimited to: multiple	ASM #2, the DON (Director of the aware of the above er information was presented failed to write an accurate care #95.  admitted to the facility on oses that included but were not sclerosis (1), anemia,					
	significant change (assessment referresident as having (brief interview for resident was cognidecisions. The resident on staff Review of the resident advantage (temperature) Intermedication as order	IDS (minimum data set), a assessment, with an ARD ence date) of 3/8/18 coded the a 14 out of 15 on the BIMS mental status) indicating the tively intact to make daily ident was coded as being for all activities of daily living.  Ident's care plan initiated on ed, "Focus. Elevated temporentions. Administer Pain ered. Coordinate with (responsible party) to identify					

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION  ING	COM	TE SURVEY MPLETED
		495299	B. WING	· .		C / <b>27/2018</b>
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HI	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		72172010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 842	An interview was comp.m. with LPN #4, nurse who initiated why residents had on "Basically they have of what they have a sked who used the "The nurses. Basic When asked if staff care plan, LPN #4 made aware of the asked if it was important to distribute the sked in the sked if it was important to distribute the sked in the sked	ems/activities that could serve		342		
	member) #1, the addirector of nursing of findings.  No further informat Basic Nursing, Ess (Potter and Perry, 2 reference for care a written guideline promoting continuit criteria to be used it care. The written on nursing care prioriti professionals. The coordinates resourcare. A correctly for	p.m. ASM (administrative staff dministrator and ASM #2, the were made aware of the were made aware of the ion was provided prior to exit.  entials for Practice, 6th edition, 2007, pages 119-127), was a clans. "A nursing care plan is for coordinating nursing care, by of care and listing outcome in the evaluation of nursing care plan communicates ies to other health care care plan also identifies and ces used to deliver nursing primulated care plan makes it are from one purse to another				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ING		COMPLETED		
		495299	B. WING		.   04	C /27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880 SS=E	If the patient's state nursing diagnosis a no longer appropriplan. An out of darcompromises the control of the material that so nervous system disand spinal cord. It the material that so nerve cells. This dismessages between leading to the symwas obtained from https://medlineplus.lnfection Prevention CFR(s): 483.80(a).  §483.80 Infection (The facility must exinfection prevention designed to provid comfortable environdevelopment and the diseases and infection program.  The facility must exinfection program a minimum, the following services staff, volunteers, very providing services.	us has changed and the and related interventions are ate, modify the nursing care te or incorrect care plan quality of nursing care."  is Multiple sclerosis (MS) is a sease that affects your brain damages the myelin sheath, urrounds and protects your amage slows down or blocks in your brain and your body, ptoms of MS. This information: a.gov/multiplesclerosis.html in & Control (1)(2)(4)(e)(f)  Control stablish and maintain an and control program e a safe, sanitary and inment and to help prevent the transmission of communicable stions.  In prevention and control stablish an infection prevention in (IPCP) that must include, at		F880  1. Infection control pract being followed for reside catheter tubing and drain longer touching the floor clean water cups during administration, bare han touching the rims of resi surfaces of residents' disputting fingers inside the fruit cup.  2. Any resident has the pubeing affected.  3. Nursing staff will be reson maintaining infection techniques for catheter.	ent #35 nage bag no r, providing medication ids not dents' cups, ihes and e residents'  potential of e-educated control	5/29/18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМ	E SURVEY PLETED
		495299	B. WING	:			C 27/2018
ELIZABE	PROVIDER OR SUPPLIER  TH ADAM CRUMP HI			3€	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD ELEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	conducted accordinaccepted national s §483.80(a)(2) Writte procedures for the but are not limited to the persons in the facili (ii) When and to who communicable disereported; (iii) Standard and trobe followed to provide to be followed to provide the persons in the facili (iii) When and how it resident; including the facility of the type and dudepending upon the involved, and (B) A requirement the least restrictive postircumstances. (v) The circumstance must prohibit employed contact with resider contact will transmit (vi) The hand hygier by staff involved in §483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must had	ing to §483.70(e) and following tandards;  en standards, policies, and program, which must include, or eillance designed to identify able diseases or ey can spread to other ty; om possible incidents of ase or infections should be ansmission-based precautions event spread of infections; solation should be used for a put not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the sible for the resident under the eses under which the facility byces with a communicable skin lesions from direct at the disease; and the procedures to be followed direct resident contact.	F	380	drainage bag not touching the floor providing clean water cups during medication administration, bare hands not touching the rims of residents' cups, surfaces of resided dishes and putting fingers inside the residents' fruit cup.  4. An audit will be conducted to ensure infection control technique are maintained for catheter tubin and drainage bag not touching the floor, clean water cups provided during medication administration bare hands not touching the rims residents' cups, surfaces of resided dishes and putting fingers inside residents' fruit cup weekly for forweeks then monthly for three months. Results of the audits will reviewed at the monthly QAPI meeting for three months to enscompliance.	ents' the es es e f ents' the ur	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION  ING		COMPLETED			
		495299	B. WING	<u> </u>	n <sub>2</sub>	C 1/27/2018		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	l	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION OATE		
F 880	infection.  §483.80(f) Annual The facility will con IPCP and update t This REQUIREME by: Based on observat document review a was determined th maintain infection residents in the su during the medical and in two of three wing dining room).  1. Resident #35's of bag was observed  2. The facility staff cup during the me observation on 4/2  3. The facility staff touching their face on 4/24/18 at 1:10 bare hands from to cups and putting th fruit cup.  4. The facility staff from touching the	review. Iduct an annual review of its heir program, as necessary. INT is not met as evidenced ation, staff interview, facility and clinical record review, it at the facility staff failed to control practices for one of 42 rvey sample (Resident #35), ition administration observation, administration observation, administration and drainage touching the floor.  failed to provide a clean water dication administration (4/18 at 12:49 p.m.)  failed to wash their hands after during the dining observation p.m., and failed to keep their buching the rims of residents' neir fingers inside the residents' failed to keep their bare hands surfaces of the resident's ing the resident's lunch in the m.		380				
		vas admitted to the facility on #35's diagnoses included but		·				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		1 IDENTIFICATION NUMBER: 1 '		X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495299	B. WING			1	27/2018	
	PROVIDER OR SUPPLIER	HEALTH AND REHAB		360	EET ADDRESS, CITY, STATE, ZIP CODE O MOUNTAIN ROAD EN ALLEN, VA 23060	1		
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F 880	weakness and ma Resident #35's ma set), a quarterly a (assessment referesident's cognitive decision-making a Section G coded lextensive assistant mobility and required or more staff with resident as having Review of Reside a physician's orded diagnosis of urinate comprehensive can documented, "Altered and bladder and a tract infections) r/ Indwelling Urinary RetentionKeep of the level of the blad observed sitting in tubing was observed sitting in drainage bag was On 4/26/18 at 7:4 observed lying in drainage bag was On 4/26/18 at 9:5 conducted with LF LPN #5 was asked tubing and drainal LPN #5 stated, "Elif the bag and tubility in the bag and tubility in the second control of the bag and tubility in the bag and tubility in the second control of the bag and tubility in the second control of the bag and tubility in the bag and tubility in the second control of the bag and tubility in the bag and tubility	o difficulty swallowing, muscle ajor depressive disorder. ost recent MDS (minimum data ssessment with an ARD rence date) of 2/2/18, coded the		380				

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

Event ID: TQ6711

Facility ID: VA0083

If continuation sheet Page 204 of 211



AND DUAN OF COORDECTION IN INCOME.		l ' ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING	i			C / <b>27/2018</b>
	PROVIDER OR SUPPLIEI	HEALTH AND REHAB	J	3600	ET ADDRESS, CITY, STATE, ZIP CO MOUNTAIN ROAD N ALLEN, VA 23060	<del></del>	27/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN DF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TD THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	conducted with Lift where a resident's bag should be possible should be possible should be in a dig hooked to the bed When asked if the touch the floor, Lift (on 4/26/18 at 5:3 staff member) #1 (the director of nuabove concern.  The facility documfailed to reveal do above findings.  No further informate on 4/24/18 (licensed practical plastic cup and he and thumb. Her becup and as she signed the cup around in cup with water and resident's room, and drank the water and the cup and the water and the cup with water and the cup and the water and drank the water and	<del>-</del>		880			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	TIPLE CONSTRUCTION  NG	сом	(X3) DATE SURVEY COMPLETED	
	495299	B. WING		1	C <b>27/2018</b>	
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE.	(X5) COMPLETION OATE	
anything wrong with resident's water cup would be cross con An interview was con p.m. with LPN (licer unit manager. When wash their hands, Livisibly soiled, in bet care." When asked with staff putting the drinking cup, LPN # control issue."  On 4/26/18 at 5:10 member) #1, the addirector of nursing virilly findings.  Review of the facility ADMINISTRATION handling of residen No further informations.	in putting bare fingers inside a p., LPN#13 stated, "Yes. That tamination."  Inducted on 4/26/18 at 3:05 insed practical nurse) #4, the in asked when staff were to i.PN #4 stated, "When they're ween residents after giving if there was, anything wrong eir fingers inside a resident #4 stated, "That's an infection in p.m. ASM (administrative staff diministrator and ASM #2 the were made aware of the ty's policy titled, "ORAL DRUG" did not address proper t's drinking cups.  It is drinking cups.  It is drinking the dining observation		,			
cups and putting the fruit cup.  A dining observation 12:59 p.m. in the B (certified nursing as resident's cup by ri	eir fingers inside the residents' n was made on 4/24/18 at Unit dining room. CNA ssistant) #20 was holding a m and set it down on the table					
	PROVIDER OR SUPPLIER ETH ADAM CRUMP HE  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa anything wrong with resident's water cup would be cross con  An interview was co p.m. with LPN (licer unit manager. Whe wash their hands, L visibly soiled, in bet care." When asked with staff putting the drinking cup, LPN # control issue."  On 4/26/18 at 5:10 member) #1, the ac director of nursing v findings.  Review of the facility ADMINISTRATION handling of residen No further informat  3. The facility staff touching their face on 4/24/18 at 1:10 bare hands from to cups and putting th fruit cup.  A dining observatio 12:59 p.m. in the B (certified nursing as resident's cup by ri by the resident. The	PROVIDER OR SUPPLIER  ETH ADAM CRUMP HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 205 anything wrong with putting bare fingers inside a resident's water cup, LPN#13 stated, "Yes. That would be cross contamination."  An interview was conducted on 4/26/18 at 3:05 p.m. with LPN (licensed practical nurse) #4, the unit manager. When asked when staff were to wash their hands, LPN #4 stated, "When they're visibly soiled, in between residents after giving care." When asked if there was, anything wrong with staff putting their fingers inside a resident drinking cup, LPN #4 stated, "That's an infection control issue."  On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.  Review of the facility's policy titled, "ORAL DRUG ADMINISTRATION" did not address proper handling of resident's drinking cups.  No further information was obtained prior to exit.  3. The facility staff failed to wash their hands after touching their face during the dining observation on 4/24/18 at 1:10 p.m., and failed to keep their bare hands from touching the rims of residents' cups and putting their fingers inside the residents' fruit cup.  A dining observation was made on 4/24/18 at 1:59 p.m. in the B Unit dining room. CNA (certified nursing assistant) #20 was holding a	PROVIDER OR SUPPLIER  ETH ADAM CRUMP HEALTH AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 205 anything wrong with putting bare fingers inside a resident's water cup, LPN#13 stated, "Yes. That would be cross contamination."  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A dining observation was made on 4/24/18 at 12:59 p.m. in the B Unit dining room. CNA (certified nursing assistant) #20 was holding a resident's cup by rim and set it down on the table by the resident. The resident picked up the cup	PROVIDER OR SUPPLIER  TH ADAM CRUMP HEALTH AND REHAB  STREFT ADDRESS, CITY, STATE, ZIP C 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 205  anything wrong with putting bare fingers inside a resident's water cup, LPN#13 stated, "Yes. That would be cross contamination."  An interview was conducted on 4/26/18 at 3:05 p.m. with LPN (licensed practical nurse) #4, the unit manager. When asked when staff were to wash their hands, LPN #4 stated, "When they're visibly solied, in between residents after giving care." When asked if there was, anything wrong with staff putting their fingers inside a resident drinking cup, LPN #4 stated. "That's an infection control issue."  On 4/26/18 at 5:10 p.m. ASM (administrative staff member) #1, the administrator and ASM #2 the director of nursing were made aware of the findings.  Review of the facility's policy titled, "ORAL DRUG ADMINISTRATION" did not address proper handling of resident's drinking cups.  No further information was obtained prior to exit.  3. The facility staff failed to wash their hands after touching their face during the dining observation on 4/24/18 at 1:10 p.m., and failed to keep their bare hands from touching the rims of residents' cups and putting their fingers inside the residents' fruit cup.  A dining observation was made on 4/24/18 at 1:2:59 p.m. in the B Unit dining room. CNA (certified nursing assistant) #20 was holding a resident's cup by rim and set it down on the table by the resident. The resident picked up the cup	PROVIDER OR SUPPLIER  ### THADAM CRUMP HEALTH AND REHAB  SUMMARY STATEMENT OF DERICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 205 anything wrong with putting bare fingers inside a resident's water cup, LPN#13 stated, "Yes. That would be cross contamination."  An interview was conducted on 4/26/18 at 3:05 p.m. with LPN (licensed practical nurse) ##, the unit manager. When asked when staff were to wash their hands, LPN ## stated, "When they're visibly soiled, in between residents after giving care." When asked if there was, anything wrong with staff putting their fingers inside a resident drinking cup, LPN ## stated, "That's an infection control issue."  On 4/26/18 at 5:10 p.m. ASM (administrative staff member) ##1, the administrator and ASM #2 the director of nursing were made aware of the findings.  Review of the facility's policy titled, "ORAL DRUG ADMINISTRATION" did not address proper handling of resident's drinking cups.  No further information was obtained prior to exit.  3. The facility staff failed to wash their hands after touching their face during the dining observation on 4/24/18 at 1:10 p.m., and failed to keep their bare hands from touching the rims of residents' fruit cup.  A dining observation was made on 4/24/18 at 12:59 p.m. in the B Unit dining room. CNA (certified nursing assistant) #20 was holding a resident's cup by fim and set it down on the table by the resident. The resident picked up the cup	

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	PROVIDER OR SUPPLIER ET <b>H ADAM CRUMP H</b> I	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZII 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		72772010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	right hand. Then put CNA #22 then pick gave it to a residen fruit cup by holding finger inside the cup paper off a straw are coffee with her bare the cup with the sare began drinking from An interview was cop.m. with CNA #20 holding the residen appropriate, CNA #2 control issue."  An interview was cop.m. with LPN (lice unit manager. Whe wash their hands, I visibly soiled, in beicare." When asked hands after touchin hands in their pock should use the wip drinking glass by the stated, "No. Now I've they're going to put putting their bare finacceptable, LPN #4 how staff were to p LPN #4 stated, "The top part (with the patter)." When asked LPN #4 stated, "Cr. Review of the facilia.	ut her hands into her pockets. ed up a cup by the rim and t. CNA #22 then picked up a it by the rim with her index p. CNA #22 then took the nd used it to stir sugar into the e hands. CNA #22 then gave me straw to a resident who		380		

AND DUAN OF CODDECTION DENTIFICATION NUMBER		l ' '	TIPLE CONSTRUCTION DING		ATE SURVEY OMPLETED		
		495299	B. WING		C 04/27/2018		
NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, 2 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	health care-associa must be performed effect, clean and he short fingernails, ar contaminationUs is appropriate for dibefore direct patient gloves"  No further informat  4. The facility staff from touching the sistes while serving C-wing dining room.  On 04/24/18 at 12: room was observed.  CNA (certified nurs the dining room from the dining room from the dining room from the dining room from the dining room from the plate and plate and plate and plate and plate and the plate and her thur placed it down on the resident. CNA#1 the hallway, opened her bare hands, resident. CNA#1 the dining room. Coresident's table, resident's tabl	ated infections, hand hygiene routinely and thoroughly. In ealthy hands with intact skin, and no rings minimize the risk of sing an alcohol based hand rub econtaminating the hands at contact; after removing ion was provided prior to exit.  failed to keep their bare hands surfaces of the resident's g the resident's lunch in the	F	380			

AND DUAN OF CORRECTION INDESCRIPTION AND DESCRIPTION AND DESCR		l ' '	TIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED	
		495299	B. WING			/27/2018
	PROVIDER OR SUPPLIER	EALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP C 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 880	front of the resident dessert bowl from thands and her thur placed it down on the resident.  CNA # 2 came into hallway with a lunch from the lunch cart food cart with her bett tray to the resident from the hot plate with the tray to the resident from the table in from the table in from the table in from the hallway, on the resident. CNA into the hallway, on with her bare hand closed the food care entered the dining the resident's table the hot plate with better im of the plate table in front of the	age 208  t. CNA #1 then removed a the serving tray with bare and so on the rim of the bowl and the table in front of the tray after removing the tray and closing the door of the pare hands. CNA # 2 took the stable, removed a lunch plate with her bare hands and her of the plate and placed it down to fithe resident. CAN#2, then bowl from the serving tray with the theorem the table in front of # 2 was observed going back bened the door to the food cart is, removed a lunch tray, it door with her bare hands and room. CNA # 2 took the tray to removed a lunch plate from are hands and her thumbs on and placed it down on the resident. CNA #2 then bowl from the serving tray with				
	her bare hands and bowl and placed it the resident.  On 04/24/18 at 1:3 conducted with CN asked to describe a serving the resident "Everything needs hot plate and set the When lifting a dish	d thumbs on the rim of the down on the table in front of  2 p.m., an interview was A # 1 and CNA # 2. When the procedure for handling and t's food CNA # 1 stated, to come off the tray and off the tem in front of the resident. hands should be on the puld not touch the surface of				

AND DUAM OF CODDECTION INCENTIFICATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495299	B. WING			04/2	27/2018
NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEALTH AND REHAB				3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	the plates or bowls, process using the firm on the feach tray is taken of contaminated and if when asked if the lather or if they oper doors and removed CNA # 1 and CNA # closed the food carthey washed their hashed their hashed their hashed their hashed they washed they don surfaces of the disher observations during # 2 stated they don surfaces of the disher of the process for hand bowls when serving OSM # 19 stated, "placed over the lippinformed of the observation of the o	"When asked about the bood carts CNA # 2 stated, ood carts are closed after but to make sure they don't get to helps keep the food warm." unch trays were handed to hed and closed the food cart the lunch trays themselves # 2 stated, "We opened and its ourselves." When asked if hands between serving each hiching the food cart and before its CNA # 1 and CNA # 2 being informed of the path meal, CNA # 1 and CNA for remember touching the nes.  a.m., an interview was M (other staff member) # 19, ager. When asked to describe dling resident's plates and gother resident's their meal. Their fingers should not be not of the plate or bowl." When hervations during lunch on the non 04/2418 at 12:18 p.m. They should use hand each resident and after art before serving the		380			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING			C / <b>27/2018</b>
NAME OF PROVIDER OR SUPPLIER  ELIZABETH ADAM CRUMP HEALTH AND REHAB			'	STREET ADDRESS, CITY, STATE, 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060		27/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	On 04/26/18 at app (administrative staf administrator and A were made aware of	proximately 5:10 p.m. ASM f member) # 1, the ASM # 2, director of nursing	F	880		

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

Event ID: TQ6711

Facility ID: VA0083

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MAY 17 2018

**VDH/OLC** 

**VDH** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ 04/27/2018 B. WING VA0083 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER DR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) F 000 Initial Comments F 000 The statements made on this plan of correction are not an admission to and do not constitute an An unannounced biennial State Licensure agreement with the alleged Inspection was conducted 4/24/18 through 4/27/18. Corrections are required for compliance deficiencies herein. To remain in with the following with the Virginia Rules and compliance with all federal and Regulations for the Licensure of Nursing Facilities. state regulations, the center has taken or is planning to take the The census in this 180 certified bed facility was 165 at the time of the survey. The survey sample actions set forth in the following consisted of 35 current residents, Resident #118, plan of correction. The following #142, #267, #119, #86, #150, #318, #90, #95, plan of correction constitutes the #157, #88, #97, #2, #6, #110, #116, #46, #41, #38 #417, #53, #369, #16, #20, #33, #144, #8, #60, center's allegation of compliance. #87, #81, #105, #35, #111, #94 and #27; and All alleged deficiencies cited have seven closed record reviews #468, #169, #319, been or are to be corrected by the #269, #268, #167 and #71. date or dates indicated. 5/29/18 F 001 F 001 Non Compliance F001 The facility was out of compliance with the 1. Facility will obtain sex following state licensure requirements: offender's registry on residents prior to admission to facility. This RULE: is not met as evidenced by: 12VAC5-371-110. Management and 2. Each residents has the potential administration. Cross reference to F625 of being affected. 12VAC5-371-140. Policies and procedures 3. Admissions staff will be re-Cross reference to F625 educated on obtaining sex offender registry on residents 12VAC5-371-150. Resident rights. prior to admission to the facility. Cross reference to F625 12 VAC 5 - 371 - 150 H 4. Audits will be conducted to Based on staff interview, facility document review

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

and clinical record review, it was determined the

registry prior to the admission of Resident #269.

The facility staff failed to obtain the sex offender's registry on Resident #269 prior to admission to the

facility staff failed to obtain the sex offenders

(X6) DATE

ensure sex offender registry are

admission to the facility weekly for four weeks then monthly for three

months. Results of the visits will

TITLE

obtained on residents prior to

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 04/27/2018 VA0083 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 MOUNTAIN ROAD ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Continued From Page 1 F 001 F 001 be reviewed at the monthly QAPI meeting for three months to facility on 9/28/17. ensure compliance. The findings include: Resident #269 was admitted to the facility on 9/28/17 with diagnoses that included but were not limited to: high blood pressure, Parkinson's disease (a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability).(2), traumatic brain injury and mood disorder. The MDS (minimum data set) assessment completed closest to the incident of 12/11/17, with an assessment reference date of 12/22/17, coded the resident as scoring a 15 on the BIMS (brief interview for mental status) score, indicating the resident was capable of making cognitive daily decisions. The resident was coded as requiring limited assistance or supervisions of one staff member for all of his activities of daily living. In Section E - Behavior, the resident was coded as not having any behaviors during the look back period. The nurse's note dated, 12/9/17 at 6:48 p.m. documented, "CNA (certified nursing assistant) observed residents' hand in another resident's pant, writer was summoned to event site. Write asked resident what occurred, resident stated you may tell the administration, all they will do is kick me out. Immediately write separated the two parties involved, supervisor notified immediately. MD (medical doctor) and R/P (responsible party) notified and Administrator made aware. Resident was placed on 1:1 close supervision at this time." Review of the clinical record failed to evidence documentation of a sex offender's registry for

HQV (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ 04/27/2018 VA0083 B. WING \_\_\_ STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 MOUNTAIN ROAD ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5)(X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) F 001 Continued From Page 2 F 001 Resident #269. A copy of the sex offender's registry for Resident #269 was requested. A copy of the sex offenders registry was provided on 4/26/18 at 8:00 a.m. The sex offenders' registry was dated to have been completed on 9/29/17. one day after the resident's admission to the facility. An interview was conducted with other staff member (OSM) #11 on 4/26/18 at 8:13 a.m. When asked the process for admissions in regards to the sex offender's registry, OSM #11 stated, "When I get a referral, I go to the sex offenders' registry. I make sure they are not on the list. I print it out and it goes into each resident's admission file." The copy of the sex offender's registry for Resident #269 was reviewed with OSM #11. When asked if the registry was obtained prior to the resident's admission, OSM #11 stated, "It appears to be that it was done the day after. I was not here then." When stated it was a concern, OSM #11 stated, "Yes it is. We will be following the protocol of doing it prior to admission. An interview was conducted with administrative staff member (ASM) #1, the administrator, on 4/26/18 at 8:22 a.m. When asked to process for admissions in regards to the sex offender's registry, ASM #1 stated, "The are to be done prior to admission. Must be completed before we admit them." ASM #1 was made aware of the above concern at this time. The facility provided a copy of the "Admission File Checklist." The Checklist documented a check off for "Sexual Predator/Offender Verification."

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		VA0083		B. WING _	0 <b>4/2</b>		7/2018
	ROVIDER OR SUPPLIER TH ADAM CRUMP HE	ALTH AND REHAB	3600 MOL	DRESS, CITY, S INTAIN ROA LEN, VA 230			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
F 001	12 VAC 5 - 371 - 18 and F 608.  12 VAC 5 - 371 - 28 12 VAC 5 - 371	ion was provided price to A cross reference to A cr	s to F 600 s to F 657 s to F 745.  sument y staff was the State s reviewed k was not ree records  tant), the rification at to obtain a no obtain a no obtain a nd failed to eck in a dietary obtain the timely		<ol> <li>Facility will obtain license verifications at the time of hi and 30-day criminal backgrothecks in a timely manner.</li> <li>No other concerns noted.</li> <li>Human resources, Theraph Manager and HCS Managers be re-educated on obtaining license verifications at the till hire and obtaining 30-day cribackground checks in a time manner.</li> <li>Audits will be conducted the ensure license verifications at obtained at the time of hire 30-day criminal background checks are obtained in a time manner weekly for four weethen monthly for three mon Results of the visits will be reviewed at the monthly QA meeting for three months to ensure compliance.</li> </ol>	y will me of iminal ly o are and ely ks ths.	5/29/18

PRINTED: 05/08/2018

FORM APPROVED VDH (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_\_\_\_\_ 1/40083 04/27/2018

		VA0083		B. WING		04/27/2018	
NAME OF P	PROVIDER OR SUPPLIER	1		DRESS, CITY, S	TATE, ZIP CODE		
ELIZABE	TH ADAM CRUMP HE	EALTH AND REHAB		JNTAIN ROA LEN, VA 230			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
F 001	Continued From Pa	age 4		F 001			
	facility staff failed to the time of hire. Cl there was no evide her file.  2. For CNA #9, the license verification was hired on 8/22/was not obtained u  3. For CNA #10, th license verification	ne facility staff failed to at the time of hire. Control of the time of hire. Control of the time of hire. The license veriforms in the license veriforms in the license veriforms.	rification at 7/25/17 and fication in obtain a CNA #9 erification to obtain a CNA #10				
	license verification obtain a 30-day cri timely manner. CN The license verifica	ne facility staff failed to at the time of hire, a minal background che NA #11 was hired on station was not obtaine 60-day criminal backgained until 11/1/17.	nd failed to leck in a 9/26/17. ed until				
	the facility failed to background check was hired on 12/16	ther Staff Member, d obtain a 30-day crim in a timely manner. 6/16. The 30-day crir was not obtained un	ninal OSM #5 minal				
	(Other Staff Memb made aware of the was new to the fac missing items. On PM, she stated tha were not found, an staff member did w	roximately 3:00 PM Cor, Human Resource findings. She stated illity but would search 4/26/18 at approximat the above identified that each above identified work, without the requirements completed.	es) was d that she in for the hately 5:50 d items entified uired				
	On 4/26/18 at 5:24	PM at the end of da	y meeting,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI IDENTIFICATION NU			' '	LE CONSTRUCTION	(X3) DATE S COMPL		
		VA0083		B. WING		04/2	7/2018
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
ELIZABE	TH ADAM CRUMP HE	EALTH AND REHAB		NTAIN ROA EN, VA 230			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
F 001	Continued From Pa	age 5		F 001			
	the Administrator and the Director of Nursing (ASM #2) were made aware of the findings. No further information was provided by the end of the survey.						
	1. These regulation	lity must comply with ns (12VAC5-371); federal, state or loca	İ				
	E. Personnel policie include, but are not 3. An accurate and each employee include. Verification of cu	complete personnel luding: rrent professional lic ificate or completion training course;	hall record for ense,				
	implement policies	lity shall develop and and procedures that defined in §§32.1-13	ensure				
	with the requirement Employment for co convicted of certain record checks requ of license. "Any pe licensed nursing ho	ome Regulation states that a facility mants of §32.1-126.01: mpensation of person offenses prohibited sired; suspension or erson desiring to work ome shall provide the a statement or affirm.	ns; criminal revocation at a tale thiring				

BNTG11 If continuation sheet 6 of 8

**VDH** (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING \_ 04/27/2018 VA0083 B. WING \_\_\_ STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 MOUNTAIN ROAD ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG DEFICIENCY) F 001 Continued From Page 6 F 001 disclosing any criminal convictions or any pending criminal charges...A nursing home shall, within 30 days of employment, obtain for any compensated employees an original criminal record clearance with respect to convictions for offenses specified in this section or an original criminal history record from the Central Criminal Records Exchange." 12VAC5-371-180, Infection control cross reference to F880. 12VAC5-371-210. Nurse staffing cross reference to F725. 12VAC5-371-220. Nursing services cross reference to F580. 12VAC5-371-220. Nursing services cross reference to F757. 12VAC5-371-250. Resident assessment and care planning cross reference to F641. 12VAC%-371-300. Pharmaceutical services cross reference to F761. 12VAC5-371.371.A. cross references to F584 F656 does not cross reference 12VAC5-371-140. Policies and Procedures cross references to F622, F623, F645, F842 12VAC5-371-250. Resident assessment and Care Planning cross references to F686, F679 12VAC5-371-220. Nursing Services cross references to F685, F686, F695, F558 12VAC5-371-110. Management and

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**VDH** (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_\_\_ 04/27/2018 VA0083 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3600 MOUNTAIN ROAD ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 001 F 001 Continued From Page 7 Administration cross references to F607, F608 of the continuation sheet 8 of 8

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MAY 17 2018

