P.6/67

State of Virginia PRINTED: 10/26/2017 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 495268 B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10/19/2017 WESTMORELAND REHABILITATION & HEALTHCA! 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (X5) COMPLETE TAG F 000 Initial Comments DATE F 000 An unannounced Medicare/Medicald standard survey was conducted 10/17/2017 through 10/19/2017. Corrections are required for Please See Federal Plan of compliance with 42 CFR Part 483 Federal Long Correction Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities.. The Life Safety Code survey/report will follow. Two complaints were investigated during the survey. The census in this 66 certified bed facility was 50 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents #1 through #13, and #18) and 5 closed records (Residents #13 through #17). F 001 Non Compliance F 001 The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following cross referenced Virginia Rules and Regulations: 12VAC5-371-150 Resident Rights 12VAC5-371-150 (C,D,E)-Cross reference to F-156. 12VAC5-371-360 Clinical Records 12VAC5-371-360 (B)-Cross reference to F-164. 12VAC5-371-220 Nursing Services 12VAC5-371-220 (H)-Cross reference F-157. 12VAC5-371-110 (B.1-3, C)-Cross reference to EVRPLIER REPRESENTATIVE'S SIGNATUR

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PRINTED: 10/26/2017 FORM APPROVED

TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI	ER/CLIA	(X2) Militaria	PLE CONSTRUCTION		M APPROV
WIN L DAIN	A CORRECTION	IDENTIFICATION NU	MBER:	,	3	(X3) DATE COMP	SURVEY LETED
***************************************		495268		B. WING			
	PROVIDER OR SUPPLIER		STREET AC	PRESS, CITY, S	TATE, ZIP CODE	10/1	9/2017
MESING	RELAND REHABIL!	TATION & HEALTHCA	2400 MC	KINNEY BÖU L BEACH, VA	EVADA		
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F 001	Continued From P	age 1		F 001	DEFICIENCY	7	- VAIE
5	12VAC5-371-110 Management and Administratio 12VAC5-371-110 (B.1-3, C)-Cross reference to F-225.						
	12 VAC5-371-140 (12VAC5-371-140-0	(A) Policies and Proce Cross reference to F-2	edures 26.	name of the state			
	12VAC5-371-200 E 12VAC5-371-200 (I	Director of Nursing B)-Cross reference to	F-281.				
12V 12V	12VAC5-371-220 N 12VAC5-371-220 (A	ursing Services I, B)-Cross reference	to F-309.				
The state of the s	12VAC5-371-220 Nursing Services 12VAC5-371-220 (D)-Cross reference to F-323.						
			}	3			
			**************************************			Parameter and the second secon	
						To the state of th	
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FORM	A service	HISO			68UI11		1

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	a (EX)	O. 0938-
		495268				OMPLETED C
NAME OF	PROVIDER OR SUPPLIER		B. WING		1	0/19/201
WESTM	OPELAND DENADULA	PATRIANA A		STREET ADDRESS, CITY, STATE, ZIP CO	DE	
		TATION & HEALTHCARE CENTER	R	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	10			
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F 000	INITIAL COMMENT	S	F 00	reas on the nealth, safety.	and	***************************************
	An unannounced M	edicare/Medicaid standard	i	wellbeing of facility resident	te	
	survey was conducted	ed from 10/17/2017 through		Although the facility does no	ot agree	
	10/19/2017. Two co	implaints were investigated		with some of the findings ar	ıd	
	during the survey. C	Offections are required for		conclusions of the surveyors	, it has	
	Term Care requirem	CFR Part 483 Federal Long ents. The Life Safety Code		implemented its plan of corr to demonstrate its continuin	ection	,
	Survey/Report will fo	ollow.		efforts to provide quality car	g	
i		1		residents.	e to its	
	The census in this 6	6 certified bed facility was 50		Any area cited by the survey	toam is i	
	at the time of the sur	vey. The survey sample		placed into our Quality Assur	ance	
	consisted of 13 curre	th #12, and #18) and 5		and Process Improvement nr	22910	
	closed records (Resi	dents #13 through #17).		and monitored through this s	vstem	
F 156	483.10(d)(3)(g)(1)(4)	(5)(13)(16)-(18) NOTICE OF	F 156	TO assure compliance		
SS=E	RIGHTS, RULES, SE	RVICES, CHARGES	IT 100	F156		
	/d)/2) The 4m attendance			State Advocacy Age	ncv	!
i	(u)(u) The facility mu: remains informed of t	st ensure that each resident the name, specialty, and way		Groups contract		!
	or contacting the phys	Sician and other primary care		information and rel	ated	
ı	professionals respons	sible for his or her care.		signage was lowered	d to a	
				level visible for all		
	§483.10(g) Informatio	on and Communication,		residents on 10/18/	17	
· (nis or her rights and a	he right to be informed of		during the annual su	rvey.	
. '	30verning resident co	of all rules and regulations induct and responsibilities		The resident council	was	
i	during his or her stay	in the facility		reconvened to discus	ss the	
:		i		signage and to ensur residents were made	e į	
(9)(4) The resident ha	s the right to receive		aware of the location		
ľ	notices orally (meanin	g spoken) and in writing		well as the correction	idS	
! \	including Braille) in a or she understands, ir	format and a language he		made.	!!!!	
, ,	in one directatatiga, ii	icidang.		2. All residents have the	.	
(i	i) Required notices as	specified in this section.		potential to be affect	ed	
f	ne racility must furnis	sh to each resident a written	į	by this alleged deficie	nt	
. d	escription of legal rigi	hts which includes -	1 1 1	practice.		
()	A) A description of the	manner of protecting	:			
RATORYD	HECTOR'S OF PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNAT	LIREA TO	IALLA SILAN .	1/2/2	(6) DATE
eficiency s	tatement ending with ania	Sterisk (*) denntag a definence to	TWW	in may be excused from correcting provid		/
safeguard:	s provide sufficient protect	ion to the nationts (See Inches)	me institutio	on may be excused from correcting provide nursing homes, the findings stated above use, the above findings and plans of corrections and plans of corrections.	IDS IL is determ	ined that

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIERICLIA

	OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	1	TIPLE CO		(X3) DATE SURVEY COMPLETED	
		495268	B. WING				С
İ	PROVIDER OR SUPPLIER ORELAND REHABILI	TATION & HEALTHCARE CENTER	₹	2400 A	T ADDRESS, CITY, STATE, ZIP CODE MCKINNEY BOULEVARD DNIAL BEACH, VA. 22443	1 10	0/19/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG	x ¦	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	I I'N DIC	(XG) COMPLETION DATE
	personal funds, und section; (B) A description of procedures for estatincluding the right to resources under se Security Act. (C) A list of names, email), and telephores state regulatory and resident advocacy of Survey Agency, the State Long-Term Caprotection and advoservices where state in long-term care far agency for informatic community and the land. (D) A statement that complaint with the Sconcerning any suspfederal nursing facility not limited to resident exploitation, misapping in the facility, non-codirectives requirement information regarding and local advocacy of and local advocacy of timited to the State Long-Term Care Om (established under second restablished restablishe	the requirements and blishing eligibility for Medicaid, or request an assessment of ction 1924(c) of the Social addresses (mailing and ne numbers of all pertinent dinformational agencies, proups such as the State State licensure office, the are Ombudsman program, the cacy agency, adult protective a law provides for jurisdiction collities, the local contact on about returning to the Medicaid Fraud Control Unit; the resident may file a tate Survey Agency pected violation of state or ty regulations, including but a tabuse, neglect, ropriation of resident property impliance with the advance into and requests for greturning to the community.	F1	56	 The facility will monit signage level one time week for two weeks or rounds to ensure sign remains in compliance. Audits will be submit to the Quality Assurational Process Improver Committee for review. Date of Completion: 11/16/17 	e per on lage e. ted nce ment	

DEP/	ARTMENT OF HEALT	TH AND HUMAN SERVICES					9,10/67
12-14	ENS FOR MEDICAR	RE & MEDICAID SERVICES				FORM	D: 10/26/20 MAPPROVE
	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILD	LTIPLE	CONSTRUCTION	(X3) DA	0.0938-039 TE SURVEY MPLETED
		495268	- 1				
NAME C	F PROVIDER OR SUPPLIE	R	8. WING			10	C /19/2017
		ITATION & HEALTHCARE CEN	TER	240	REET ADDRESS, CITY, STATE, ZIP CODE	10	119/2017
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F 15	Continued From p.	200 7		-			
	U.S.C. 3001 et ser	1) and the protection	F 1	56			
	ACTACHON 242(6)11) 1	AS decidented by the	nd				
	Disabilities Assista	nce and Bill of Bights And as	•				
	#VVV (74 U.J.U.	OUUT AT CAA \				i	
	19483.10(g)(4)(li) w November 28, 201	ill be implemented beginning 7 (Phase 2)]					
	(iii) Information rega	arding Medicare and Medicaid	,			į	
	and cover	48 8	•	;		\$	
	November 28, 2017	/III be implemented beginning (Phase 2)]					
	(iv) Contact informa	tion for the Aging and		!			
	DISCOURT RESOURCE	Ceriter (actablished	1			j	
	THE PROPERTY OF THE PARTY OF TH	B)(iii) of the Older Americans					
	[§483.10(g)(4)(iv) wi November 28, 2017	libe implemented have				1	
	(v) Contact informati	on for the Medicaid Fraud	:				
	Control Onit; and						
	November 28, 2017	be implemented beginning (Phase 2)]		Ì			-
	(vi) Information and c	contact information for filing					
	SUPPLIED OF COUNTY	HILLS CONCORDING CO					
- 1	racing reduiations in	f state or federal nursing cluding but not limited to				į	
	resident abuse, nedle	of evalation !					ļ
; •	rnisappropriation of re acility, non-compliant	Sident propose.	s 1				
,	Jii cuives reduiremen	to and community to					
į	ntormation regarding	returning to the community.					
(g)(5) The facility mus	t nost in a form				i	
1	namer accessible an	d understandable te					
P	esidents, resident rep	presentatives:	1				İ

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILC	LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
	İ	495268	B. WING	,		С	
	PROVIDER OR SUPPLIER DRELAND REHABILIT	TATION & HEALTHCARE CENTER	<u> </u>	STREET AUDRESS, CITY, STATE, ZIP (2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443	CODE	0/19/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 156	Continued From page	ge 3	F t	56			
	and telephone number agencies and advoc Survey Agency, the protective services in jurisdiction in long-ter of the State Long-Terprogram, the protect home and community and the Medicaid From the Medicaid From the Medicaid From the Medicaid From the Medicaid From the Medicaid From the Medicaid From the Medicaid From the Sconcerning any suspfederal nursing facilities to resident at misappropriation of a facility, and non-combinated to resident at misappropriation of a facility, and non-combinated to require the the community. (g)(13) The facility moving the medicare and Medicare and Medicare and Medicare and Medicare and Medicare and Medicare and Services to the readmission and during the facility must in and services to the readmission and during the facility must in and in writing in a fan	rected violation of state or ty regulation, including but not puse, neglect, exploitation, resident property in the upliance with the advanced nts (42 CFR part 489 subpart information regarding returning ust display in the facility and provide to residents and sion, oral and written w to apply for and use aid benefits, and how to revious payments covered by ust provide a notice of rights esident prior to or upon					

TATEMEN	IT OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	TANK THE		FORM APPRO OMB NO. 0938-)39
IND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		495268	B. WING		C	
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	10/19/201	7
WESTM		TATION & HEALTHCARE CENTE	R 2	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	VIEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL GROSS-REFERENCED TO THE APPRO DEFICIENCY)	M DC	TION
F 156	Continued From pa	ae 4		URPIDIENCY)		
	regulations governing	ng resident conduct and ng the stay in the facility,	F 156			
	(ii) The facility must the State-developed obligations, if any.	also provide the resident with dinotice of Medicaid rights and	4			
g ;	(iii) Receipt of such amendments to it, in writing;	information, and any nust be acknowledged in				
	(g)(17) The facility m	nust) in the second of the second			
	writing, at the time of	caid-eligible resident, in f admission to the nursing resident becomes eligible for				
	nursing facility service	ervices that are included in ses under the State plan and it may not be charged;				
	facility offers and for	s and services that the which the resident may be ount of charges for those	17 10 10 10 10 10 10 10 10 10 10 10 10 10			
ć . (changes are made to	caid-eligible resident when the items and services hs (g)(17)(i)(A) and (B) of				
5 8 8	perore, or at the time periodically during the evailable in the facility ervices, including an	ust inform each resident of admission, and president's stay, of services r and of charges for those y charges for services not pre/ Medicaid or by the				

STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL) A. BUILDI	TIPLE CONSTRUCTION	((X3) DATE SURVEY COMPLETED	
		495268	B. WING				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	10/	19/2017
WESTM	DRELAND REHABILIT	TATION & HEALTHCARE CENTER	2	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 2Z443			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULDB	BE ATE	(X5) COMPLETION DATE
	and services covered Medicaid State plan notice to residents or reasonably possible (ii) Where changes items and services facility must inform 60 days prior to import (iii) If a resident diest transferred and doe facility must refund representative, or edeposit or charges apper diem rate, for the resided or reserved facility, regardless of discharge notice received facility must resident representative resident within 3 date of discharge from the resident within 3 date of discharge from the resident within 3 date of discharge from the resident material and the resident within 3 date of discharge from the resident material and the resident within 3 date of discharge from the resident material and the resident ma	in coverage are made to items and by Medicare and/or by the and the facility must provide of the change as soon as is at a soon as is at a soon as is at a soon as is at a soon as is at a soon as is a	F 15				
	these regulations. This REQUIREMEN by: Based on observati documentation revision	ion, staff interview and facility w, the facility staff failed to y Advocacy Group information					

PRINTED: 10/26/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING Ċ 495268 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MCKINNEY BOULEVARD **WESTMORELAND REHABILITATION & HEALTHCARE CENTER** COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID (XS) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 156 Continued From page 6 F 156 The State Agency Advocacy Groups contact information was posted across from the nursing station, above standing eye level, which made it difficult for residents in wheelchairs to read. The findings included: On 10/18/17 at 2:00 p.m. a resident group meeting was conducted with 9 alert and verbal residents. When the group was asked by the inspector, "Do you know how to contact an advocacy agency such as the ombudsman office?" 2 of 9 residents stated they did not and 2 of 9 residents stated the sign was "too high, can't see." On 10/18/17 at 3:45 p.m. the Advocacy Groups contact information was observed hung on the wall across from the nursing station. The information sheet was above eye level and potentially difficult to see if a resident was in a wheelchair. On 10/18/17 at 4:30 p.m., the Administrator and Director of Nursing were informed of the observation and resident concerns of the Advocacy Group information being posted too high on the wall. On 10/19/17 at 8:30 a.m. the posting was observed lowered to a level readable at wheelchair level. No further information was provided by facility staff. F157 F 157 483.10(g)(14) NOTIFY OF CHANGES F 157 The physician and ss=D (INJURY/DECLINE/ROOM, ETC) responsible party for R#2 was notified of (g)(14) Notification of Changes. medication refusals on 10/31/2017.

		I AND HUMAN SERVICES E & MEDICAID SERVICES					FOR	D: 10/26/2017 MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CO		TION	(X3) DA), 0938-0391 TE SURVEY MPLETED
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l	PROVIDER OR SUPPLIER ORELAND REHABILIT	TATION & HEALTHCARE CENTER	₹	2400 1	MCKINN	ESS, CITY, STATE, ZIP CODE EY BOULEVARD BEACH, VA 22443	_1 _70	0/19/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PR	OVIDER'S PLAN OF CORRECTIVE ACTION SHOUL- REFERENCED TO THE APPRO DEFICIENCY)	COC	(X5) COMPLETION DATE
F 157	consult with the resconsistent with his consistent with his corepresentative(s) with All and accident inverselts in injury and physician intervention. (B) A significant charmental, or psychosodeterioration in heal status in either life-tolinical complication. (C) A need to alter the aneed to discontinuate treatment due to adcommence a new for the commence and the fact \$483.15(c)(1)(ii). (iii) When making not (14)(i) of this sectional pertinent informal is available and proving physician. (iii) The facility must resident and the resident and the resident there is— (A) A change in room as specified in §483.	mediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- plying the resident which has the potential for requiring an; ange in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or is); reatment significantly (that is, ie an existing form of verse consequences, or to orm of treatment); or insfer or discharge the cility as specified in \$483.15(c)(2) in, the facility must ensure that tion specified in \$483.15(c)(2) inded upon request to the indent representative, if any, an or roommate assignment	E	157	5.	Residents that refuse medication are at risk for this alleged deficient practice.	re- for nd or vill	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/26/2017 I APPROVED : 0938-0391
STATEMENT AND PLAN (OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
		495268	B. WING			i	C
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 10/	19/2017
WESTM	ORELAND REHABILIT	TATION & HEALTHCARE CENTER	₹	240	0 MCKINNEY BOULEVARD		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	Qı dı		LONIAL BEACH, VA 22443		
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F 157	Continued From pa	ge 8	F	: - :57			
	State law or regulat (e)(10) of this section	ions as specified in paragraph on.		,			
	update the address phone number of th	t record and periodically (mailing and email) and e resident representative(s). IT is not met as evidenced	·	4 :			
	Based on staff inter review, and clinical in failed to notify the R physician of Resider	view, facility document record review, the facility esponsible party, and nt refusals to accept Resident (Resident #2), in					
	the survey sample of For Resident #2, the	f 18 residents. facility staff failed to notify				Î	
1	the physician, and remedication refusals.	esponsible party of					
	The findings include	d: ;					
;	6-9-14. Diagnoses f schizophrenia, atrial	mitted to the facility on or Resident #2 included; fibrillation, high cholesterol, a, and hypothyroidism.				į	
	assessment protoco Reference Date of 9- assessment, and co- interview for mental : unable, as the Resid impaired. In addition coded Resident #2, a	ecent Minimum Dala Set (an I) with an Assessment -6-17, was a quarterly ded Resident #2 with a brief status (BIM's) score of ent was severely cognitively is, the Minimum Data Set as requiring total assistance of or all Activities of Daily		1		į	
	Living care, such as bathing.	bed mobility, toileting, and				:	

A review of Resident #2's clinical record was

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 10/26/2017 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA1	. 0938-0391 TE SURVEY MPLETED
-		495268	B. WING	; <u> </u>		1	C
	· · · · · · · · · · · · · · · · · · ·	ATION & HEALTHCARE CENTER	₹	24	REET ADDRESS, CITY, STATE, ZIP CODE 00 MCKINNEY BOULEVARD DLONIAL BEACH, VA 22443	1 10	/19/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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
	revealed medication (MAR's), physician progress notes which months of Septemb Resident had spit or would at times refus period there was no responsible party, or aware of the medication refusals. Interviews with staff medications indicate evening staff on duty with the Resident duto the family or doctorefusals. An interview was concursing and the Concursing and the Concursing and the Concursing and the concursing and the farther ecent medication where one could locate progress notes." Review of all clinical disciplines revealed been notified that the administered. The facility administre findings during an erforce which was not extended the concursion of the facility administre findings during an erforce would be with the facility administre findings during an erforce would be with the facility administre findings during an erforce would be with the facility administre findings during an erforce would be with the facility administre findings during an erforce which was not the facility administre findings and the concursion of the facility administre findings during an erforce which was not the facility administre findings during an erforce which was not the facility administre findings during an erforce which was not the facility administre findings during an erforce which was not the facility and the facility administre findings during an erforce which was not the facility and the facility	ne survey. The review of administration records progress notes, and nursing the revealed that during the er, and October 2017 the at medications regularly, and se meals as well. During that undication that the Resident's rephysician, was ever made ation refusals, and no et to the care plan for the members who administered at that none of the day or y during survey, and working uring survey, had made calls for to notify them of these that they could find no milly, or doctor was aware of an refusals. When asked ate that information, They all be documented in the progress notes for all that the physician had not be medications had not been action was informed of the add of day briefing on	F	157			
1	10-18-17, and 10-19	-17. The facility did not reformation about the findings.		-		1	

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			þ	RINTED: 10/26/2017
		& MEDICAID SERVICES				FORM APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495268	B. WING			C
NAME OF	PROVIDER OR SUPPLIER		<u> </u>		EET ADDRESS, CITY, STATE, ZIP CODE	10/19/2017
WESTM	ORELAND REHABILIT	ATION & HEALTHCARE CENTER	R	2400	MCKINNEY BOULEVARD	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IÓ PREFIX TAG	i	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE COUDIERS
F 164	Continued From page	ma 40			F164	
			F 16	1	1. The picture displayed i	n l
F 104	PRIVACY/CONFIDE	83.70(i)(2) PERSONAL ENTIALITY OF RECORDS	F 16	54	public view for R#18 w	
00-0	110000000000000000000000000000000000000	INTIALITY OF RECORDS	ŀ	1	removed from the	
	483.10				location identified on	i i
	(h)(l) Personal priva	cy includes accommodations,			10/19/17 during the	
	medical treatment, v	written and telephone		i	annual survey and plac	ed
	communications, pe	ersonal care, visits, and and and resident groups, but this			in a confidential area.	
	does not require the	facility to provide a private		į	2. Residents identified as	
	room for each reside	ent.			elopement risk are at r	1
					for this alleged deficien	nt
	(h)(3)The resident h	as a right to secure and			practice.	.
	confidential persona	I and medical records.		ĺ	3. Staff members from al	1
	(i) The recident has	the right to refuse the release		-	departments will recei	ve
	of personal and med	ine right to refuse the release lical records except as			re-training on	
	provided at	illour records except as			confidentiality and	,
ļ	§483.70(i)(2) or othe	r applicable federal or state			privacy. Photos of residents at risk for	
	laws.				elopement have been	
	C 400 70				placed in designated	
	§483.70 (i) Medical records.	8			notebooks. The Social	
	(2) The facility must	keen confidential all			Worker will monitor	
	information contained	d in the resident's records,			adherence to resident	
ļ	regardless of the form	n or storage method of the			privacy by weekly	
	records, except when	n release is-			monitoring notification	n
	AN The Aleman Samuel Colored Color			1	boards for the present	1
	(i) To the individual, of	or their resident			confidential resident	
	rebreserrance where	permitted by applicable law;		1	information.	
MA. 49 AMAZAMATANA	(ii) Required by Law;					
	(iii) For treatment, pa operations, as permit with 45 CFR 164,506	yment, or health care ted by and in compliance				1
				İ		
:	(iv) For public health neglect, or domestic	activities, reporting of abuse, violence, health oversight				
1						,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. SUILO		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495268	B. WING	- striken mandet i marenene		40	C
WESTMO	SUMMARY STA	TATION & HEALTHCARE CENTER MEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	U) PREFI	2400 COL	EET ADDRESS, CITY, STATE, ZIP CODE MCKINNEY BOULEVARD ONIAL SEACH, VA 22443 PROVIDER'S PLAN OF CORRECTION (SACH CORRECTIVE ACTION SHOULD	N BE	/19/2017
TAG	REGULATORY OR U	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	RIATE	DATE
F 164	law enforcement purposes, research medical examiners, a serious threat to he by and in compliant This REQUIREMENT by: Based on staff intereview, and clinical failed to ensure privice too fidential for a survey sample of Resident #18's picture board across from the hallway of the facility	and administrative proceedings, urposes, organ donation purposes, or to coroners, funeral directors, and to avert nealth or safety as permitted ce with 45 CFR 164 512. NT is not met as evidenced eview, facility documentation record review, the facility staff rate health information was a 1 Resident (Resident #18) in 18 Residents. The was placed on a bulleting the nursing station, in the main ty, and was notated as a "code ext to the code green policy,"	F 1	164	4. Residents identified as risk for elopement will le reviewed weekly by the interdisciplinary risk committee for continue risk/need for alert bracelet. Results of the weekly audits complete by the Social Worker will be reported to the monthly QAPI meeting for a months. Date of Completion: 11/16/2017	be ed d	
,	The findings include	∍d:					
	6-7-17. Diagnoses kidney fallure, repea	admitted to the facility on included: dementia, acute ated falls, hypothyroid, adult s, fractured scapula, and ulna,					***
The conversion of the second	set) with an ARD (as 8-16-17 was coded Resident #18 was o deficits, with a BIM's status) score of 14 c and required extens staff members for as	st recent MDS (minimum data ssessment reference date) of as a quarterly assessment, oded as having no cognitive to (brief interview for mental of a possible 15 points scored, sive to total assistance of 2 ctivities of daily living, with the which only required set up					

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FOR	D: 10/26/2017 MAPPROVEC O: 0938-0391	
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		CONSTRUCTION	(X3) D.	ATE SURVEY DMPLETED	
<u> </u>		495268	B. WING	;		C		
WESTM		ATION & HEALTHCARE CENTER	R	240	REET ADURESS, CITY, STATE, ZIP CODE 00 MCKINNEY BOULEVARD OLONIAL BEACH, VA 22443	RD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	CACCE	(X5) COMPLETION DATE	
F 164	the nursing unit, it was across from the nurhallway of the facility notated as a "code of bulletin board (next was a copy of the coother residents, visit #18's elopement stated the nursing station a was there. She stated the nursing progress not 8-29-17, the Resident behaviors, confusion physician's order was and it was applied. Culture showed that tract infection (UTI), ordered and administ seeking behaviors in 10-10-17, with the cere Resident was reasseful to be no longer in discontinued.	0 a.m. during observations of as observed that this as placed on a bulletin board sing station, in the main y, and Resident #18 was green" Resident. Also on the to Resident #18's picture) ode green policy, alerting fors, and vendors to Resident attus. or of Nursing was sitting at and was asked why the picture ed that was a code green was a code green and searching for family. A sobtained for a wandergard, Dn 8-30-17 results of a urine the Resident had a urinary and an antibiotic was a tered. No further exit ad been noted, and on assation of the behaviors, the essed. The wandergard was sessed.	; F	184				

The Administrator stated during interview, that the

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 495268 8. WING NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (XS) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 164 Continued From page 13 F 164 picture should have never been placed on the bulletin board denoting Resident #18 as an elopement risk, as it was a breach of the Health Insurance Portability and Accountability Act (HIPAA). The picture was removed immediately after the interview by staff. The administrator and Director of Nursing were made aware of the deficient practice at the end of day debrief on 10-17-17, and on 10-18-17. The facility presented no further information, F 203 483.15(c)(3)-(6)(8) NOTICE REQUIREMENTS F203 F 203 SS=D BEFORE TRANSFER/DISCHARGE R#14 no longer resides in the facility. (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility Residents discharged mustfrom facility for nonemergent reasons have (i) Notify the resident and the resident's the potential to be representative(s) of the transfer or discharge and affected by the alleged the reasons for the move in writing and in a deficient practice. language and manner they understand. The The interdisciplinary team facility must send a copy of the notice to a was educated on facility representative of the Office of the State policy for discharge Long-Term Care Ombudsman. notification. The Social (ii) Record the reasons for the transfer or Worker will be discharge in the resident's medical record in responsible for ensuring accordance with paragraph (c)(2) of this section; residents and/or their and representatives receive written notice of (iii) Include in the notice the items described in discharge or transfer by paragraph (b)(5) of this section. maintaining a log documenting completion (c) (4) Timing of the notice. of discharge activities. (i) Except as specified in paragraphs (b)(4)(ii) and (b)(8) of this section, the notice of transfer or

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FOR	ED: 10/26/201 RM APPROVE
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION ((X3) C	O. 0938-039 PATE SURVEY OMPLETED
		495268	B. WING				C
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	0/19/2017
WESTM	ORELAND REHABILIT	TATION & HEALTHCARE CENTE	R	24	000 MCKINNEY BOULEVARD OLONIAL BEACH, VA 22443		
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	made by the facility resident is transferred. (ii) Notice must be in before transfer or discussion. (A) The safety of indicate the endangered under this section; (B) The health of indicate the section; (C) The resident is healtown a more immediated and an area of the required by the residunder paragraph (b)(in the para	under this section must be at least 30 days before the at least 30 days before the ad or discharged. Inade as soon as practicable scharge when- lividuals in the facility would ar paragraph (b)(1)(ii)(C) of lividuals in the facility would er paragraph (b)(1)(ii)(D) of lividuals in the facility would er paragraph (b)(1)(ii)(D) of lividuals in the facility would er paragraph (b)(1)(ii)(D) of lividuals in the facility to iate transfer or discharge, (1)(ii)(B) of this section; unsfer or discharge is ent's urgent medical needs, 1)(ii)(A) of this section; or lividuals in the facility for 30 er notice. The written notice h (c)(3) of this section must linsfer or discharge;	F 2	03	4. The Social Worker w present his discharge to the monthly QAPI meeting for review. 5. Date of Completion: 11/14/17	ill	
	(ii) The effective date (iii) The location to wh ransferred or dischar	of transfer or discharge; nich the resident is ged;		ļ			
((iv) A statement of the	e resident's appeal rights,		ţ			

PRINTED: 10/28/2017 FORM APPROVED

AND PLAN	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(97) + # #		OMB NO	MAPPROV 0. 0938-00
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION IING	(X3) DA	TE SURVEY MPLETED
MALE OF		495268	B. WING			C
	PROVIDER OR SUPPLIER					
WESTM	ORELAND REHABILIT	TATION & HEALTHCARE CENT		STREET AUDRESS, CITY, STATE, ZIP COD	Ę	13/2017
			ER	2400 MCKINNEY BOULEVARD		
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	10	COLONIAL BEACH, VA 22443		
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F 203	Continued From pag	n= 15		The state of the s		
	including the name, and telephone numb receives such reque to obtain an appeal f	address (mailing and email), per of the entity which sts; and information on how orm and assistance in and submitting the appeal	F 20	93		
	(v) The name, addrest telephone number of Long-Term Care Oml	es (mailing and email) and the Office of the State oudsman;				
t t	disabilities, the mailing elephone number of the protection and addeded developmental disability of the Development	g and email address and the agency responsible for rocacy of individuals with ties established under Part al Disabilities Assistance				
ei ac es	mail address and tele gency responsible for dvocacy of individuals	with a mental disorder	The second secon			
or red	discharge, the facility	otice. If the information in r to effecting the transfer must update the as soon as practicable nation becomes available.				
(c) cas	(8) Notice in advance	of facility closure. In the he individual who is the ity must provide written				The state of the s

STATEMEN	<u>IRS FOR MEDICARE</u> TOF DEFICIENCIES	E & MEDICAID SERVICES			(PORM OMB NO	1APPROVE . 0938-039		
AND PLAN	OF CORRECTION	(X1) PROVIDEN/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495268	B. WING			C			
NAME OF	PROVIDER OR SUPPLIER			ड 1स	EET ADDRESS, CITY, STATE, ZIP CODE	10	19/2017		
WESTM		TATION & HEALTHCARE CENTE	ER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFILE OFFICIENCY)	200	(X5) COMPLETION DATE		
F 203	Continued From pa	ge 16	F 20	2					
	State Survey Agend Long-Term Care Or facility, and the resi	the impending closure to the cy, the Office of the State mbudsman, residents of the dent representatives, as well	1 20	3					
	as the plan for the trest relocation of the rest 483.70(I).	ransfer and adequate sidents, as required at §							
	This REQUIREMEN by:	IT is not met as evidenced							
	of a complaint inves	rview, clinical record review, on review, and in the course tigation, the facility staff failed 14) of 18 residents in the				;			
	survey sample, to pr	rovide written notice of ansferring the resident to							
	#14's Responsible F impending discharge obtain a written sign.	nted evidence that Resident Party (RP) was aware of however, the facility failed to ed discharge agreement prior lent #14 to another facility.							
	The findings include	·				THE PARTY OF			
	7/22/17 with the diag dementia without bel viral hepatitis C, and Resident #14 was dis on 8/4/17. Resident	dmitted to the facility on moses of, but not limited to havioral disturbance, chronic diabetes mellitus type 2, scharged to another facility #14 was a new admission, in Data Set (MDS) was due							
	Resident #14 was no therefore a closed re	longer in the facility cord review was conducted.							
1 1	On 10/19/17 at 10:15 record was reviewed.	a.m Resident #14's clinical The review revealed the				!			

P.25/67

CENT	ERS FOR MEDICARI	AND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 10/26/201 M APPROVEI	
AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE (CONSTRUCTION	(X3) DA	O. 0938-039 ATE SURVEY OMPLETED	
		495268	B. WING			C		
NAME OF	PROVIDER OR SUPPLIER		1	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1(0/19/2017	
		TATION & HEALTHCARE CENTE	R .	2400	MCKINNEY BOULEVARD LONIAL BEACH, VA 22443			
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F 203	Continued From pa	ria 17		:				
	following "Resident		F 20	3:				
	7/22/17 2:08 p.m. "Tarrived to facility at (long term care-diagarrived in facility will Resident is pleasan verbal cues and red 7/22/17 6:41 p.m. " throughout facility, a on and working." A wanderguard can worn like a bracelet resident goes near owanderguard allows	7-3. Resident new admission 10:00 for LTC DX Alzheimer's gnosis-Alzheimer's). Resident in family, ambulating.		The second secon				
	attempting to exit. 7/22/17 4:37 a.m. "P. this shift" 7/23/17 12:49 p.m. ". shift, going through fi wander guard in plac want to go home." R timeFamily at beds. wandering"	atient was directed to bed onResident wandering all of ont door several times, with e. Resident stating "I just esident redirected each de this afternoon, aware of		· · · · · · · · · · · · · · · · · · ·		* * **********************************		
	has not set off door a wanderguard on and doing puzzlesactivit games w/other resident at amongst all staff on 3 7/24/17 12:37 p.m. "R	working. In activity room y room after supper playing nt, listening to music, nurse all timesVisual monitoring						

TATEME	NT OF DEFICIENCIES OF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	OMB N	MAPPROV 0. 0938-03	
		TOTAL TOTAL TOTAL MODES EN	A. BUILD	ING	(X3) D	ATE SURVEY DMPLETED	
NAME OF	PROVIDER OR SUPPLIER	495268	B. WING			C	
		TATION & HEALTHCARE CENTE	R	STREET ADDRESS, CITY, STATE, 2406 MCKINNEY BOULEVARD	ZIP CODE	10/19/2017	
(X4) ID PREFIX TAG	EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	COLONIAL BEACH, VA 22/ PROVIDERS PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	F CORRECTION OTION SHOULD BE OTHE APPROPRIATE	(XS) COMPLETI DATE	
F 203	Continued From pa	rie 18			101)		
	to RLE (right lower		F 20	23			
	about golf and bowl	(Resident Name) is up early g. Resident enjoys talking inghas a wonder (sic) guard utside with other staff."					
	300 hallway, nurse a inside, resident wan	Resident went out 300 halfway nurse went running down able to redirect resident back ted to call his girlfriend, nurse iend, Redirected resident in les"	The state of the s				
	room and put things services) director sp.	redirecting by several sident has packed up his back later after SS (social oke to him. Wander guard in hity. Resident ambulating own"					
ı	7/29/17 1:35 p.m. "R roommate. Had pact to leave facility"	esident upset with ked his clothes and wanted			·		
; ; ;	resident obtained so: nurse stepped away i absence, resident cut Upon nurses return, r guard to nurse stating because I am checkir resident in residents r guard could be applie monitored throughout	During morning med pass ssors off of med cart while oriefly. During the nurse wander guard from ankle, esident handed wander of "I removed this for you go ut today." Nurse kept dom until a new wander d to ankle. Resident closely shift. MD and RP		1			
(guard could be applie monitored throughout responsible party) no 8/1/17 9:32 a.m. "Re	d to ankle. Resident closely shift. MD and RP					

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF	DOWNER OF STREET	495268	B. WING		į	C	
1	·	TATION & HEALTHCARE CENTE	R	STREET ADDRESS, CITY, STATE, 2 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 2244	TIP CODE	/19/2017	
PREFIX TAG	TONGM DEELCHENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (SACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 203	Continued From pa	ge 19	F 20	35			
	(every 2) hours."	~	F 20	13		İ	
	at and what he is do	esident wanders around unit, y 2 hours to see where he is ling. Cooperative. Returns to y at times. Wanderguard			, i		
1	around the unit. The (sic-valium), or anoti restrain resident. Sy do restraints at this f resident needs a loci recommended place	s in Richmond or Northern ed closer facility and stated					
	monitored for wander present and intact to frequently for scisson bracelet. Resident ke 8/3/17 2:30 p.m., "Dr. MD made aware that increased wandering that resident have medical wandering behavior as	s or a knife to cut his ept asking to go home" (Name) to unit at this time. resident is exhibiting behavior. MD made aware nember requesting that					
ti F	nis time. Resident or ime. Residents prima Resident refusing to re Resident states that he	m to 300 hallway alerted at utside of building at this try nurse with resident. Benter building at this time. Wants to go home resident back into facility at			•		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING _ COMPLETED 495268 B. WING __ NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 SIJMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (SACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION DATE TAG PREFIX TAG DEFICIENCY) F 203 Continued From page 20 F 203 this time. Resident agitated. Resident swinging arms in aggression. Resident states that he "does not want to come back inside. We cant make him do anything he doesn't want to do..." (note that Director of Nursing, social worker, administrator and police department were notified)...Resident continues to refuse to reenter facility. Will continue to sit with resident. 8/3/17 4:25 p.m. "Residents nephew/RP calling facility at this time. Resident agrees to reenter facility to talk to nephew..." 8/3/17 4:28 p.m. "Resident speaking with nephew at this time. RP made aware of residents intent to leave facility. RP made aware that resident is increasingly more difficult to redirect. Social worker discussing with RP the need for someone to come and visit with resident. Per social worker RP unable to come to visit with resident at this time. Will continue to monitor resident at this 8/3/17 5:00 p.m. "Received phone call from resident sister regarding residents behavior...Explained to sister that resident has been exhibiting increased wandering behavior and that it is determined by the administrator that the resident is posing a threat to his safety. Residents sister verbalizes understanding." 8/4/17 5:37 a.m. "...Wander guard intact to R ankle, working properly..." 8/4/17 12:45 p.m. "(Name of Facility resident was being discharged to) called and said they spoke to RP and RP was in agreement to send resident

there. RP told social worker yesterday that he understands and he was okay with sending

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495268 8. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MCKINNEY BOULEVARD **WESTMORELAND REHABILITATION & HEALTHCARE CENTER** COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETION DATE EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 203 | Continued From page 21 F 203 resident out." 8/4/17 1:01 p.m. "...wander guard in place to right ankle. No attempts to remove from ankle this 8/4/17 2:29 p.m. "social worker spoke to RP who said once he speaks to the dr (Resident Name) can be discharged." 8/4/17 2:39 p.m. "RP gave permission to send the resident at 4 pm." 8/4/17 2:51 p.m. "resident found in halfway at this time, wander guard noted to not be on resident ankle. Resident states that he does not know what happened to his wander guard...Wander guard found in residents toiletry bag at this time...Wander guard replaced at this time to R 8/4/17 2:51 p.m. "Spoke with RP (sister) this morning regarding residents wandering, she mentioned while he was living at home he would pack up his things and try to leave..." 8/4/17 3:21 p.m. "resident d/c (discharged) with (Name of Medicaid transportation company) to

(Name of Facility) in Richmond. RP aware and gave permission. (Receiving Facility name) confirmed they received pt. (patient)."

The facility form titled "INTERDISCIPLINARY DISCHARGE SUMMARY" was reviewed and listed the reason for discharge as "higher level of care needed." The "POST-DISCHARGE PLAN OF CARE" included the receiving facility's name.

Ombudsman name, address, and phone number;

address, and phone number; the State

		AND HUMAN SERVICES		F	RINTED: 10/26/2017
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVED MB NO. 0938-0391
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NAME OF	PROVIDER OR SUPPLIER		1 5	TREET ADDRESS, CITY, STATE, ZIP CODE	10/19/2017
WESTM	ORELAND REHABILIT	ATION & HEALTHCARE CENTER	. 2	460 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443	
(X4) ID PREFIX TAG	. (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS REFERENCED TO THE APPROP DEFICIENCY)	DRF COMPLETION
F 203	Continued From pa	ge 22	F 203		
	the transportation o	ompany's name and phone	. 200		:
	number; and "Resid	lent requires Memory Care			1
	plan of care there w	page of the post-discharge ras a section that read;			
	 These discharge in reviewed with me in 	structions have been a language I understand. All		!	
	questions have bee	n answered to my			
	satisfaction" and	an area for the signature line			
	read: "Resident una	ble to sign/RP aware of			
	transfer" with a date	of 8/4/17.			
	On 10/19/17 at 11:3	5 a.m. an interview was	1		
	conducted with the	Social Worker (Admin-G),			
	Admin-G explained community referral:	that Resident #14 was a and came to the facility from			
	home not from a ho	spital. He stated he went to			
	the resident's house	to evaluate for potential 3 stated the residents			
-		request placement." He			
3	stated the facility wa	is not originally aware that	- American		
		e to Florida with \$20 in his ere." Admin-G stated "If I			
	knew I would not ha	ve admitted him." When	200		
	asked why Resident	#14 couldn't stay at the	ļ		
	wanderguard, attem	ted "He would stretch out the pt to remove the			
	wanderguard." He s	itated he spoke with the			
	resident's nephew to	discuss the need to move to an ephew (RP) was in			
	agreement. When a	asked how the resident was			
;	transported to the re	ceiving facility, Admin-G			
	name)," but did not l	insportation company know if it was a transport van			
	or car that transporte	ed him.			İ
	On 10/19/17 at 11:58	5 a.m. an interview was			The second second
	conducted with Regi	stered Nurse-B (RN-B).			

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		(XZ) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495268	B. WING				C	
		TATION & HEALTHCARE CENTER		240	REET ADDRESS, CITY, STATE, ZIP CODE 00 MCKINNEY BOULEVARD DLONIAL BEACH, VA 22443	1	0/19/2017	
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	When asked about RN-B stated they w dementia, was very was confused about state he wanted to g "Instead of acclimate behaviors increased his wanderguard off facility." "He tried to the police were called Resident #14 was d RN-B stated "As a trunit would be benefit behavior issues and stated part of the samain road outside of who walked Resident discharge, RN-B stated bare was walked him out but the When asked if she was a tracked to the was tracked to the control of the samain formed that the control of the samain formed that the control of the samain formed of the failure notification of dischalling a informed of the failure notification of dischalling informed of the failure notification of dischalling informed of the failure notification of dischalling informed of the failure notification of dischalling informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification of dischalling in the same informed of the failure notification in the same informed of the failure notification in the same informed of the failure notification in the same informed of the failure notification in the same informed of the failure notification in the same informed of the same informed of the same informed of the same informed of the same inf	Resident #14's behaviors, ere told "he had mild sweet and very pleasant but tolocation and continued to go home." She stated ling to facility his wandering I." RN-B stated "He had cut and walked out of the hit me, became aggressive, ed." When asked why ischarged to another facility, sam, we decided a dementia icial. We told the family of his concern for his safety." She fetly concern was there was a fithe facility. When asked int #14 out the day of steed she "couldn't recall who here was someone with him." In the went via car/taxi or van. The Director of Nursing lere was no written RP's signature found in the boumentation regarding reation of discharge was p.m. the Administrator, and Corporate Nurse were re to obtain signed written rige from the RP. No further rided by the facility staff.	F2	203				
	Complaint Dencienc	<i>y.</i>						

TATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/Y21 KR a 'e	m c n-	in the street of the		OMB NO	
IND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTIO		(X3) DA	TE SURVEY MPLETED
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WESTM	ORFI AND PEUADU I	FATION DISCUSSION AND ADDRESS.	_	2400 A	ACKININEV	BOULEVARD		
	MCCAND RENABILI	TATION & HEALTHCARE CENTER	۶			ACH, VA 22443		
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG		(≅ACH C	ORRECTIVE ACTION SHOUL FERENCED TO THE APPROF DEFICIENCY)	000	COMPLET DATE
F 225	Continued From pa	ge 24	E 00	_		F225 and F226		
F 225	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT	F 22		1.	The report of fall rela	atad	
SS=D	ALLEGATIONS/INC	PIVIDUALS	F 22	5	1.	injury was filed for R		
	488 184 185					prior to the survey b		
	483,12(a) The facilit	y must-		1		identified as late.		
	(3) Not ampley as at	Samuel Community of the			2.	The facility will ident	ifv all	
	who-	herwise engage individuals				residents involved in		
	*******					incidents and/or acci	idents	
	(i) Have been found	guilty of abuse, neglect,				potentially resulting		
	exploitation, misapp	ropriation of property, or				major bodily injury a		
	mistreatment by a co	ourt of law;				risk for this alleged		-
	7795 L.F					deficient practice.	-	
	(II) Have had a findir	ig entered into the State			3.	The Director of Nursi	ng,	
	exploitation mistro	oncerning abuse, neglect, tment of residents or				Unit Manager and		
	misappropriation of t	heir property of		1		licensed nurses, will	ļ	
		itell property, or				receive training on		
	(iii) Have a disciplina	ry action in effect against his				reporting guidelines.	The	
	or ner protessional li	cense by a state licensura				facility management	team	
	body as a result of a	finding of abuse mediant				will discuss		
	exploitation, mistreat	ment of residents or				incidents/accidents a	t	
	misappropriation of r	esident property.				daily morning meetin	ıg.	
	(4) Report to the Stat	te nurse aide registry or				Incidents and/or acci		
i	icensing authorities	any knowledge it has of				resulting in major boo		
á	actions by a court of i	law against an employee				injury that occur afte		
1	which would indicate	unfitness for service as a				hours will be reported	d to	
ſ	nurse aide or other fa	cility staff.				the Director of Nursir		
,	\					and Administrator at	the	
(c) in response to alle	gations of abuse, neglect,				time of occurrence.		
	Appointment, or mistre	atment, the facility must:				Compliance with		
1	1) Ensure that all alla	eged violations involving				reporting guidelines v		
۱ 3	buse, neglect, explo	itation or mistreatment,				be audited weekly for	four	
ii ii	ncluding injuries of ur	nknown source and				weeks to ensure		
П	nisappropriation of re	sident property are				compliance.		
T.	eported immediately,	but not later than 2 hours						
а	fter the allegation is i	made, if the events that						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED					
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	serious bodily injury the events that cause abuse and do not rethe administrator of officials (including to adult protective senfor jurisdiction in lor accordance with Staprocedures. (2) Have evidence to thoroughly investigation or mistrinvestigation is in procedures. (3) Prevent further pexploitation, or mistrinvestigation is in procedures. (4) Report the result administrator or his representative and to with State law, including Agency, within 5 wor if the alleged violatic corrective action multiple action multiple and facility documentalled to report injurication in the survey sample of the survey	n involve abuse or result in a provide abuse or result in a provide abuse or result in a provide abuse in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides a provides are law through established that all alleged violations are ted. International abuse, neglect, reatment while the pagress. Is of all investigations to the provide abuse of the reading to the State Survey are king days of the incident, and in is verified appropriate at the state of the provide appropriate and the state of the stat	F 225	4. Incident/accidents reviewed at weekl Committee meetin Reportable incider be reviewed at mo QAPI committee. 5. Date of Completio 11/20/2017	ly Risk ngs. nts will onthly				

	TATÉMÉNT ÓF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X3) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER DRELAND REHABILIT	TATION & HEALTHCARE CENTER	₹	2400 MCKINNI	ESS, CITY, STATE, ZIP C EY BOULEVARD BEACH, VA 22443	:00E	10/19/2017	
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F 225	Continued From pa	ded:	FZ	225		Terrority to proper property and an account		
· manan one or or	6-27-16. Resident a metabolic encephal dementia, diabetes, hypertension, glaud cholesterol. Reside	ras admitted to the facility on #13's diagnoses included; alopathy with psychosis, s, vitamin D, and B deficiency, coma, seizures, and high ent #13 was no longer in the ents were reviewed as a	 	:				
	quarterly Assessme Reference Date of as being severely of Resident was also of one to two staff n	linimum Data Set, which was a ent with an Assessment 1-4-17, coded Resident #13 cognitively impaired. The coded as extensive assistance members for activities of daily eption of eating which only p.		,				
	documentation, reve dated 1-7-17, which Resident on the floo bleeding from her lip unreactive. 911 was	ew was conducted of facility realing a nursing progress note in described finding the or of her room lying face down ip, with her pupils fixed and is called and an ambulance orted the Resident to the local y room.						
	The documents revellarge "cerebral hem- in the frontal lobes to (emergency room) prinjury that may required. "Nontraumatic intractions of the contraction in the cont	ere obtained, and reviewed, realed that Resident #13 had a natoma surrounded by edema bilaterally," and "per the ER physician, it seems this is an lire comfort care,", and cerebral hemorrhage". The notifled of the Resident's le night for the brain						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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495268		D. VIIIVO			10/19/2017		
NAME OF PROVIDER OR SUPPLIER WESTMORELAND REHABILITATION & HEALTHCARE CENTER				240	REET ADDRESS CITY, STATE, ZIP CODE 00 MCKINNEY BOULEVARD DLONIAL BEACH, VA 22443		
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F 225	Continued From pa	ge 27	F	225			
	and follow up report that no initial report the state agency ur incident), and no fo investigation was m 7-15-17 (8 days afte state law required a occurred, that the ir 24 hours or as soor follow up report muthe incident's discolon 10-18-17 an intended and initial and injuries of unknown injury that was not vintact Resident can suspicious due to s number of injuries: the facility policy and the state of t	erview was conducted with the stated "yes, the reports are corigin are defined as; An witnessed, and the cognitively not explain it, and the injury is everity, suspicious location or overtime.					
	was reviewed and r not include reportin	Suspected Resident Abuse" evealed that the policy does g requirements for injuries of md misappropriation.					
F 226 SS=D	and Director of nursideficient practice. further information. 483.12(b)(1)-(3), 48	0-19-17, the Administrator sing were made aware of the The facility presented no 33.95(c)(1)-(3) ENT ABUSE/NEGLECT, ETC	Fí	226			

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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	
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NAME OF PROVIDER OR SUPPLIER WESTMORELAND REHABILITATION & HEALTHCARE CENTER			₹	STREET ACCRESS, CITY, STATE, ZIP C 2400 MCKINNEY BOULEVARO COLONIAL BEACH, VA 22443	ODE		
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F 226	Continued From pa	age 28	F2	228			
	483.12 (b) The facility mus written policies and	st develop and implement i procedures that:					
		event abuse, neglect, and dents and misappropriation of					
	(2) Establish polici investigate any suc	es and procedures to ch allegations, and	4 4				
	(3) Include training §483.95,	as required at paragraph					
	the freedom from a requirements in §	, and exploitation. In addition to abuse, neglect, and exploitation 483.12, facilities must also their staff that at a minimum	· v				
		at constitute abuse, neglect, nisappropriation of resident th at § 483.12.					
		for reporting incidents of abuse, on, or the misappropriation of					
	prevention.	anagement and resident abuse NT is not met as evidenced					
	Based on staff int and facility docum failed to develop a regard to employe	erview, clinical record review, entation review, the facility staff and operationalize policies in a abuse pre-screening, and eparting for 1 Resident				!	

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PRINTED: 10/26/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/GLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495268 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP GODE 2400 MCKINNEY BOULEVARD **WESTMORELAND REHABILITATION & HEALTHCARE CENTER** COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X4) ID (XS) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 226 Continued From page 29 F 226 (Resident #13) in a sample of 18 Residents. 1. For Resident #13, the facility staff failed to submit a Facility Reported Incident to the Office of Licensure and Certification (OLC) within 24 hours of an injury of unknown origin. The Findings included: 1. Resident #13 was admitted to the facility on 6-27-16, Resident #13's diagnoses included; metabolic encephalopathy with psychosis, dementia, diabetes, vitamin D, and B deficiency, hypertension, glaucoma, seizures, and high cholesterol. Resident #13 was no longer in the facility, and documents were reviewed as a closed record. The most recent Minimum Data Set, which was a quarterly Assessment with an Assessment Reference Date of 1-4-17, coded Resident #13 as being severely cognitively impaired. The Resident was also coded as extensive assistance of one to two staff members for activities of daily living, with the exception of eating which only required set up help. On 10-18-17 a review was conducted of facility documentation, revealing a nursing progress note dated 1-7-17, which described finding the Resident on the floor of her room lying face down bleeding from her lip, with her pupils fixed and unreactive. 911 was called and an ambulance arrived and transported the Resident to the local hospital emergency room.

Hospital records were obtained, and reviewed. The documents revealed that Resident #13 had a large "cerebral hematoma surrounded by edema

PRINTED: 10/26/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495268 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MCKINNEY BOULEVARD WESTMORELAND REHABILITATION & HEALTHCARE CENTER COLONIAL BEACH, VA 22443 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 226 | Continued From page 30 F 226 in the frontal lobes bilaterally," and "per the ER physician, it seems this is an injury that may require comfort care,", and "Nontraumatic intracerebral hemorrhage". The nursing home was notified of the Resident's admission that same night for the brain hemmorhage. The facility investigation, facility reported incident and follow up report were reviewed, and revealed that no initial report of the incident was made to the state agency until 7-10-17 (3 days after the incident), and no follow up report of the investigation was made to the state agency until 8-15-17 (8 days after the incident). Federal and state law required at the time that this incident occurred, that the initial report take place within 24 hours or as soon as it was identified, and a follow up report must take place within 5 days of the incident's discovery. On 10-18-17 an interview was conducted with the Administrator, who stated "yes, the reports are late". Injuries of unknown origin are defined as; An injury that was not witnessed, and the cognitively intact Resident can not explain it., and the injury is suspicious due to severity, suspicious location or number of injuries overtime. The facility policy and procedure on "Abuse-Reporting Actual or Suspected Resident Abuse" was reviewed and revealed that the policy does not include reporting requirements for injuries of unknown source, and misappropriation.

These incidents are mandated by state and federal law to be reported immediately to the administrator and to other officials including the

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IER BILITATION & HEALTHCARE CENTER	R 2	TREET ACORESS, CITY, STATE, ZIP CO 400 MCKINNEY BOULEVARD OLONIAL BEACH, VA 22443	DOE
ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(ÉACH CORRECTIVE ACTION	SHOULD BE COMPLETION
As this was omitted in the policy, vare of the reporting requirements, g requirements were not followed and 10-19-17, the Administrator nursing were made aware of the ce. The facility presented notion.	F 226	F246	
ect and Dignity. The resident has ated with respect and dignity, to reside and receive services in reasonable accommodation of and preferences except when to danger the health or safety of the er residents. MENT is not met as evidenced ervation, staff interview, Resident stractor interview, and facility review, the facility staff failed to the bathing needs and preferences (Resident's #8, #4, and #9) in a of 18 Residents. If #8, the facility staff failed to ther bathing needs and so both shower rooms in the facility endaily, as the hot water boiler was to the facility staff failed to the facility as the hot water boiler was the #4, the facility staff failed to		1. Bathing facilities restored to comp R#8, R#4, and R#5 made aware of compliance. 2. The facility has id all residents to be for this alleged depractice. 3. The facility has ensecond contracted on the boiler syst the primary cont was unable to ful obligation. A dai of water temperations on the ongoing and will to be ongoing in the object of the object of the object of the object of the ongoing in the object of the ongoing in the object of the ob	entified e at risk eficient angaged a or to work eem as ractor ifill the ly review eatures is continue definitely. ure logs d to mmittee ew.
	y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) In page 31 As this was omitted in the policy, were of the reporting requirements, and 10-19-17, the Administrator foursing were made aware of the ce. The facility presented no tion. EASONABLE ACCOMMODATION REFERENCES pect and Dignity. The resident has eated with respect and dignity, It to reside and receive services in reasonable accommodation of and preferences except when to danger the health or safety of the er residents. EMENT is not met as evidenced ervation, staff interview, Resident intractor interview, and facility in review, the facility staff failed to	Y STATEMENT OF DEFICIENCIES INFORMATION & HEALTHCARE CENTER Y STATEMENT OF DEFICIENCIES INFORMATION TAG IN page 31 As this was omitted in the policy, ware of the reporting requirements, agrequirements were not followed and 10-19-17, the Administrator for nursing were made aware of the ce. The facility presented no tion. EASONABLE ACCOMMODATION EASONABLE ACCOMMODATION EAFERENCES Pect and Dignity. The resident has eated with respect and dignity, It to reside and receive services in reasonable accommodation of and preferences except when to indanger the health or safety of the er residents. EMENT is not met as evidenced ervation, staff interview, Resident intractor interview, and facility is review, the facility staff failed to the bathing needs and preferences (Resident's #8, #4, and #9) in a of 18 Residents. In the facility staff failed to the bathing needs and so both shower rooms in the facility le daily, as the hot water boiler was at #4, the facility staff failed to	PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION OR LSC IDENTIFYING INFORMATION) TAG PRESIX TAGE PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TAG PRESIX TAGE PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TAG PRESIX TAGE PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORN COTON CROSS-REFERENCED TO THE CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CORN COTON CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR (EACH CON THE CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR STORM CROSS-REFERENCED TO THE CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF COR STORM CROSS-REFERENCED TO THE DEFICIENCY TAG PROVIDERS PLAN OF CORN CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF CORN CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF CORN CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF CORN CROSS-REFERENCED TO THE DEFICIENCY) TAG PROVIDERS PLAN OF CORN CROSS TO THE DEFICIENCY TAG PROVIDERS PLAN OF CROSS TO THE CROSS TO THE CROSS TO THE CROSS TO THE CROSS TO THE CROSS TO THE CROSS TO THE CROSS TO THE CROSS TO THE CROSS TO

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495268		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		£ CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		a. WING		С			
		ATION & HEALTHCARE CENTER	₹ 2	TREET ADDRESS, CITY, STATE, ZIP COD 100 MCKINNEY BOULEVARD OLONIAL BEACH, VA 22443	10 E	<u>)/19/2017</u>	
(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OU DEC	(X5) COMPLETION DATE	
	preferences. 3. For Resident #9, accommodate his b preferences. The findings include 1. Resident #8 was a facility on 3-24-07 i. Hypertension, atrial and seizure disorder Resident #8's most r (MDS) was a Quarte Assessment Reference MDS coded Resident with a most requiring limited to estaff person for Activibathing; Resident #8 assistance of one starequired set up only it continent of bowel ar	the facility staff failed to athing needs and d: originally admitted to the Diagnoses included, ibrillation, Hypothyroidism, /not active. ecent Minimum Data Set rly Assessment with an nee Date (ARD) of 7-15-17, ident #8 with a BIMS (Brief Status) of 15/15 indicating no; Resident #8 was coded as ktensive assistance of one ties of Daily Living except for was coded as requiring total of person for bething, and or eating. The Resident was id bladder.	F 246				
t t	the facility Resident # and was complaining not getting to take a s why it took a month to neater/boiler. The Re reported this to the Ac yes" she went on to s here told her every d been fixed, and she w shower rooms were in acility did not have ar	at the end of initial tour of 8 approached surveyors, that she was angry about shower, and wanted to know of fix the hot water esident was asked if she had siministrator, and she stated say that the administration ay it was fixed, but it had not was angry. She stated both toperable because the not water. Resident #8 not had hot water for four			;		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/26/2017 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING COMPLETED 495268 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MCKINNEY BOULEVARD **WESTMORELAND REHABILITATION & HEALTHCARE CENTER** COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DATE DEFICIENCY) F 246 | Continued From page 33 F 246 weeks. She stated she was not able to get a bath or shower because of no hot water. Resident #8 stated she preferred to get a shower but could not tolerate the cold water. She stated the staff used wipes/towelettes to bathe them, and this was unacceptable, and she was tired of "stinking, and feeling dirty all over". Resident #8 stated she only got to wash her "face, underarms and private area." Resident #8 stated the water was too cold to even wash those areas but she could do no better. Resident #8 stated the facility staff should not expect the residents to bathe in cold water. She stated the staff let the water run a long time but it still stayed cold. Resident #8 stated she really hoped the surveyors could help them get some hot water, as the administration told them every day the hot water was fixed, and it wasn't. Resident #8 stated she was sure the cold water at the facility was going to make her get sick. Resident #8 stated "as much as we pay to stay here, don't you think we could get hot water for bathing?, this is ridiculous in this day and age." "no one wants to be near people stinking and nasty, it makes you not want to let anyone see you.' On 10-17-17 directly after Resident #8's interview, the Housekeeping Director. Maintenance assistant, and CNA(C) were interviewed in the shower room, while testing the water temperature with a thermometer. The water had been running for "about 10 minutes" according to the House Keeping Director and maintenance assistant. The temperature was measured with 2 devices by the staff members and never went above 98 degrees Fahrenheit. According to the House Keeping Director and maintenance assistant, the hot water boiler had

been not working correctly for "about 2 weeks".

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LT:PLE CONSTRUCTION DING	()	(X3) DATE SURVEY COMPLETED	
		495268	B. WING	Name of the last o		C 10/19/	2017
		TATION & HEALTHCARE CENTER	₹	STREET ADDRESS, CITY, STATE, ZIP CO 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443		10/10/	2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD B		(XS) OMPLETION DATE
F 246	Resident #8 that da too cold for the Resident Administrator was in Resident's were be receiving a "bath in could be heated. He boiler had persisted On 10-18-17 a grouwith Residents. Se attendees were in a they were unable to because of the lack frustrated with the state attendance, ranged On 10-18-17 the country is water boiler entered interviewed. He istate boiler had been kept having trouble it. When asked hot the problem, he stated	e was providing care for ay, and stated the water was sident to get a shower. Ity after the staff interview, the interviewed, and stated the eing bathed, that they were in a bag", which were wipes that the stated the problem with the d "about 2 weeks". Up council interview was held even of the 9 resident unanimous agreement that or receive showers or baths k of hot water, and were very situation. The time frame for facilities, as stated by those in	F2	246			
	problem, and had no During the end of d 10-19-17, the facilit Nursing and Corpor	ot water problem was still a not been completely repaired. day debriefing on 10-18-17, and ty Administrator, Director of orate Consultants were dings. No further information					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	7		OMB NO	0.0938-03
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DA	TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	TATION & HEALTHCARE CENTE		STREET ADDRESS, CITY, STATE, 2400 MCKINNEY BOULEVARD	ZIP CODE	/19/2017
(X4) ID PREFIX TAG	I SAUM DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	COLONIAL BEACH, VA 224 PROVIDER'S PLAN OF (EACH CORRECTIVE ACC CROSS REFERENCED TO DEFICIENCE	CORRECTION TION SHOULD BE THE APPROPRIATE	(X3) COMPLETE DATE
F 246	Continued From pa	ge 35	F 2			·
•	2. For Resident # 4 accommodate her I preferences.	, the facility staff failed to pathing needs and	:			
r	eadmitted 8/11/201 not limited to, Diabe typothyroidism, Ga	Strnesonhaggal Doffing				
w V	leurogenic Bladder leurogenic Bowel, t	ord Syndrome C1-C4, with Foley Catheter, Jrethritis, Psychotic Disorder Seizure Disease and Morbid				
R cc fo im ex fo Re as	eference Date (AR odded Resident #4 w r Mental Status) of npairment; Resident etensive assistance of Activities of Dally lesident #4 was cooksistance of one staguired set up only fe	imum Data Set (MDS) was a nt with an Assessment D) of 9/2/17. The MDS with a BIMS (Brief Interview 15/15 indicating no cognitive t 4 was coded as requiring of one to two staff person Living except for bathing; ded as requiring total ff person for bathing, and or eating; and was coded as of bowel and bladder.				
an	d clinical record rev	Resident # 4's clinical The review of the MDS realed Resident # 4 required a staff person for bathing.				
On cor ups wai hot	10/18/2017 at 8:40 nducted with Reside set because the fac fer. Resident #.4 sta water for over two	a.m., an interview was ent # 4 who stated she was ility did not have any not sted the facility had not had weeks. She stated she was	· ;			
CM5-2567(02	-99) Previous Versians Obs	olete Event ID: 894111	Faci	lity ID. VA0160		

NAME OF PROVIDER OR SUPPLIER WESTMORELAND REHABILITATION & HEALTHCARE CENTER (24) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH NA 2243) SUMMARY STATEMENT OF DEFICIENCIES (EACH PAPER NOTE) AND SUBJECT OF THE PROVIDERS AND OF CORRECTION THAT REGULATORY OR LISC IDENTIFYING INFORMATION) F 246 Continued From page 36 not able to get a bath or shower because of no hot water. Resident # 4 stated she preferred to get a shower but could not tolerate the cold water. Resident # 4 stated she only allowed the staff to help her with a bed bath and to only wash her "face, underarms and private area." Resident # 4 stated the staff is the water was too cold to even wash those essential areas but that was the only way to feel a little bit clean. Resident # 4 stated the facility staff should not expect the residents to bathe in cold water. She stated the staff is the water run a long time but it still stayed cold. Resident # 4 was observed blowing her nose and coughing while stilling in her room watching TV. Resident # 4 was observed blowing her nose and coughing while stilling in her room watching TV. Resident # 4 was observed sitting in a wheelchair in her room getting her hair curied by a visitor. Resident # 4 stated she was sure the cold water at the facility was going to make her get sicker. Resident # 4 stated she was sure the cold water at the facility was going to make her get sicker. Resident # 4 stated she was observed sitting in a wheelchair in her room getting her hair curied by a visitor. Resident # 4 stated she liked to go to Activities programs and sometimes liked to go to a devine story programs and sometimes liked to go to tactivities programs and sometimes liked to go to the divisite of the Activity Room after her hair was curied.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A BIJILE	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
WESTMORELAND REHABILITATION & HEALTHCARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCES (SACH OFFICIENCY MUST SE PRECEDED BY PULL PROFUDENCY MUST SE PRECEDED BY PULL PROFUDENCY MUST SE PRECEDED BY PULL PROFUDENCY MUST SE PRECEDED BY PULL PROFUDENCY MUST SE PRECEDED BY PULL PROFUDENCY MUST SE DEATHERING INFORMATION) F 246 Continued From page 36 not able to get a bath or shower because of no hot water. Resident # 4 stated she preferred to get a shower but could not tolerate the cold water. Resident # 4 stated she only allowed the staff to help her with a bed bath and to only wash her "face, underarms and private area." Resident # 4 stated the water was too cold to even wash those essential areas but that was the only way to feel a little bit clean. Resident # 4 stated the facility staff should not expendith to explain to both ein cold water. She stated the staff let the water run a long time but it still stayed cold. Resident # 4 was observed blowing ther nose and coughing while sitting in her room watching TV. Resident # 4 stated she was beginning to catch a cold and stated she was			495268	B. WING	S		
FREEIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 246 Continued From page 36 not able to get a bath or shower because of no hot water. Resident # 4 stated she preferred to get a shower but could not toierate the cold water. Resident # 4 stated she only allowed the staff to help her with a bed bath and to only wash her "face, underarms and private area." Resident # 4 stated the water was too cold to even wash those essential areas but that was the only way to feel a little bit clean. Resident # 4 stated the facility staff should not expect the residents to bathe in cold water. She stated the staff let the water run a long time but it still stayed cold. Resident # 4 was observed blowing;her nose and coughing while sitting in her room watching TV. Resident # 4 stated she was sure the cold water at the facility was going to make her get cickor. Resident # 4 stated she was sure the cold water. She stated they a visitor, Resident # 4 stated was gobserved blowing;her nose and coughing while sitting in her room watching TV. Resident # 4 was observed was sure the cold water at the facility was going to make her get cickor. Resident # 4 stated she was sure the cold water at the facility was going to make her get cickor. Resident # 4 stated she was sure the cold water. She she was beginning to catch a cold and stated she was sure the cold water at the facility was going to make her get cickor. Resident # 4 stated she liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go to Activities		:			2400 MCKINNEY BOULEVARD	DDE	10/19/2017
not able to get a bath or shower because of no hot water. Resident # 4 stated she preterred to get a shower but could not tolerate the cold water. Resident # 4 stated she only allowed the staff to help her with a bed bath and to only wash her "face, underarms and private area." Resident # 4 stated the water was too cold to even wash those essential areas but that was the only way to feel a little bit clean. Resident # 4 stated the facility staff should not expect the residents to bathe in cold water. She stated the staff let the water run a long time but it still stayed cold. Resident # 4 stated she really hoped the surveyors could help them get some hot water. On 10/18/2017 at 10:30 a.m., Resident # 4 was observed blowing her nose and coughing while sitting in her room watching TV. Resident # 4 stated she was beginning to catch a cold and stated she was sure the cold water at the facility was going to make her get sicker. Resident # 4 stated "this is terrible! We need hot water." On 10/18/2017 at 2:00 p.m., Resident # 4 was observed sitting in a wheelchair in her room getting her hair curled by a visitor. Resident # 4 stated she liked to go to Activities programs and sometimes liked to go to Activities programs and sometimes liked to go outside during the day. Resident # 4 stated she did not want to go around other people if she did not feel clean and if she did not look good. On 10/18/2017 at 4 p.m., Resident # 4 was observed wheeling herself in the hallway. Resident # 4 stated she had gone to the Activity	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD	BE COMPLETION
During the end of day debriefing on 10/13/2017, the facility Administrator, Director of Nursing and	F 246	not able to get a b hot water. Resider get a shower but of Resident # 4 state help her with a bed "face, underarms a stated the water wessential areas builttle bit clean. Resident water. She stated time but it still stay she really hoped the get some hot water. On 10/18/2017 at observed blowing sitting in her room stated she was be stated was suit was going to make stated "this is territory on 10/18/2017 at observed sitting in getting her hair cut stated she liked to sometimes liked to Resident # 4 state other people if she did not look good. On 10/18/2017 at observed wheeling Resident # 4 state Room after her hair cut of the people if she did not look good.	ath or shower because of no not #4 stated she preferred to could not tolerate the cold water, dishe only allowed the staff to dishe only allowed the staff to dishe only allowed the staff to dishe only allowed the staff to dishe only wash her and private area." Resident #4 tas too cold to even wash those it that was the only way to feel a lident #4 stated the facility staff the residents to bathe in cold the staff let the water run a long red cold. Resident #4 stated the surveyors could help them for. 10:30 a.m., Resident #4 was her nose and coughing while watching TV. Resident #4 glinning to catch a cold and re the cold water at the facility sher get sicker. Resident #4 ple! We need hot water." 2:00 p.m., Resident #4 was a wheelchair in her room fled by a visitor, Resident #4 go to Activities programs and o go outside during the day. If she did not want to go around the did not feel clean and if she herself in the hallway. If she had gone to the Activity ir was curled.	F	246		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING_ COMPLETED 495268 8. WING NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 246 Continued From page 37 F 246 Corporate Consultarits were informed of the findings. On 10/19/2017 at 8:50 a.m., Resident # 4 was observed sitting in her wheelchair in her room. Resident # 4 stated the water still was not completely fixed. No further information was provided. 3. For Resident # 9, the facility staff failed to accommodate his bathing needs and preferences. Resident #9 was admitted to the facility on 3/13/2017, with the diagnoses of, but not limited to Hypertension, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Solitary Pulmonary Nodule, Diverticulitis, Heart Failure, Single Thyroid Nodule and Pressure Ulcer. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 9/14/2017. The MDS coded Resident # 9 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 9 was coded as requiring extensive to total assistance of one to two staff person for Activities of Daily Living; required set up only for eating; and was coded as always incontinent of bowel and bladder. On 10/18/2017 at 8:40 a.m. during medication pass and pour observation involving other residents on the 200 Hall, Resident # 9 was

observed sitting in his bed watching TV. Resident

CENTE	RS FOR MEDICARE	I AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 10/26/201 FORM APPROVEI OMB NO. 0938-039
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. SUILO	TIPLE CONSTRUCTION	(X3) DATÉ SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, STAT	10/19/2017
WESTM	ORELAND REHABILI	TATION & HEALTHCARE CENTE	R	2400 MCKINNEY BOULEVAR COLONIAL BEACH, VA 2	D
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST SE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN	OF CORRECTION (X5) ACTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
	Resident # 9 stated about the hot water have any hot water, a month." Resident and stated the prob been going on too le could not take a sho too cold. He stated in the previous mon "entirely too cold." I with the facility staff and was told the hot not fixed. Resident our home but I did in had hot water and c with hot or warm wa Resident # 9 stated but could not tolerate 9 stated he observer	ge 38 eyor to come into his room, "something needs to be done in this building. We don't We haven't had any for over # 9 consented to an interview Iem with the hot water had ong. Resident # 9 stated he ower because the water was he had only taken 3 showers th because the water was Resident # 9 stated he talked about the lack of hot water water was fixed but it was # 9 stated " they say this is of live like this at my home. I ould take a bath or a shower ter whenever I wanted." he did not really feel clean a cold shower. Resident # d that some of the other I showers in cold water	F 2	46	
	On 10/18/2017 at 2:0 altended the Group I residents and anothe complained during the lack of hot water in the period of time.	ght that was terrible. 00 p.m., Resident # 9 Interview with 9 other or surveyor. Other residents the Group interview about the the facility for an extended			
	record was reviewed and clinical record re	p.m., Resident # 9's clinical . The review of the MDS vealed Resident # 9 required ance of two staff persons for			
(observed sitting in his	0 a.m., Resident # 9 was s bed eating breakfast, ne hot water still was not			

8045274502 PRINTED: 10/26/2017 OCT-26-2017 14:13 From:VDH OLC FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING ... 10/19/2017 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 495268 2400 MCKINNEY BOULEVARD NAME OF PROVIDER OR SUPPLIER COLONIAL BEACH, VA 22443 WESTMORELAND REHABILITATION & HEALTHCARE CENTER PROVIDER'S PLAN OF CORRECTION (XSI COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (X4) ID PREFIX TAG F 246 F 246 Continued From page 39 fixed. He stated the staff said it was fixed but it "was warm one minute and then not warm the next time" he used it to wash his hands. Resident # 9 stated the facility really needed to fix the hot water. During the end of day debriefing on 10/19/2017. the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings. No further information was provided. F282 F 282 483.21(b)(3)(ii) SERVICES BY QUALIFIED The care plan for R#5 has been clarified and R#5 is F 282 PERSONS/PER CARE PLAN now being transferred per (b)(3) Comprehensive Care Plans the care plan guidance. The services provided or arranged by the facility, Residents requiring as outlined by the comprehensive care plan, mechanical lift transfers have been identified as at must-(ii) Be provided by qualified persons in risk for this alleged accordance withleach resident's written plan of deficient practice. Nursing personnel will be This REQUIREMENT is not met as evidenced trained on appropriate utilization of Care Plans Based on observation, staff interview, and clinical and Resident Profile for record review, the facility staff failed to transfer one (Resident #5) of 18 residents in the survey resident transfer requirements. sample per plan of care. Additionally, a review of Resident #5 was transferred from her wheelchair all transfer care plans for to bed without the use of a mechanical (hoyer) lift residents requiring mechanical lift transfers as directed in her care plan. will be completed to ensure these are resident

The findings included:

Resident #5 was originally admitted to the facility

specific.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495268 B. WING NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION PRESIV TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 282 Continued From page 40 F 282 The Director of Nursing diagnoses of, but not limited to, dementia, and/or Designee will Creutzfeldt-Jakob disease (rare, degenerative, conduct audits three invariably fatal brain disorder (ninds.nih.gov)). times per week for four anxiety, and adult failure to thrive. weeks through visual monitoring of compliance. The most recent/Minimum Data Set (MDS) was a quarterly assessment with an Assessment All audits will be Reference Date (ARD) of 8/8/17. The MDS submitted to the QAPI coded Resident #5 with severe cognitive committee for review. impairment; required extensive assistance from Date of Completion: 11/30/2017 staff for bed mobility, transfers, toileting, hygiene dressing, and eating; was dependent of staff for bathing. On 10/18/17 at approximately 11:00 a.m. Resident #5's care plan was reviewed and included: "Problem Start Date: 12/28/2015 (Resident Name) is at risk for decline in ADLs (activities of daily living) due to diagnosis of Creutzfeldt-Jacob dementia and FTIT (failure to thrive)." "Approach" included: "...12/28/2015 Transfer with hoyer lift and 2 staff members." On 10/18/17 at 1:45 p.m. Resident #5 was observed being rolled in her wheelchair by Certified Nursing Assistant-A (CNA-A) followed by CNA-B. Resident #5 was rolled in her wheelchair next to her bed. CNA-A and CNA-B placed their arms under Resident #5's underarms and gently

transfer.

lifted and performed a turn pivot transfer from the wheelchair to bed. They sat Resident #5 on the edge of the bed then assisted her to a lying position. Resident #5 did not show any signs of discomfort or anxiety during the transfer. When asked if they use a lift to transfer the resident, CNA-A stated she usually stands her to

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PRINTED: 10/26/2017 FORM APPROVED

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) Wil	TIO	E CONSTRUCTION		<u> </u>	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:			CC CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495268	B. WING	;			C	
· · · · · · · · · · · · · · · · · · ·	FATION & HEALTHCARE CENTER		24	TREET ADDRESS, CITY, STATE, ZIP CODE 400 MCKINNEY BOULEVARD OLONIAL BEACH, VA 22443	<u>. 10</u>	<u>)/19/2017</u>	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	ם מי	(XS) COMPLETION DATE	
provided to resident consistent with profithe comprehensive and the residents g (I) Dialysis. The fact residents who requiservices, consistent of practice, the compared plan, and the repreferences. This REQUIREMEN by: Based on staff interreview, and clinical realled for one (Resident failed for one (Resident review) and clinical realled for one (Resident #5 was additimes in September non-pharmacological administering the imediagnoses of, but not Creutzfeldt-Jakob disinvariably fatal brain anxiety, and adult failed.	e following: ent. sure that pain management is a who require such services, essional standards of practice, person-centered care plan, cals and preferences. lility must ensure that re dialysis receive such with professional standards prehensive person-centered esidents' goals and IT is not met as evidenced view, facility documentation record review, the facility staff ent #5) of 18 residents in the tempt non-pharmacological administering the as needed edication, Xanax. ministered PRN Xanax 4 2017 without attempted 1 approaches prior to edication. d: pinally admitted to the facility mitted on 7/30/16 with the limited to, dementia, sease (rare, degenerative, disorder (ninds.nih.gov)),	F	309	Residents on prn psychoactive medication will have their care plan reviewed for the presen of resident target behaviors, triggers and resident specific non- pharmacologic approaches. 4. The Director of Nursing and/or Designee will conduct a monthly audit of prn psychoactive medication use for review at the monthly QAPI committee meeting. 5. Date of Completion: 11/30/2017	s ce		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(XZ) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	ı	495268	B. WING			1	0 19/2017
	PROVIDER OR SUPPLIER DRELAND REHABILI	TATION & HEALTHCARE CENTER	R	STREET ADDRESS, CITY, STATE, ZIP (2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443	CODE	100	1372017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	4 SHOULD	8E	(X5) COMPLETION DATE
F 309	Reference Date (A coded Resident #5 impairment; requin staff for bed mobili dressing, and eatir bathing. On 10/18/17 at 3:0 record was review, physician orders w Xanax (alprazolam oral as needed for order date was 7/2 Review of Residen Administration Rec 2017 revealed the on 9/14/17 at 2:08 9/22/17 at 2:26 p.n 9/27/17 at 7:49 p.n 9/28/17 at 12:50 lp. Review of "Resident dated 9/14/17" Resident agitated Husband requeste Xanax given. Resident given foll no non-pharmacol as attempted prior There was no door 9/28/17 to describe attempted prior to Resident #5's care of "Has prn order frestlessness form	ent with an Assessment (RD) of 8/8/17. The MDS is with severe cognitive ed extensive assistance from ty, transfers, toileting, hygieneing; was dependent on staff for 0 p.m. Resident #5's clinical ed. The review revealed hich included: 1) 0.5 mg (milligrams) on tab; agitation every 12 hours. The 8/17.	F 34	09			

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DEPAR CENTE	RTMENT OF HEALT	H AND HUMAN SERVICES				PRINTE	D: 10/26/201
O I W I E WIE I	O UE DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				FOR: OMB NO	MAPPROVE 0. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	(XS) WAL	TIPLE CONS	RUCTION		J. 0938-035 ITE SURVEY
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	once assessed no	longer needed "	r 30	9			
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	On 10/19/17 at 1:3	0 p.m. the Administrator,					
	Corporate Nurse :	and Director of Nursian (non	r\ :				
	were intomited of y	BOAY DOING administrated	17				i
i	without documente	© non-pharmacological					
	approaches attemn	Med first. The DON status at					
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	Denavior, severity a	Ind enisodes" and "To		!			!
	nun-pharmacologic	al redirect remove the animal	_				
	CHACL SOLUTIONS INC. THE	medications and manifests					
÷	side effects." The f	acility psychotropic medication		*			
	use and medication	administration policies were	on _.				
	requested by inspec	tor					
	, by moper	7.Q1,					
	Facility policy titled	PSYCHOACTNE				,	
	MEDICATIONS PE	VISTAT, ADMINISTRATION					
r 1	OF" dated 7/2/12 w	as received and reviewed.		i			
	The policy included:	as received and reviewed.	1				
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10	PURPOSE Thelia	fant of these activities		-		i	
ļ	ensure that all node:	tent of these guidelines is to					
1	neasures are imple	ble non-pharmacological					
r	btaining orders and	mented/attempted prior to	# 4 5				
2	antipsychotic medica	administering stat or p.r.n.					
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v	COLD COLAR DISSUITED	resident and attamented	İ				
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'n	hysician for medicat	seeking an order from	: :				1
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in	clude, but not limite	pted. Such approaches my					
131	cious, out not ilmite	a to:				i	1
	a. Calm, gentle r	edirection.	:				}
	b. Diversional ac	tivities.					
e.	c. Assessment of	the resident's					
. St	ırroundings: e.g., te	mperature; noise.	!			4	1

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 495268 8. WING NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (X5) COMPLETION DATE TAG DEFICIENCY) F 309 Continued From page 45 F 309 d. Assessment of resident's physical condition: e.g., pain; fatigue; hunger; thirst. e. Allow the resident sufficient time to calm, and re-approach. f. When possible, ask family to come assist in efforts to calm resident..." No further information was provided by the facility F 323 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT F 323 HAZARDS/SUPERVISION/DEVICES F323 SS=D R#14 no longer resides in (d) Accidents. the facility. The facility must ensure that -The facility has identified all residents to be at risk (1) The resident environment remains as free for this alleged deficient from accident hazards as is possible, and practice. All staff will be trained on (2) Each residentireceives adequate supervision and assistance devices to prevent accidents. appropriate placement of potentially dangerous (n) - Bed Rails. The facility must attempt to use items, including scissors, appropriate alternatives prior to installing a side or and ensuring safety of bed rail. If a bed or side rail is used, the facility residents in the must ensure correct installation, use, and surrounding areas. maintenance of bed rails, including but not limited Scissors will be stored in to the following elements. the treatment cart when (1) Assess the resident for risk of entrapment not in use by nursing from bed rails prior to installation. personnel. 4. The Director of Nursing (2) Review the risks and benefits of bed ralls with and/or Designee will the resident or resident representative and obtain make rounds with an eye informed consent prior to installation. for monitoring the nursing

(3) Ensure that the bed's dimensions are

appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced

area for unsafe objects. If

objects are found, they

will immediately remove them. Audits will be

DEPAR' CENTE	TMENT OF HEALT RS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 10/26/2017 APPROVED
STATEMENT	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		495268	B. WING			C
NAME OF	PROVIDER OR SUPPLIEF	3	1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 10	/19/2017
WESTMO	DRELAND REHABIL	ITATION & HEALTHCARE CENTER	٤	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	n ac	(X5) COMPLETION DATE
	facility documentation of a complaint investo maintain a safe #14) of 18 resident #14 obtained facility at the findings included Resident #14 was 7/22/17 with the dischard without by viral hepatitis C, and Resident #14 was on 8/4/17. Resident #14 was on 8/4/17. Resident #14 was on 8/4/17. Resident #14 was on 8/4/17. Resident #14 was on 8/4/17. Resident #14 was on 8/4/17. Resident #14 was on 8/4/17. Resident #16 was reviewed following "Resident in the completed in facility at (long term care-dial arrived in facility with Resident is pleasard verbal cues and record was reviewed in facility at (long term care-dial arrived in facility, son and working." A wanderguard can worn like a bracelet	erview, clinical record review, tion review, and in the course estigation, the facility staff failed environment for one (Resident its in the survey sample. Ined scissors from the diremoved his wanderguard. Ited: admitted to the facility on agnoses of, but not limited to behavioral disturbance, chronic addiabetes mellitus type 2, discharged to another facility and the facility and behavioral disturbance, chronic addiabetes mellitus type 2, discharged to another facility and the facility and behavioral disturbance, chronic addiabetes mellitus type 2, discharged to another facility and behavioral disturbance, chronic addiabetes mellitus type 2, discharged to another facility and behavioral discharged to another facility and behavioral disturbance, chronic and dispersion of the facility and the facility and the facility and the family, ambulating. The review revealed the progress Notes: The review revealed the progress Notes: The review revealed the progress Notes: Resident new admission for the family, ambulating. The with confusionrequires directing Resident wondering (sic) ambulates self, wanderguard be described as a device that triggers an alarm when a	F 32:	,	ing	
1	resident goes near	or opens an exit door. The sthe resident to ambulate				

DEPART	TMENT OF HEALTH	AND HUMAN SERVICES		To:918042242282	P.55/6	
STATEMENT	OF DESIGNATION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			PRINTED: 10/26 FORM APPRI	OV
AND PLANO	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MUC A. BUILD:	FIPLE CONSTRUCTION NG	OMB NO. 0938- (X3) DATE SURVI COMPLETED	FY
NAME OF P	ROVIDER OR SUPPLIER	495268	B. WING		С	
WESTMO	RELAND REHABILI	ATION & HEALTHCARE CEN	ITER	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MCKINNEY BOULEVARD	10/19/201	17
(X4) ID PREFIX TAG		TEMENT OF DEFICIÊNCIES MUST 8E PRECEDED BY FULL IC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED TO THE APPR		i) ETIC
ě	Continued From page around the facility but attempting to exit	ge 47 at alerts staff to a resident	F 32			
i 7	7/22/17 4:37 a.m., "P his shift"	atient was directed to bed o	ın			
w w ti	/ander guard in plac /ant to go home." ≅	Resident wandering all of ront door several times, with e. Resident stating "I just esident redirected each ide this afternoon, aware of	i			
wa do ga rec	anderguard on and only placed on and only puzzlesactivity ones worther reside	working. In activity room y room after supper playing nt. listening to music, nurse				
7/2 ow to	24/17 12:37 p.m. "Ro In throughout facility RLE (right lower ext	esident up ambulating on with wander guard intact remity)"			:	
abo but	put golf and bowling still likes to go outs	esident Name) is up early Resident enjoys talking has a wonder (sic) guard ide with other staff."				
300 insidet r	hallway, nurse able de, resident wanted	ident went out 300 hallway rse went running down to redirect resident back to call his girlfriend, nurse d, Redirected resident in				
7/25 diffe	5/17 3:15 p.m. "rec erent people. Reside	lirecting by several ant has packed up his	i		İ	

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MIN TIGHT	CONSTRUCTION	OMR NO. 08)38-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SU COMPLE	
	!					:160
***************************************		495268	B. WING		C	
NAME OF	PROVIDER OR SUPPLIEF	₹	ST	REET ADDRESS, CITY, STATE, ZIP CODE	10/19/	2017
WESTM	ORELAND REHABIL	ITATION & HEALTHCARE CENTER		00 MCKINNEY BOULEVARD		
	i i		' co	DLONIAL BEACH, VA 22443		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES CY MUST SE PRECEDED BY FULL	QI	PROVIDER'S PLAN OF CORRECTI	DM	
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F 323	Continued From p	age 48	F 323			
	room and put thing	is back later after SS (social	1 02.3			
	services) directoris	spoke to him. Wander quard in				
	: place to lower extra	emity. Resident ambulating				
	, throughout facility	on own"	ļ		Ì	
	7/29/17 1:35 p.m.	'Resident upset with				
	roommate. Had ba	acked his clothes and wanted				
	to leave facility"	wanted				
	0141477.7					
	8/1/17 9:10 a.m. 17	3. During morning med pass				
	nirea etannad awa	cissors off of med cart while by briefly. During the nurse			-	
	absence, resident	out wander guard from ankle.	i			
	Upon nurses return	resident handed wander				
	guard to nurse stati	ing, "I removed this for you	į			
	because I am chec	king out today." Nurse kept				
	duard could be abo	s room until a new wander lied to ankle. Resident closely				
	monitored througho	out shift. MD and RP	!		,	
ì	(responsible party)	notified."				
	8/1/17 9:32 a.m. "	Resident's care plan updated.				
	(every 2) hours."	uard checks increased to Q2				
	8/1/17 8:37 p.m. "Re	esident wanders around unit.				
1	Monitoring him ever	V 2 hours to see where he is	į			
	at and what he is do	ping. Cooperative, Returns to			j	
İ	intact right ankle."	y at times. Wanderguard				
					i	
	8/2/17 9:58 a.m. "SV	W (social worker) called RP to				
	discuss the dangers	of resident wondering (sic)	i			
	around the unit. The	e RP requested valume				İ
: 16	(Sic-vallum), or ariot	her form of medication to				1
	do restraints at this f	W explained that we do not facility. It was discussed that				ļ
İ	resident needs a loc	k down unit, and	ĺ		1	j
	recommended place	s in Richmond or Northern	-			
		The state of the s				1

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIFLE CONSTRUCTION (X3) DATE SURVEY DENTIFICATION NUMBER: A BUILDING COMPLETED 495268 8. WING NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX (X5) COMPLETION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 323 Continued From page 49 F 323 Virginia. RP requested closer facility and stated to "get him out today." 8/3/17 1:58 p.m. ⁴7-3. Resident continuing to be monitored for wandering. Wander guard bracelet present and intact to right ankla...asked frequently for scissors or a knife to cut his bracelet. Resident kept asking to go home..." 8/3/17 2:30 p.m. "Dr. (Name) to unit at this time. MD made aware that resident is exhibiting increased wandering behavior. MD made aware that residents family member requesting that resident have medication to help decrease wandering behavior and "relax" resident. No new orders received at this time. 8/3/17 3:50 p.m. "Alarm to 300 hallway alerted at this time. Resident outside of building at this time. Residents primary nurse with resident. Resident refusing to reenter building at this time. Resident states that he "wants to go home" Attempting to redirect resident back into facility at this time. Resident agitated. Resident swinging arms in aggression. Resident states that he "does not want to come back inside. We cant make him do anything he doesn't want to do..." (note that Director of Nursing, social worker, administrator and police department were notified)...Resident continues to refuse to reenter facility. Will continue to sit with resident. 8/3/17 4:25 p.m. "Residents nephew/RP calling facility at this time. Resident agrees to reenter facility to talk to nephew..." 8/3/17 4:28 p.m. "Resident speaking with nephew

at this time. RP made aware of residents intent to leave facility. RP made aware that resident is

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES <u>OMB NO. 0938-0391</u> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY A. BUILDING _ COMPLETED 495268 C 8. WING NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET ADDRESS. CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG COMPLETION DEFICIENCY) F 323 Continued From page 50 F 323 Increasingly more difficult to redirect. Social worker discussing with RP the need for someone to come and visit with resident. Per social worker RP unable to come to visit with resident at this time. Will continue to monitor resident at this time." 8/3/17 5:00 p.m. Received phone call from resident sister regarding residents behavior...Explained to sister that resident has been exhibiting increased wandering behavior and that it is determined by the administrator that the resident is posing a threat to his safety, Residents sister verbalizes understanding. 8/4/17 5:37 a.m. "...Wander guard intact to R ankle, working properly..." 8/4/17 12:45 p.m. "(Name of Facility resident was being discharged to) called and said they spoke to RP and RP was in agreement to send resident there. RP told social worker yesterday that he understands and he was okay with sending resident out." 8/4/17 1:01 p.m. "...wander guard in place to right ankle. No attempts to remove from ankle this 8/4/17 2:29 p.m. social worker spoke to RP who said once he speaks to the dr (Resident Name) can be discharged." 8/4/17 2:39 p.m. "RP gave permission to send the resident at 4 pm." 8/4/17 2:51 p.m. "resident found in hallway at this time, wander guard noted to not be on resident ankle. Resident states that he does not know

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIEN/CLIA IDENTIFICATION NUMBER;	(X2) MUL	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
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WESTMORELAND REHABI	LITATION & HEALTHCARE CENTE	R	STREET ACCRESS, CITY, STATE, ZIP, 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443	CODE 10	/19/2017
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F 323 Continued From	dage 51			7	-
what happened to guard found in res	his wander guardWander sidents toiletry bag at this and replaced at this time to R	F 32	23		
mentioned while h	Spoke with RP (sister) this gresidents wandering, she lie was living at home he would and try to leave"			;	
(Name of Facility) gave permission.	resident d/c (discharged) with d transportation company) to in Richmond. RP aware and (Receiving Facility name) elived pt. (patient)."				
listed the reason for care needed." The OF CARE" include address, and phone	led "INTERDISCIPLINARY IMARY" was reviewed and ir discharge as "higher level of i "POST-DISCHARGE PLAN d the receiving facility's name, e number; the State			!	
the transportation of	, address, and phone number; ompany's name and phone dent requires Memory Care				
Admin-G explained community referral	5 a.m. an interview was Social Worker (Admin-G). that Resident #14 was a and came to the facility from	ļ			
the resident's house admission. Admin-0 "nephew came in to stated the facility wa Resident #14 "drove pocket and found the	spiral. He stated he went to to evaluate for potential 3 stated the residents request placement." He s not originally aware that to Florida with \$20 in his				
knew I would not have CMS-2567(02-99) Previous Versions O	/e admitted him," When				
· · · · -	=Vent (L): 5/94111	P	The Physics and the Physics of the P		_ 1

DEPARTMENT OF HE CENTERS FOR MEDI-	ALTH AND HUMAN SERVICES CARE & MEDICAID SERVICES			PRINTED: 10/26/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO	LTIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZI	10/19/2017
	ABILITATION & HEALTHCARE CENT	TER	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 2244	
だいなとし (これじか しきを)	RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF A	CORRECTION (X5) ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 323 Continued Fro		1		,
asked why Re- facility, Admin- wanderguard, wanderguard," resident's neph	sident #14 couldn't stay at the G stated "he would stretch out the attempt to remove the He stated he spoke with the new to discuss the need to move tond the nephew (RP) was in		23	
conducted with When asked al RN-8 stated the dementia, was was confused a state he wanted "Instead of accility." "He trie	11:55 a.m. an interview was Registered Nurse-B (RN-B). Dout Resident #14's behaviors, ey were told "he had mild very sweet and very pleasant but about location and continued to it to go home." She stated imating to facility his wandering ased." RN-B stated "He had cut doff and walked out of the ed to hit me, became aggressive, called." When asked why			
Resident #14 w. RN-B stated "As unit would be be behavior issues stated part of the main road outsid how he got the swanderguard, R of safely scissor stated "He actual wanderguard 2 c	as discharged to another facility, a team, we decided a dementia energicial. We told the family of his and concern for his safety." She is safely concern was there was a de of the facility. When asked icassors and remove the N-B stated "He had gotten a pair is off the nursing cart." She ally removed and cut off the other times." She stated "he was			
a very intelligent should be left on should not." Resident #14's c	the cart, RN-B stated "No, they are plan included: "Problem 17is at risk for elopement and dx of dementia and recent			***

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495268	5. WING	i	C
NAME OF PROVIDER OR SUPPLIER WESTMORELAND REHABILITATION & HEALTHCARE CENTER		l	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443	10/19/2017	
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F 323	"Attempt non-phairesident starts was resident starts was "Ensure placemer functionality Q2 he "Maintain photo id as well as the receivable facility policy titled ASSESSMENT" included: "PURPOSE: To er the facility are safe provide additional may by considered "JUSTIFICATION: outside independed going to walk into unsafely. However suffer from demer and/or perform locutiside independed of wandering into the resident's exprotocol6. The posserved at least of the control of the contro	ded but not limited to: macologic approaches when ndering" In of wandering bracelet. Check burs" entification in resident records eption desk" If "ELOPEMENT RISK with a revised date of 4/25/16 Insure residents residing within and enable facility staff to interventions for those who did at risk for exiting facility." Some residents are safe to go ently, knowing that they are not the street or parking lot er, some of the residents who intia are able to safely ambulate comotion but if allowed to go ently, those residents are at risk traffic or away from facility." 3. The bracelet will be applied extremity according to facility wander alert bracelet will be daily for proper placement"	F3	323	
	notified of the safe ability to obtain a s	g and Corporate Nurse were ety concern of Resident #14's scissor and remove his further information was cility staff.			:
F 456	Complaint deficien 483.90(d)(2)(e) ES	ncy. SSENTIAL EQUIPMENT, SAFE	F 4	1 56	

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(Y'D) AND TIME TO ADMINISTRATION OF THE PARTY OF THE PART			<u>OMB NO. 0938-039</u>			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED			
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WESTM	ORELAND REHABIL	ITATION & HEALTHCARE CENTER		2400	MCKINNE	Y BOULEVARD			
			`	COL	ONIAL B	EACH, VA 22443			
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	10			VIDER'S PLAN OF CORRECTION			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	FREFI	₹	(CAC)	CORRECTIVE ACTION COND.	0.00	(X5) COMPLETION	
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	:		***	ţ					
F 456	Continued From p	age 54	F 4	56	F456	William Control of the Control of th			
\$\$= E	OPERATING CON	IDITION	,			Dothin - francis		1	
		•			1.				
	(d)(2) Maintain all	mechanical, electrical, and				restored to compliance		į	
	patient care equipi	ment in safe operating				R#8, R#4, and R#9 wer	e all		
	condition.			1		made aware of			
	(a) Paridas D			į	_	compliance.	Ì		
	(e) Resident Room	S late to a standard source of the standard s			2.	The facility has identifi	ed		
	for adequate oursid	ust be designed and equipped ng care, comfort, and privacy of				all residents to be at ri			
:	residents.	ig care, comfort, and privacy of				for this alleged deficier	١t		
,	This REQUIREMEN	NT is not met as evidenced			_	practice.			
	by:				3.	The facility has engage	d a		
1	Based on observat	tion, staff interview, Resident				second contractor to w		!	
i	interviews, Contrac	for interview, and facility				on the boiler system as			
1	documentation review	ew the facility staff falled to				the primary contractor			
	maintain in good re	pair, hot water in 2 of 2				was unable to fulfill the			
	2 to 4 wooks Posit	esident use, for approximately				obligation. A daily revie	5M	į	
	sample of 18 Regide	dents #8,# 4, and #9 in a ents were affected by this.		.		of water temperatures		1	
	and so were added	to the evidence provided for		.		ongoing and will contin	ue	I	
	the deficient practice	e.		:		to be ongoing indefinite	اب.	ŀ	
1		İ			4.	Water temperature logs	5	;	
	1. For Resident #8,	the situation was identical.				will be submitted to QA	PI		
	I ne facility staff faile	ed to maintain operable		!		Committee for review.			
	bathing areas, as bo	oth shower rooms in the			5.	Date of Completion:	İ	:	
	hailas was broken	ble daily, as the hot water				11/20/2017			
	boiler was broken.			i					
	2. For Resident #4	the situation was identical.							
-	The facility staff faile	ed to maintain operable		1					
1.0	pathing areas, asibo	th shower rooms in the							
ţ	acility were inoperat	ole daily, as the hot water		İ					
t	poiler was broken.	Process of the contract of the						1	
Ç	o. nor Resident #9, (he situation was identical.		;		•			
} **	ne racility staff faile	d to maintain operable							
f.	aumy areas, as bol	th shower rooms in the						1	
h	oiler was broken.	ile daily, as the hot water						1	
***************************************	was orange								

P.63/67 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 10/26/2017 FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 495268 8. WING NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERÊNCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREEIX (X5) COMPLETION TAG DATE DEFICIENCY) F 456 Continued From page 55 F 456 The findings included: Resident #8 was originally admitted to the facility on 3-24-07. Diagnoses included; Hypertension. atrial fibrillation, Hypothyroidism, and seizure disorder/not active. Resident #8's most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 7-15-17. The MDS coded Resident #8 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident #8 was coded as requiring limited to extensive assistance of one staff person for Activities of Daily Living except for bathing; Resident #8 was coded as requiring total assistance of one staff person for bathing, and required set up only for eating. The Resident was continent of bowel and bladder. On 10-17-17 at 3 p.m., at the end of initial tour of the facility Resident #8 approached surveyors, and was complaining that she was angry about not getting to take a shower, and wanted to know why it took a month to fix the hot water heater/boiler. The Resident was asked if she had reported this to the Administrator, and she stated "yes" she went on to say that the administration there told her every day it was fixed, but it had not been fixed, and she was angry. She stated both shower rooms were inoperable because the facility did not have any hot water. Resident #8 stated the facility had not had hot water for four weeks. She stated she was not able to get a bath or shower because of no hot water. Resident #8

stated she preferred to get a shower but could not tolerate the cold water. She stated the staff used

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED 495268 B. WING 10/19/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 (X4) ID FREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 456 | Continued From page 56 F 456 unacceptable, and she was tired of "stinking, and feeling dirty all over". Resident #8 stated she only got to wash her "face, underarms and private area." Resident #8 stated the water was too cold to even wash those areas but she could do no better. Resident #8 stated the facility staff should not expect the residents to bathe in cold water. She stated the staff let the water run a long time but it still stayed cold. Resident #8 stated she really hoped the surveyors could help them get some hot water, as the administration told them every day the hot water was fixed, and it wasn't. Resident #8 stated she was sure the cold water at the facility was going to make her get sick. Resident #8 stated "as much as we pay to stay here, don't you think we could get hot water for bathing?, this is ridiculous in this day and age." "no one wants to be near people stinking and nasty, it makes you not want to let anyone see you. On 10-17-17 directly after Resident #8's interview, the Housekeeping Director, Maintenance assistant, and CNA (C) were interviewed in the shower room, while testing the water temperature with a thermometer. The water had been running for "about 10 minutes" according to the House Keeping Director and maintenance assistant. The temperature was measured with 2 devices by the staff members and never went above 98 degrees Fahrenheit. According to the House Keeping Director and maintenance assistant, the hot water boiler had been not working correctly for "about 2 weeks". CNA (C) stated she was providing care for Resident #8 that day, and stated the water was too cold for the Resident to get a shower.

On 10-17-17 directly after the staff interview, the

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING_ COMPLETED 495268 B. WING NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET ADDRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF CORRECTION ID PREFIX PRÉFIX (X5) COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 456 Continued From page 57 F 456 Administrator was interviewed, and stated the Resident's were being bathed, that they were receiving a "bath in a bag", which were wipes that could be heated. He stated the problem with the boiler had persisted "about 2 weeks". On 10-18-17 a group council interview was held with Residents. Seven of the 9 resident attendees were in unanimous agreement that they were unable to receive showers or baths because of the lack of hot water, and were very frustrated with the situation. The time frame for the lack of shower facilities, as stated by those in attendance, ranged from 3-4 weeks. On 10-18-17 the contractor working on the hot water boiler entered the facility, and was interviewed. He stated that the problem was that the boiler had been installed improperly and they kept having trouble with it, but he was there to fix it. When asked how long he had known about the problem, he stated he had made 2 trips to the facility and had known about the problem "at least 2-3 weeks". On 10-19-17 at 10:00 a.m., Observation of the shower rooms was conducted again during the "General Observations" of the physical plant portion of the survey process. It was noted at this time, that the hot water problem was still a problem, and had not been completely repaired. During the end of day debriefing on 10-18-17, and 10-19-17, the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings. No further information was provided.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/26/2017 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING ___ C 495268 8. WING NAME OF PROVIDER OR SUPPLIER 10/19/2017 STREET AODRESS, CITY, STATE, ZIP CODE WESTMORELAND REHABILITATION & HEALTHCARE CENTER 2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 456 Continued From page 59 F 456 3. Resident # 9 was admitted to the facility on 3/13/2017, with the diagnoses of, but not limited to Hypertension, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Solitary Pulmonary Nodule, Diverticulitis, Heart Failure, Single Thyroid Nodule and Pressure Ulcer. The most recent Minimum Data Set (MDS) was a Quarterly Assessment with an Assessment Reference Date (ARD) of 9/14/2017. The MDS coded Resident # 9 with a BiMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; Resident # 9 was coded as requiring extensive to total assistance of one to two staff person for Activities of Daily Living; required set up only for eating, and was coded as always incontinent of bowel and bladder. On 10/18/2017 at 8:40 a.m. during medication pass and pour observation involving other residents on the 200 Hall, Resident # 9 was observed sitting in his bed watching TV. Resident #9 asked the surveyor to come into his room. Resident # 9 stated "something needs to be done about the hot water in this building. We don't have any hot water. We haven't had any for over a month." During the end of day debriefing on 10-18-17, and 10-19-17, the facility Administrator, Director of Nursing and Corporate Consultants were informed of the findings. No further information

was provided.