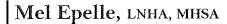


June 06, 2019

Dear Ms. Laura Veuhoff, LTC Supervisor:

Please find the enclosed corrected plan of correction for the standard survey conducted on May 14, 2019 through May 16, 2019 for your review. If you have any questions about this plan of correction, please do not hesitate to call me.

Sincerely,



CONCORDIA CARE

Executive Director







757-539-8744

200 W Constance Road

Suffolk, VA 23434

Mellanby.epelle@concordiacare.net



### COMMONWEALTH of VIRGINIA

Department of Health
Office of Licensure and Certification

TYY 7-1-1 OR 1-800-828-1120 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 Fax (804) 527-4502

May 23, 2019

M. Norman Oliver, MD, MA

State Health Commissioner

Mr. Mellanby Epelle, Administrator Concordia Transitional Care Rehab-Nansemond Pointe 200 West Constance Road Suffolk, VA 23434

RE:

Concordia Transitional Care Rehab-Nansemond Pointe

Provider Number 495247

Dear Mr. Epelle:

An unannounced standard survey, ending May 16, 2019, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. Five complaints were investigated during the survey. Four complaints were substantiated, with no deficiencies. One complaint was unsubstantiated, with no deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

#### Survey Results

The results of this survey are reflected on the enclosed Statement of Isolated Deficiencies, "A" Form and/or the Statement of Deficiencies and Plan of Correction, CMS 2567. All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g), the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.



Mr. Mellanby Epelle, Administrator May 23, 2019 Page 2

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

#### Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) <u>must be submitted within ten (10) calendar days of receipt of these survey findings</u> to Laura Veuhoff, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.** 

To be considered acceptable, the PoC must:

- 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
- 5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45<sup>th</sup> calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

#### Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.virginia.gov/licensure-and-certification/the-division-of-long-term-care/.

Mr. Mellanby Epelle, Administrator May 23, 2019 Page 3

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

#### Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

Pursuant to §488.408(c)

- Directed Plan of Correction (PoC) (§488.424).
- State monitoring (§488.422).
- Directed In-Service Training (§488.425).

Pursuant to §488.408(d)

- Denial of payment for new admissions (§488.417).
- Denial of payment for all individuals (§488.418).
- Civil Money Penalty, \$50 \$3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of \$1,000 \$10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Mr. Mellanby Epelle, Administrator May 23, 2019 Page 4

#### Survey Response Form

The LTC Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at:

"http://www.vdh.virginia.gov/content/uploads/sites/96/2019/02/LTC-facility-survey-response-form.pdf" We will appreciate your participation.

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Laura S. Veuhoff, LTC Supervisor Division of Long Term Care

Lawa Apacuse Venhoff

Enclosure

cc:

Joani Latimer, State Ombudsman ( Sent Electronically )

Bertha Ventura, Dmas (Sent Electronically)

State of Virginia		(X2) MULTIPLE	(X3) DATE SURVEY		
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		- CONOTINGOTION	COMPLETED
AND PLAN	OF CORRECTION	ADDITION ATTENDED	A. BUILDING.		l c
					05/16/2019
		VA0169	B. WING		03/10/2013
		CTDEET AD	DRESS CITY S	TATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER		CONSTANC		
CONCOR	DIA TRANSITIONAL		, VA 23434	E NOAD	
CONCON			, VA 23434	PROVIDER'S PLAN OF CORRECTI	ON (X5)
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID PREFIX	' (EACH CORRECTIVE ACTION SHOUL	DBE COMPLETE
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE DATE
TAG	KEGOEMIONI ONE			DEFICIENCY)	
			E 000		
F 000	Initial Comments		F 000		06/20/2019
	An unannounced b	iennial State licensure			
	inspection was con	ducted 5/14/19 through			
	5/16/19. Five comp	plaints were investigated during		•	
,	the survey. The fac	cility was not in compliance with			
	the Virginia Regula	tions for the Licensure of			1.1-
	Nursing Facilities.			This Plan of Correction is the center's credit allegation of compliance.	ole :
	The concue in this	148 certified bed facility was			
	120 at the time of t	he survey. The survey sample		Preparation and/or execution of this plan of	correction
	consisted of 56 res	sident reviews: 49 current		does not constitute admission or agreement provider of the truth of the facts alleged or c	oy tne
	residents and 7 clo	sed record reviews.		set forth in the statement of deficiencies. Th	e plan of
	1001001110			correction is prepared and/or executed sole	ly because
E 004	Non Compliance		F 001	it is required by the provisions of federal an	a state taw.
F 001	Molt Compilation			F001	,
_	The facility was ou	t of compliance with the		12 VAC 5-371-150 B1, F	
	following state lice	nsure requirements:		1. Please see plan of correction	n (POC)
				F625.	` '
	This RULE: is not	met as evidenced by:			
	The facility was no	t in compliance with the		12 VAC 5-371-180 A, C.	,
	following Rules an	d Regulations for the Licensure		2. Please see plan of correction	on (POC)
	of Nursing Facilitie	es:		F881.	
	<b></b>	nt T D 11 The Diable Cross	1		:
		B1, F. Resident Rights. Cross		12 VAC 5-371-200 (A)	(7.0.5)
	Reference to F625	Σ,		3. Please see plan of correction	on (POC)
•	403/40/5 074 490	A. C. Infaction Control Cross		F727.	
•	12 VAC 5-3/1-180	A, C. Infection Control. Cross		10 114 0 5 271 220	
	Reference to F881	1.		12 VAC 5-371-220. 4. Please see plan of correction	yn (POC)
	12 \/\C 5-371-200	) (A) RN/8 HRs 7 days/week.	-	F658, F659.	M (100)
	Cross reference F	727		ross, ross.	·
	Ologa leicieilog I	· ·			
	12VAC5-371-220.	Nursing Services. Cross		12 VAC 5-371-240.	
	Reference F658, I	F695.		5. Please see plan of correction	on (POC)
				F712.	
	12VAC5-371-240.	Physician Services. Cross			,
	Reference F712.			12 VAC 5-371-250 (C) (F	) (G).
				6. Please see plan of correction	on (POC)
	12 VAC5-371-250	(C) (F) (G) Resident		F656.	
	A mant and (	Care Planning Cross			

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIEF

OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

WARDING STREET OF TITLE

WAS A STREET OF THE STREET

06/06/2019

6899

State of	Virginia T OF DEFICIENCIES	(X1) PROVIDER/SUPPLI	ER/CLIA		E CONSTRUCTION	(X3) DATE COMP	
AND PLAN	OF CORRECTION	IDENTIFICATION NU	IMBER:	A. BUILDING:			
		),40460		B. WING		05/1	6/2019
		VA0169	l		TATE ZID CODE		
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
CONCOR	RDIA TRANSITIONAL	CARE REHAB-N/		CONSTANG , VA 23434	JE ROAD		
CONCOR					PROVIDER'S	PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	/FACU DESIGNATION	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED 8' LSC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN E	CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
F 001	Continued From pa	age 1		F 001	This Plan of Correction allegation of complian	n is the center's credible ce.	06/20/2019
, 00,	Reference F656.	•		,	Preparation and/or ex	ecution of this plan of correction	
	Reference Popo.				door not constitute adi	nission or agreement by the f the facts alleged or conclusions	
	12VAC5-371-340 (A) Garbage Disposal. Cross			not forth in the stateme	ent of deficiencies. The plan of		
	Reference F812.				agregation is propared	l and/or executed solely because	
	12VAC5-371-140.	Policies and Proced	ures.	ļ Į	it is required by the pr	ovisions of federal and state law.	
	Based on staff inte	erview and employee	record				
	review it was dete	ermined that the facil	ity stan		12 VAC :	5-371-340 (A)	
	I failed to obtain lice	ense verification prior	rio			e plan of correction (POC)	
	amployment and	failed to complete a	Cililinai		F812.		
	background check 25 employee reco	and sworn stateme	11[10] 5 01		F371-140	um 110 114 115 3 110 omo	
	25 employee reco	ia leviews.	•		1. Employed	e #7, #3, #4, #5 and #8 are tly employed at the	
	The findings include	de:			facility.	my employed at the	
			25			_	
	On 5/15/19 at app	proximately 11:00 a.m are requested from C	SM (other		2. All newly	hired employees have the	
	toff member) #2	human resources a	nu Aoivi		potential 1	to be affected.	
	(administrative sta	aff member) #1. Rev	iew of the		3. The SDC	designee will perform a	
	employee files rev	realed the following:			one-time	audit of newly hired	
			nr.		employee	s within the last 4 months	
	RN (Registered in	urse) #7 was hired fo /25/18. Human Reso	ources could		to ensure	license verifications,	
	not present an en	nployee file for this s	taff		criminal	background check and stement was completed.	
	member.				Newly hi	red employee files will be	
	1	·;_;_440	ne hired for		reviewed	by the Executive Director.	
	CNA (certified nul	rsing assistant) #3 w /5/19. Human Resou	irces could				
	employment on 2	nployee file for this s	taff		4. The SDC	/designee will audit new	
	member.	ipioyee iii.			hire pers	onnel files weekly x 4 and x 3 to ensure compliance.	
			0/00/40				'
	CNA #4 was hired	d for employment on	2/28/18.		5. Results of	of audit will be taken to the	
	Human Resource	es could not present this staff member.	ali		monthly	Performance Improvement	
	1				meeting	which consist of Executive	
	CNA #5 was hire	d for employment or	2/13/18.		Director	, Medical Director, DNS, ocial Services Director,	
	Human Resource	es could not present	an		Dietitian	n, C.N.A & Pharmacy for	
	employee file for	this staff member.			review,	corrective action will be	
	1 m 1 / 2	ratical nurse) #8 wa	s hired for		initiated	if appropriate.	<u> </u>
1	LPN (licensed pr	actical nurse) #8 wa	3 1311 00 101				

State of	Virginia IT OF DEFICIENCIES	(X1) PROVIDER/SUPPL	IER/CLIA		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION N	UMBER:	A. BUILDING: _			,
		VA0169		B. WING		1	6/2019
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
		CARE REUAR NA		CONSTANC	E ROAD		
CONCOR	RDIA TRANSITIONAL			, VA 23434	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	VEVCA DEELGIENG;	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
F 001	Continued From pa	ige 2		F 001			06/20/2019
	employment on 6/1 not present an emp member.	9/18. Human Reso ployee file for this st	urces could aff				
	present any of the #2 stated that emp to obtain since the a new company.  On 5/16/19 at 7:07 staff member) #1, aware of the above 12VAC5-371-150.  Based on staff inte documentation rev register with the Dereceive automatic Offender Registry reregistration of an	p.m., ASM (adminithe administrator, was findings. Resident Rights (Government of State notification from the facility searches and facility staff apartment of State notification from the registration on the sex offender with	been hard yed over to distrative yas made  failed to Police to e Sex or in the same		This Plan of Correction is the ce allegation of compliance.  Preparation and/or execution of does not constitute admission or provider of the truth of the facts set forth in the statement of defic correction is prepared and/or exit is required by the provisions of F371-150  1. The facility was resulted to receive a notification from 2. All residents have be affected. All cuthe facility have be	this plan of correction agreement by the alleged or conclusions itencies. The plan of ecuted solely because f federal and state law.  egistered on he Virginia State automatic the sex registry.	
,	registered and faile perspective reside access the Sex Of		resident and on how to		information on ho sex offender regis  3. The Executive Di Inservice the Adn	w to access the try.  rector will hissions	
	would receive auto	iled to ensure that to matic notification of gistration of Sex O a contiguous zip of ered.	f ffenders		Director/designee prospective reside information on ho sex offender regis	ents with ow to access the stry.	
	The findings include	ded:		**************************************	ensure informatio	orning meeting to n was provided to	
	conducted with the Administrator was "Who in the facility	at 9:25 a.m., an interest and a state of the Administrator. The asked, as registered with the State Police to reco	e the		new admissions o the sex offender r		

	ate of Virginia ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION		
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			LETED
			B. WING		05/4	; 6/2019
		VA0169			1 03/1	0/2013
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CONCOR	RDIA TRANSITIONAL	CARE RELIAD NI	T CONSTANC	CE ROAD		
		00,102.	K, VA 23434	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
F 001	Continued From pa	· ·	F 001			06/20/2019
	reregistration of Se	on, updates of registration or ex Offenders in the facility istrator stated, "We don't have				
	On 05/16/2019 at 5:15 p.m., at the pre-exit			This Plan of Correction is the center's credit allegation of compliance.	ble	
	meeting the Admin anyone in the facili State Police to receive the Sex Registry?" "Just registered too the Director of Nurfindings. The facili information about to Based on staff interested documentation revide each resid with information or Offender Registry.  2. The facility staff	istrator was asked, "Is there ty that is registered with the eive automatic notification from The Administrator stated, day." The Administrator and sing was informed of the ity did not present any further the findings.  erviews and facility riew the facility staff failed to ent and perspective resident in how to access the Sex  If failed to provide each resident esident with information on how		Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or a set forth in the statement of deficiencies. The correction is prepared and/or executed solel it is required by the provisions of federal and 5. Results of audit will be take monthly Performance Impremeeting which consist of E. Director, Medical Director, Director of Nursing, Staff Development, Social Service Director, Dietitian, C.N.A. & Pharmacy for review, correaction will be initiated if appropriate.	by the onclusions e plan of y because d state law.  en to the overnent executive	
	The findings include					
	interview was cond and the Admissions D residents and pers information on how Registry?" The Ad Director stated, "N "Is this new? We	approximately 9:30 a.m., an ducted with the Administrator is Director. The Administrator irector was asked, " Are spective residents provided w to access the Sex Offender ministrator and Admissions to." The Administrator stated, have never done this."				
	meeting the Admir	5:15 p.m., at the pre-exit nistrator and Director of Nursing ne findings. The Administrator	3		-	

	tate of Virginia (X3) DATE SURVEY										
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED						
WIAD I FWIA	OF GOTTREOTION	, <u> </u>	A. BUILDING.		С						
	•	VA0460	B. WING		05/16/2019						
		VA0169	,								
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE							
CONCOR	RDIA TRANSITIONAL		T CONSTANG K, VA 23434								
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU	_DBE   COMPLETE						
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE						
				BELLIOETT							
F 001	Continued From page 4		F 001		W THE PARTY OF THE						
	and Director of Nur	sing was asked, "Would you									
	like to add anything else?" The Director of Nursing stated, "Going to start today."										
•	Nuising stated, Ot	oning to start today.									
,	•										
		٠		,							
		•									
					T						
		·		·							
					ļ						
				·							
					****						
	,										

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A.·BUILI		COM	PLETED			
		495247	B. WING	ì		i i	C 16/2019
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434				1012010
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	An unannounced Emergency Preparedness survey was conducted 5/14/19 through 5/16/19. No emergency preparedness complaints were investigated during the survey.			000	This Plan of Correction is the center's crea allegation of compliance.  Preparation and/or execution of this plan does not constitute admission or agreemer provider of the truth of the facts alleged of set forth in the statement of deficiencies. Correction is prepared and/or executed so it is required by the provisions of federal of the content of the provisions of federal of the content of the provisions of federal of the content of the provisions of federal of the provisions of the pro	of correction  It by the  conclusions  The plan of  lely because	06/20/2019
E 007 SS=C	CFR Part 483.73, Care Facilities. EP Program Patie CFR(s): 483.73(a) [(a) Emergency Pl and maintain an e that must be revie	gram Patient Population		007	<ol> <li>The facility has reviewed documented it's identified population at risk during emergency.</li> <li>All residents residing in the have been identified as have</li></ol>	the facility aving the Chere is no lents	
	(3) Address patier but not limited to, services the [facili an emergency; an including delegation plans.**	at/client population, including, persons at-risk; the type of ty] has the ability to provide in d continuity of operations, ons of authority and succession at risk" does not apply to: ASC,			3. Executive Director/SDC will educate staff on ider facility population at risk resident acuity levels ide the Facility Tools Assess section of Special Treats conditions.	designee atifying the c, and on antified in sment	The state of the s
	hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on review of the facility's emergency preparedness (EP) program and interview with the Administrator, the Director of Maintenance and Director of Human Resources, the facility was not able to identify specificity related the facility's patient populations that would be at risk in the event of an emergency.  The findings included:				<ol> <li>The ED/SDC/designee of facility emergency prepare plan monthly x three monther annually to ensure</li> <li>The findings will be revised monthly Performance Important which consist of Execution Director, Medical Direct Director of Nursing, State Development, Social Sendirector, Dietitian, C.N., Pharmacy.</li> </ol>	ewed in the aprovement ve or, ff	

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

rogram participation.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				PLETED	
		495247	B. WING			05/1	6/2019
	ROVIDER OR SUPPLIER DIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE	20	TREET ADDRESS, CITY, STATE, ZIP CODE DO WEST CONSTANCE ROAD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		BE	(X5) COMPLETION DATE	
E 015	conducted with the of Maintenance.  The Administrator, the Director of Hunto present the indivof an emergency. of Nursing (DON) to determine how mater Approximately and brought forth that is oxygen. When as Administrator states to identify, but und way to update the facility and their sp. Subsistence Need CFR(s): 483.73(b)  [(b) Policies and proceing policies and updated the communication. The previewed and updated and updated policies and patients whether place, include, but (i) Food, water, manual policies and patients whether place, include, but (ii) Food, water, manual policies and patients whether place, include, but (ii) Food, water, manual policies and patients whether place, include, but (iii) Food, water, manual policies and patients whether place, include, but (iii) Food, water, manual policies and patients whether place, include, but (iii) Food, water, manual policies and patients whether place, include, but (iiii) Food, water, manual policies and patients whether place, include, but (iiiii) Food, water, manual place, include, but (iiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	Administrator and the Director Director of Maintenance and nan Resources were not able vidual resident's needs in case They called to ask the Director to go to each unit and ny residents needed oxygen. Hour later, report sheets were temized the resident's on ked why just oxygen, the ed it is what he asked the DON erstood he needed to find a vulnerable populations in the recific needs, not just oxygen. In sor Staff and Patients  (1)  rocedures. [Facilities] must ment emergency preparedness dures, based on the emergency uragraph (a) of this section, risk regraph (a) of this section, eation plan at paragraph (c) of rolicies and procedures must be ated at least annually.] At a cies and procedures must	E	015	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of co does not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The proceeding is prepared and/or executed solely bit is required by the provisions of federal and secondary in the have been identified as having potential to be affected. There negative outcome to residents currently residing at the facility emergency prepared plan with vendor contract agreement to provide provisis sewage and waste disposal or 05/16/2019.  3. Executive Director/SDC/desin-serviced staff on current for vendor contract agreement to provide provision for sewage waste disposal.  4. The Executive Director/designal review facility emergency preparedness plan monthly amonths, and then annually to compliance.	facility ag the e is no sity.  In the mess ion for an in signee facility o e and ignee accy at three ice is no sity.	06/20/2019

#### PRINTED: 05/23/2019 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_\_ C 05/16/2019 B WING 495247 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 WEST CONSTANCE ROAD CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE SUFFOLK, VA 23434 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG 06/20/2019 E 015 E 015 Continued From page 2 following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. This Plan of Correction is the center's credible (C) Fire detection, extinguishing, and alarm allegation of compliance. systems. Preparation and/or execution of this plan of correction (D) Sewage and waste disposal. does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions \*[For Inpatient Hospice at §418.113(b)(6)(iii):] set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because Policies and procedures. it is required by the provisions of federal and state law. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the 5. The findings will be reviewed in the following: monthly Performance Improvement (iii) The provision of subsistence needs for which consist of Executive hospice employees and patients, whether they Director, Medical Director, evacuate or shelter in place, include, but are not

limited to the following:

(2) Emergency lighting.

(C) Sewage and waste disposal.

supplies.

following:

systems.

bv:

of provisions.

(A) Food, water, medical, and pharmaceutical

(B) Alternate sources of energy to maintain the

(1) Temperatures to protect patient health and safety and for the safe and sanitary storage

(3) Fire detection, extinguishing, and alarm

This REQUIREMENT is not met as evidenced

Based on review of the facility's emergency preparedness (EP) program and interview with the Administrator, the Director of Maintenance and Director of Human Resources, the facility staff was unable to provide a plan that included provision for sewage and waste disposal.

Director of Nursing, Staff

Pharmacy.

Development, Social Services

Director, Dietitian, C.N.A &

STATE	MENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMP	LETED
AND P	LAN OF	CORRECTION	IDENTIFICATION OF THE PROPERTY	A. DOILD			С	
			495247	B. WING		OTTY CTATE ZIP CODE	05/1	6/2019
		OVIDER OR SUPPLIER DIA TRANSITIONAL	CARE REHAB-NANSEMOND POI	NTE	20	REET ADDRESS, CITY, STATE, ZIP CODE 30 WEST CONSTANCE ROAD UFFOLK, VA 23434		
PR	4) ID EFIX AG	(CACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	) BE	(X5) COMPLETION DATE
E		Continued From pa The findings includ On 5/15/19 at 11:50 conducted with the of Maintenance.		E :	015	This Plan of Correction is the center's credibl allegation of compliance. Preparation and/or execution of this plan of c does not constitute admission or agreement by provider of the truth of the facts alleged or co set forth in the statement of deficiencies. The	orrection the nclusions	06/20/2019
E 023 SS=C		the Director of Hur plan for port-a-pott contract to have widisposing of soiled disposable items. 4:45 p.m., the Adm quotation for 20, 3 with a disposal pla Policies/Procedure CFR(s): 483.73(b)	trator, Director of Maintenance and of Human Resources presented a a-potties, but stated they did not ave waste disposal to include soiled briefs, wipes and other tems. On 5/16/19 at approximately a Administrator presented a 20, 30 and 40 cubic yard containers sal plan. Cedures for Medical Documentation 1.73(b)(5)  and procedures. The [facilities] must be implement emergency preparedness procedures, based on the emergency h in paragraph (a) of this section, risk at paragraph (a)(1) of this section, amunication plan at paragraph (c) of the policies and procedures must be ad updated at least annually. At a ne policies and procedures must		023	it is required by the provisions of federal and  E023  1. All residents residing in the have been identified as having potential to be affected.  2. The facility Emergency Preparedness Plan has a	because state law. facility ag the e patient ly	
SS=C	develop and imple policies and proce plan set forth in pa assessment at pa and the communic this section. The p				of care for resident during a emergency.  3. Executive Director/SDC/de will in-service staff on prote the confidentiality of patien ensure records are secure ar readily available to support continuity of care for reside during emergency.	n signee ecting ts, ad		
		preserves patient confidentiality of p and maintains ava (3),(4),(6)] A syste that preserves pa	edical documentation that information, protects patient information, and secures allability of records. [(5) or the error of medical documentation tient information, protects patient information, and secures allability of records.			4. The ED/SDC/designee will facility Emergency Prepare Plan to ensure patients recording readily available to support continuity of care for reside during an emergency month three months, and then anniensure compliance.	dness rds are the ents aly x	

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE	CONSTRUCTION		SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
			B. WING	<b>.</b>	_	1	C 16/2019
	ROVIDER OR SUPPLIER	495247		ST 20	REET ADDRESS, CITY, STATE, ZIP CODE O WEST CONSTANCE ROAD	1 03/	10/2013
CONCOR	DIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INIE	SI	JFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 023	Continued From paragrams of the Administrator, and Director of Huwas unable to ver and procedures the Administrator, and Director of Huwas unable to ver and procedures the Administrator, and Director of Huwas unable to ver and procedures the Administrator, and Director of Huwas unable to ver and procedures the Administrator, and Director of Huwas unable to ver and procedures the protects confident secures and main.  The findings inclusion of the Director of Huwas unable to ver and procedures the protects confident secures and main.  The findings inclusion of the Director of Humas unable to ver and procedures the protects confident secures and main.  The findings inclusion of the Director of Humas unable to ver and procedures and main.	age 4 403.748(b):] Policies and system of care documentation wing: Interpretation and information. Interpretation and system of patient information. Interpretation and system of medical and actual protects confidentiality of all donor information, and tains the availability of records. ENT is not met as evidenced of the facility's emergency of program and interview with the Director of Maintenance and preserve patient information, itality of patient information, and tains accessibility of records de:  56 a.m., an interview was e Administrator and the Director of Maintenance and and Resources stated that the leet with diagnoses, physician in Administrator Records (MAR), istration Records (TAR) would in the computer and securely		023	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of condoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The process of the provisions of federal and sit is required by the	orrection of the oclusions olan of because state law.	06/20/2019
,	cent with the resi	dent in their packets that is kept esident. They showed this writer					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		B, WING	_	C 05/16/2019	
	495247	D. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,10,20.1	
NAME OF PROVIDER OR SUPPLIER CONCORDIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE	200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(CACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
that resident the interest asked if there was place for the designate aforementioned know what to do, be and procedures relected confidentiality and INITIAL COMMENTAILY AN unannounced survey was conducted to complaints we survey. Correction	nyards and a slipped folder formation is placed in. When a policy and procedure in nated staff to follow based on d process, it was stated, "They ut we did not develop policy lated to the process to maintain accessibility of records."  TS  Medicare/Medicaid standard cted 5/14/19 through 5/16/19. Here investigated during the sare required for compliance 42 CFR Part 483 Federal Long		000		
The Life Safety Co The census in this 129 at the time of consisted of 56 represented and 7 closes and 7 close	ode survey/report will follow.  148 certified bed facility was the survey. The survey sample sident reviews: 49 current osed record reviews. mmodations Needs/Preferences		558		

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COM	PLETED
ANDILANO							0
		495247	B. WING			05/	16/2019
	PROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	INTE	20	FREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONSTANCE ROAD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 558	56 residents (Resisample.  The facility's staff is system was in place capable of using to the findings included the finding included finding the finding the findicated finding the findicated finding indicated finding indicated finding included finding included finding included finding included finding. The coded for poor bile extremity. Both of severely contract and they were with the finding included finding	dent #50), in the survey ailed to ensure a call bell be that Resident #50 was be contact the staff.	y	558	This Plan of Correction is the center's credit allegation of compliance.  Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or a set forth in the statement of deficiencies. The correction is prepared and/or executed sole it is required by the provisions of federal and the facility. A specialty called been installed for resident as been installed for resident as a conducted on all currer residents residing in the facility residents residing in the facility residents residing in the facility as a conducted on all currer residents residing in the facility residents residing in the facility residents residing in the facility residents with physical liminate and certified Nursing Assistant been in-serviced by Staff Development Coordinator (SDC)/designee on ensuring residents with physical liminate provided with specialty bell.  4. DNS/ADNS/Unit Managers/designee will conduct on new admissions/readmissions to determine the ability to use standard call	f correction by the conclusions see plan of ly because ad state law.  des in 1 bell has #50.  mitations ving the n audit ent cility to  d ts have	06/20/2019

CENTER	<u>IS FOR MEDICARE</u>	& MEDICAID SERVICES	<del></del>			(X3) DATE	CLIDVEV
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
AND PLAN O	F CORRECTION		A. BUILI	JING _			
		495247	B. WING	ì		05/1	16/2019
	ROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 558	resident's head of tresident's reach. Be were opened and the Resident #50 didn'to During the medical approximately 9:57 Nurse (LPN) #4 enexplained she had resident accepted resident's windows was extremely cold beneath the bed liroutside the linen. It attention that the wextremely cold and light to contact state Resident #50 was "Yes." LPN #4 closother open, then so call light, which was the bed near the flight to the resident An interview was on Nursing Assistant approximately 1:450 can't do anyth hands are contract resident's right had left hand and prior hospital in Decembroom and in the ot was used but since a new room he's control was used but since a new r	y hanging behind the he bed and out of the oth of the double windows he room was very cool. It respond to questions asked.  John pass on 5/15/19 at a.m., Licensed Practical tered the resident's room and his medications, which the without problem. Again the were opened and the room and the right hand was are and the right hand was are and the right hand was are was brought to LPN #4's vindows were up, the room was the resident was without a call if if needed. LPN #4 asked he cold and he responded hed one window and left the he looked for Resident #50's is located behind the head on bor. LPN #4 attached the call the gown top and left the room.  The conducted with Certified (CNA) #1 on 5/16/19 at a conducted with Certified (CNA) #1 on 5/16/19 at a conducted with the call the head moved a little better than the to Resident #50 going to the ber, he resided in a another her room a specialty call light the her return from the hospital to only had a regular call light be to activate.		558	This Plan of Correction is the center's credib allegation of compliance.  Preparation and/or execution of this plan of does not constitute admission or agreement by provider of the truth of the facts alleged or consect forth in the statement of deficiencies. The correction is prepared and/or executed solely it is required by the provisions of federal and  5. Audit tools will be presented Performance Improvement Committee consists of Exect Director, Medical Director, Director of Nursing, Staff Development, Social Service Director, Dietitian, C.N.A & Pharmacy, monthly for three months for review, recommendation and continued for further monitoring sustain compliance.	le correction by the onclusions plan of because state law. d to utive es c t	06/20/2019
	CNA#1 stated Re	sident #50's window is			-		

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		С	;
		495247	B. WING			05/1	6/2019
	ROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	INTE	STREET ADDRESS, CITY, STATE, ZIP COL 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE I	(X5) COMPLETION DATE
F 558	lot, and on occasion the air to be cut on #1 also stated the stools related to a	age 8 because the resident sweats a n the resident has requested to aid him in cooling off. CNA resident has frequent smelly medication he is administered often opened to help remove	F	558			
	5/16/19 at approxing stated she had new window staying op LPN #4 also stated required use of a seasily activate with limited hand move he didn't have it unattention. LPN #4	conducted with LPN #4 on mately 1:58 p.m. LPN #4 wer noticed Resident #50's ened for long periods of time. If she was aware the resident specialty call light he could his chin or hand because of ment but she had not noticed ntil it was bought to her stated she contacted the ctor on 5/15/19, and the was immediately installed in the room.					
F 622 SS=D	Administrator and at approximately 6 Nursing stated the #50 to have a call reach and the stat Maintenance department of CFR(s): 483.15(c) \$483.15(c) Transfer and Disc CFR(s): 483.15(c) \$483.15(c)(1) Factorial Research Administratory and Disc CFR(s): 483.15(c)		F	622			
	remain in the facil	ity, and not transfer or ident from the facility unless-					The state of the s

	AND HI IMAN SERVICES			PRINTED: FORM A OMB NO.	(PPROVED
DEPARTMENT OF HEALTH				(X3) DATE	SURVEY
CENTERS FOR MEDICARE		(X2) MULTIP	PLE CONSTRUCTION	COMP	LETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3		;
WAD LEVIA OF GOLD		n wwo		05/1	6/2019
	495247	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			200 WEST CONSTANCE ROAD		1
INVARIATE OF THE PARTY OF THE P	CARE REHAB-NANSEMOND PO	NTE	SUFFOLK, VA 23434	_	
			THE PROPERTY OF CORRECT	TION	(X5) COMPLETION
	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	I GAOL CODDECTIVE ACTION SHO		DATE
F 622 Continued From particular forms of the transfer or resident's welfare a cannot be met in the services provided (C) The safety of it endangered due to status of the resident of the resident of the resident in the appropriate notice under Medicare of Nonpayment appropriate notice under Medicare or Med	discharge is necessary for the and the resident's needs ne facility; discharge is appropriate ent's health has improved resident no longer needs the by the facility; ndividuals in the facility is the clinical or behavioral ent; individuals in the facility would angered; nas failed, after reasonable and ent, to pay for (or to have paid or Medicaid) a stay at the facility. It is if the resident does not sary paperwork for third party the third party, including icaid, denies the claim and the to pay for his or her stay. For a somes eligible for Medicaid after acility, the facility may charge a lowable charges under Medicaid; eases to operate. The appeal is pending, pursuant to a comes of the facility pursuant to a chapter, when a resident her right to appeal a transfer or the facility pursuant to a finite chapter, unless the failure inster would endanger the health resident or other individuals in the facility must document the danger ansfer or discharge would pose.	F 62		of correction at by the recordusions. The plan of lely because and state law.  1, & #106 crently  the facility having the services the law in the let of the rector of audit 5 ek for one or 2 months ded by ment.	
§483.15(c)(2) <sup>E</sup> When the facili	Documentation. ty transfers or discharges a		Facility ID: VA0169 If o	continuation st	neet Page 10 of 5

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) MUI	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY LETED
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
			B. WING			05/1	6/2019
		495247	B. WING	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00//	<u></u>
	PROVIDER OR SUPPLIER				0 WEST CONSTANCE ROAD		
CONCO	RDIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE	SI	JFFOLK, VA 23434	<del> </del>	
(X4) ID PREFIX TAG	TO A CHARGE TO SENCE	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	,	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	JRE I	(X5) COMPLETION DATE
F 622	resident under any in paragraphs (c) (1) section, the facility or discharge is do medical record and communicated to institution or provid (i) Documentation must include: (A) The basis for the facility attended, and the section, the specific be met, facility attendeds, and the section, the resident's discharge is necessary under this section. (ii) The document (2)(i) of this section (A) The resident's discharge is necessary under this section. (iii) Information pure this section.	r of the circumstances specified (1)(i)(A) through (F) of this must ensure that the transfer cumented in the resident's dappropriate information is the receiving health care der. in the resident's medical record the transfer per paragraph (c)(1)(i)(A) of this fic resident need(s) that cannot empts to meet the resident ervice available at the receiving eneed(s). In must be made by paragraph (c) (1) (i) (ii) (iii) (iii) (iiii) (iiiiiiiii		622	This Plan of Correction is the center's credical legation of compliance.  Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or a set forth in the statement of deficiencies. The correction is prepared and/or executed sole it is required by the provisions of federal and.  4. Results of audit will be taken monthly Performance Impromeeting which consist of Endirector, Medical Director, Director of Nursing, Staff Development, Social Service Director, Dietitian, C.N.A. Pharmacy for review, correction will be initiated if appropriate.	f correction by the conclusions ep plan of ly because d state law. en to the ovement xecutive  ces &	06/20/2019

NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE    STREET ADDRESS, CITY, STATE, 2IP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA. 23434	STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  200 WEST CONSTANCE ROAD SUFFOLK, VA 23434  SUFFOLK, VA 23434  FOR CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  SUMMARY STATEMENT OF DEPICIENCY MUST BE PRECEDED BY TULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FOR 201 CAMPERIC CROSS-HEFERENCED TO THE APPROPRIATE DEPICIENCY  FOR 21 A safe and effective transition of care. This REQUIREMENT is not met as evidenced by:  Based on staff interviews and clinical record reviews the facility staff failed to send care plan summary goals for 4 residents (Resident #17, Resident #121, Resident #111, Resident #17, Resident #121, Resident #111, Resident #17, Resident #121, Resident #111, Resident #106) out of 56 residents in the survey sample when discharged to the hospital.  1. The facility staff failed to send Resident #17's care plan summary goals when discharged to the hospital.  2. The facility staff failed to ensure that Resident #11's Plan of Care Summary to include their care plan goals was sent upon transfer/discharge to the hospital on 04/11/19.  4. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 21/21'9 and 3/14/19 or as soon as possible to the actual time of transfer for Resident #106.  The findings included:			495247	B. WING			1	
PREFIX TAG  FREDLATORY OR LSC IDENTIFYING INFORMATION)  FREDLATORY OR LSC IDENTIFYING INFORMATION)  FREDLATORY OR LSC IDENTIFYING INFORMATION)  F 622  Continued From page 11 a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record reviews the facility staff failed to send care plan summary goals for 4 residents (Resident #17, Resident #121, Resident #111, Resident #106) out of 56 residents in the survey sample when discharged to the hospital.  1. The facility staff failed to send Resident # 17's care plan summary goals when discharged to the hospital.  2. The facility staff failed to end care plan summary goals for Resident #121 when discharged to the hospital.  3. The facility staff failed to ensure that Resident #111's Plan of Care Summary to include their care plan goals was sent upon transfer/discharge to the hospital on 04/11/19.  4. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 2/12/19 and 3/14/19 or as soon as possible to the actual time of transfer for Resident #106.  The findings included:				INTE	200 WEST CONSTANCE ROAD			
asafe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews and clinical record reviews the facility staff failed to send care plan summary goals for 4 residents (Resident #17, Resident #121, Resident #111, Resident #106) out of 56 residents in the survey sample when discharged to the hospital.  1. The facility staff failed to send Resident # 17's care plan summary goals when discharged to the hospital.  2. The facility staff failed to send care plan summary goals for Resident #121 when discharged to the hospital.  3. The facility staff failed to ensure that Resident #111's Plan of Care Summary to include their care plan goals was sent upon transfer/discharge to the hospital on 04/11/19.  4. The facility staff failed to include in the transfer summary indication that the facility staff conveyed to the receiving providers the resident's comprehensive care plan goals at the time of discharge to the local hospital on 2/12/19 and 3/14/19 or as soon as possible to the actual time of transfer for Resident #106.  The findings included:	PRÉFIX	(EACH DEEICIEN	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	OBE	COMPLETION
on 02/01/2019 and readmitted to the facility on 02/08/2019. Diagnoses included but were not limited to Hemiplegia and Diabetes Mellitus.	F 622	a safe and effecti This REQUIREM by: Based on staff ir reviews the facilit summary goals for Resident #121, I) out of 56 reside discharged to the 1. The facility standard sta	ve transition of care. ENT is not met as evidenced  atterviews and clinical record by staff failed to send care plan or 4 residents (Resident #17, Resident #111, Resident #106 ants in the survey sample when be hospital.  aff failed to send Resident # 17's ary goals when discharged to the aff failed to send care plan or Resident #121 when be hospital.  aff failed to ensure that Resident are Summary to include their are Summary to include their as sent upon transfer/discharge an 04/11/19.  aff failed to include in the transfer ion that the facility staff conveyed broviders the resident's care plan goals at the time of local hospital on 2/12/19 and on as possible to the actual time asident #106.  uded:  was discharged to the hospital and readmitted to the facility on agnoses included but were not		622			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		SURVEY PLETED
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(	
		495247	B. WING		05/1	16/2019
	PROVIDER OR SUPPLIER RDIA TRANSITIONAL	CARE REHAB-NANSEMOND PO		STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		·
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 622	BIMS (Brief Intervi- 14 indicating no co- addition, the Minim #17 as requiring ex- bed mobility, trans- assistance of 1 with personal hygiene a bathing.  On 5/15/19 at 2:08 conducted and Re	02/15/2019 was coded with a ew for Mental Status) score of agnitive impairment. In the num Data Set coded Resident extensive assistance of 2 with fer and toilet use, extensive the dressing, eating and and total dependence of 1 for a p.m., an interview was gistered Nurse (RN) #6, Unit	F 622			
	Manager on Butler residents are discipled the SBAR/Interact copy of the Medica (MAR), Treatment discharge summa Resuscitate (DNR findings. When as policy was issued Representative (Ra copy of the complan goals forward and mot aware of the series of the s	Hall who stated when harged from the nursing facility document is sent along with a lation Administration Record (TAR), ry, history and physical, Do Not form and any laboratory ked if the bed hold reserve to the resident or the Resident R) at the time of discharge, and prehensive summary of care led to the hospital, she stated, the documents you are talking told you are the only ones we	**			
	conducted with the Hall and when ask the comprehensive to the local hospits something I don't	D p.m., an interview was P.M. Unit Manager on Joyner and if he forwarded a copy of e summary of care plan goals al, he responded, "This is know about and I know we are vith the resident or forwarding al at this time."				
	On 5/16/19 at 11:	45 a.m., an interview was e Director of Nursing (DON) and	d			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	DING	COM	PLETED
		495247	B. WING	·	1	C 16/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 622	she said, "I can sa care plan summar discharge or that withe hospital. We was soon as possib. The Administrator informed of the fin p.m. at the pre-expresent any further.  2. The facility states summary goals for discharged to the Resident #121 was 04/17/2019 and reconstruction of the discharged for the short-term memor problems and with skills for daily deconstruction of Daily Living.  On 5/15/19 at 2:0 conducted and Reconstructed and Reco	y for certain we are not sending ies with the resident upon we fax over those summaries to will be training on this process le."  and Director of Nursing was dings on 05/16/2019 at 5:15 it meeting. The facility did not r information about the findings. If failed to send care plan r Resident #121 when		622		

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMP	LETED
٠		495247	B. WING			05/1	6/2019
	PROVIDER OR SUPPLIE RDIA TRANSITIONA	R L CARE REHAB-NANSEMOND PO	INTE	STREET ADDRESS, CITY, STATE, ZIP C 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	OBE	(X5) COMPLETION DATE
F 622	comprehensive si forwarded to the laware of the doct. The ones I told your conducted and with Manager on Joyn reserve policy to time of discharge he thought that my rocess, but was the hospital. Who of the comprehengoals to the local something I don't not sending that over to the hospital over to the hospital over to the hospital over to the hospital of the stated "I can sending care plaupon discharge of summaries to the this process as something I don't sending care plaupon discharge of summaries to the this process as something that informed of the figure and the present any furth 3. The facility states that the present any furth 3. The facility states the hospital on the plan goals, was at the hospital on the president #111 with the sendent #111 with the se	sked if a copy of the ummary of care plan goals hospital, she stated, "I am not uments you are talking about. Ou are the only ones we send."  100 p.m., an interview was hen asked of the RN Unit her Hall if he issued the bed hold the resident or the RR at the hospital, he stated that hight have been an admissions not given when discharged to en asked if he forwarded a copy noive summary of care plan hospital, he responded, "This is a know about and I know we are with the resident or forwarding that at this time."  145 a.m., an interview was the Director of Nursing (DON) and a say for certain we are not an summaries with the resident or that we fax over those to hospital. We will be training on soon as possible."  147 and Director of Nursing was indings on 05/16/2019 at 5:15 exit meeting. The facility did not her information about the findings of the failed to ensure that Resident are Summary to include the care sent upon transfer/discharge to 4/11/19.					
1	facility on 09/30/	17. The resident was					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	TIPLE COI	NSTRUCTION	COM	PLETED
			D WIND		•	l l	C 16/2019
	DOMBER OF CHORLES	495247	B. WING		T ADDRESS, CITY, STATE, ZIP CODE	1 05/	10/2013
	PROVIDER OR SUPPLIER RDIA TRANSITIONAL	. CARE REHAB-NANSEMOND PO	INTE	200 W	EST CONSTANCE ROAD OLK, VA 23434		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 622	for Resident #111 Cerebral infarction Respiratory Failure Resident #111's cu (MDS), a significal Reference Date (Aresident with a 10 the Brief Interview indicating moderal An interview was of Practical Nurse (Lapproximately, 12: transfer/discharge paperwork is sent being sent out to t that "We usually w (Medication Admir Sheet, bed hold not (Situation ,Backgr Recommendation He was asked if t He stated, "We do An interview was Administrator and 05/16/19 at appro asked what should the above issue. To send care plan to  4. The facility staf summary indication to the receiving procomprehensive co discharge to the leteral	facility on 04/17/19. Diagnoses included but were not limited to, Acute and Chronic		622			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	COMF	PLETED
		495247	B. WING	à		05/1	6/2019
	PROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	INTE	2	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE j	(X5) COMPLETION DATE
F 622	Continued From pof transfer for Resident #106 was on 3/12/19 with diend stage renal diamputation.  Resident #106's r (MDS) assessme dated 4/4/19 and of 14 out of a pos Interview for Menindicated the resident was indepartment (ED)	rage 16 sident #106.  Is admitted to the nursing facility agnoses that included diabetes, is ease and left below the knee most recent Minimum Data Set int was a quarterly assessment coded the resident with a score sible score of 15 on the Brief tal Status (BIMS) which dent was fully intact in the cessary for daily decision  Is dated 2/12/19 indicated as transported to the local ry. Resident #106 was nursing facility on 2/15/19. Cumentation in the clinical record onveyed to the receiving dent's comprehensive care plan of discharge or soon thereafter tal.  Is dated 3/14/19 indicated the sferred to the emergency for evaluation due to dark blood		622	DEFICIENCY)		
	He was admitted to the nursing fact documentation in staff conveyed to resident's compretime of discharge hospital.	urinary tubing and drainage bag. to the hospital and re-admitted ility on 3/21/19. There was no the clinical record that facility the receiving provider the chensive care plan goals at the cor soon thereafter to the local					
1	On 5/15/10 at 2:0	)8 n.m., Registered Nurse (RN)	1				l

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					COM	PLETED
							05/4	
NAME OF	PROVIDER OR SUPPLIER	495247	·B. WING		FREET ADDRESS, CITY, STATE, ZIP C	ODE	05/	16/2019
		CARE REHAB-NANSEMOND PO	INTE		00 WEST CONSTANCE ROAD UFFOLK, VA 23434			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD	BE	(X5) COMPLETION DATE
F 622	Unit Manager on B are discharged fror SBAR/Interact door copy of the Medica (MAR), Treatment discharge summar Resuscitate (DNR) findings. When ask comprehensive surforwarded to the hoaware of the document of the ones I told you on 5/16/19 at 11:44 (DON) stated "I car sending care plant upon discharge or	utler hall stated when residents in the nursing facility the ument is sent along with a tion Administration Record (TAR), y, history and physical, Do Not form and any laboratory ted if a copy of the mmary of care plan goals ospital, she stated, "I am not nents you are talking about, are the only ones we send."  5 a.m., the Director of Nursing in say for certain we are not summaries with the resident that we fax over those nospital. We will be training on	F. 6					
F 625 SS=E	identified issuance plan summary upo  The Administrator I additional document 5/16/19 at 7:30 p.m. Notice of Bed Hold CFR(s): 483.15(d)( §483.15(d)(1) Notice §483.15(d)(1) Notice for the resident goes on the resident goes on the resident goes on the resident goes of the resident go	Policy Before/Upon Trnsfr	F	625				

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	СОМІ	SURVEY PLETED
	,	405047	B. WING			05/	; 16/2019
NIME OF	PROVIDER OR SUPPLIER	495247	D. WIIVO		REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
		CARE REHAB-NANSEMOND PO	INTE		0 WEST CONSTANCE ROAD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DESIGNENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 625	(i) The duration of any, during which the return and resume facility; (ii) The reserve be plan, under § 447. (iii) The nursing fabed-hold periods, paragraph (e)(1) or resident to return; (iv) The information of this section.  §483.15(d)(2) Bed the time of transfer hospitalization or the facility must provide resident represents specifies the durated described in paragraph (e)(1) Bed the time of transfer hospitalization or the facility must provide resident represents specifies the durated described in paragraph (e)(1) Bed the time of transfer hospitalization or the facility must provide resident represents the durated described in paragraph (e)(1) Based on staff interviews the facility Hold Notices to 3 Representatives (e) Resident #106) or sample, when discussion of the Resident and written Bed Hold (e) For Resident #17 to 102/01/2019 and the Resident and written Bed Hold (e) For Resident #15 to 102/01/2019 and the Resident and written Bed Hold (e) For Resident #15 to 102/01/2019 and the Resident and written Bed Hold (e) For Resident #15 to 102/01/2019 and the Resident and written Bed Hold (e) For Resident #15 to 102/01/2019 and the Resident #15 to 102/01/2019 an	the state bed-hold policy, if he resident is permitted to residence in the nursing d payment policy in the state 40 of this chapter, if any; cility's policies regarding which must be consistent with f this section, permitting a and in specified in paragraph (e)(1)  -hold notice upon transfer. At r of a resident for herapeutic leave, a nursing le to the resident and the ative written notice which tion of the bed-hold policy graph (d)(1) of this section.  ENT is not met as evidenced erviews and clinical record estaff failed to issue written Bed Residents and/or Resident #17, Resident #121, at of 56 residents in the survey charged to the hospital.  Was discharged to the hospital d the facility staff failed to issue or Resident Representative a Notice.		625	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of does not constitute admission or agreement by provider of the truth of the facts alleged or coset forth in the statement of deficiencies. The correction is prepared and/or executed solely it is required by the provisions of federal and re-admitted and currently re the facility.  2. All residents residing in the have been identified as having potential to be affected.  3. The Director of Nursing Ser (DNS)/ Staff Development Coordinator (SDC)/Designe serviced license staffs — Nurensure that written bed hold are being sent with resident discharge to the hospital. The Managers/Assistant Directon Nursing (ADNS) will audit residents' chart per week and weeks, then monthly x 2 months and then as recommended by Performance Improvement Committee to ensure complete.	le correction by the conclusions plan of because I state law.  So were esides in facility ing the correction in the Unit or of 5 4 conths by the	06/20/2019

Facility ID: VA0169

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		CONSTRUCTION	COM	PLETED
			B. WING			05/1	C 16/2019
		495247	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE		10,2010
	PROVIDER OR SUPPLIER RDIA TRANSITIONAL	. CARE REHAB-NANSEMOND PO	INTE	20	WEST CONSTANCE ROAD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 625	3. The facility staff or Resident Representative (Indings included to the serve policy hospital on 2/12/15. The findings included to the finding included includ	failed to ensure Resident #106 sentative (RR), who resided on sued a written notice of the bed y upon transfer to the local 9 and on 3/14/19.  ded:  vas discharged to the hospital d readmitted to the facility on noses included but were not egia and Diabetes Mellitus. Inimum Data Set (an icol) with an Assessment of 02/15/2019 was coded with a riew for Mental Status) score of ognitive impairment. In mum Data Set coded Resident extensive assistance of 2 with effer and toilet use, extensive ith dressing, eating and and total dependence of 1 for the B.m., an interview was egistered Nurse (RN) #6, Unit extensive assistance of 2 with start and total dependence of 1 for the B.m., an interview was egistered Nurse (RN) #6, Unit extension Administration Record of Administration Record (TAR), ary, history and physical, Do Not R) form and any laboratory sked if the bed hold reserved to the resident or the Resident RR) at the time of discharge she		625	This Plan of Correction is the center's credib allegation of compliance.  Preparation and/or execution of this plan of does not constitute admission or agreement by provider of the truth of the facts alleged or consection is prepared and/or executed solely it is required by the provisions of federal and  4. Results of audit will be taken monthly Performance Impromeeting which consist of Expirector, Medical Director, Director of Nursing, Staff Development, Social Service Director, Dietitian, C.N.A & Pharmacy for review, correction will be initiated if appropriate.	correction by the original to the overnent executive	06/20/2019
	stated, "I am not talking about. The ones we send."	aware of the documents you are e ones I told you are the only					t Domo. 20 of E4

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING			PLETED		
		495247	B. WING	i		1	16/2019		
NAME OF E	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE				
CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POI									
(X4) ID PREFIX TAG	(EACH DEEICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 625			F	625	•				
	conducted and wh Manager on Joyn reserve policy to t time of discharge	0 p.m., an interview was nen asked of the RN Unit er Hall if he issued the bed hold he resident or the RR at the to the hospital, he stated that ight have been an admissions not given when discharged to							
	conducted with the she said, "We do clinical record the	45 a.m., an interview was the Director of Nursing (DON) and not have documentation in the state we are issuing the bed hold lent or family at time of will be training on this process as							
·	informed of the fi	r and Director of Nursing was ndings on 05/16/2019 at 5:15 xit meeting. The facility did not er information about the findings	4						
	issue a written Board/or Resident	#121, the facility staff failed to ed Hold Notice to the Resident Representative (RR)when hospital on 04/17/2019.							
	04/17/2019 and 1 04/28/2019. Dia limited to Anoxic and Dry Eye Syn Gland. Resident assessment prot Reference Date short-term memory	as discharged to the hospital on readmitted to the facility on gnosis included but were not Brain Damage, Tracheostomy drome of unspecified Lacrimal #121's Minimum Data Set (an ocol) with an Assessment of 04/29/2019 was coded with bry problems, long-term memory th severely impaired cognitive							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED	
						1	6/2019
		495247	B. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/1	0/2013
	PROVIDER OR SUPPLIER				00 WEST CONSTANCE ROAD		
CONCOR	RDIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE	1	SUFFOLK, VA 23434	- I	(VE)
(X4) ID PREFIX TAG	/EVCH DEELGENG	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	DBE [	(X5) COMPLETION DATE
F 625	Minimum Data Set requiring total deposit of Daily Living.	age 21 sion making. In addition, the coded Resident #121 as endence, on staff, for Activities	F	625		ease to the second seco	
	conducted and Re Manager on Butler residents are discitute SBAR/Interact copy of the Medica (MAR), Treatment discharge summa Resuscitate (DNR findings. When as policy was issued Representative (R stated, "I am not a talking about. The ones we send."	gistered Nurse (RN) #6, Unit Hall who stated when harged from the nursing facility document is sent along with a ation Administration Record (TAR), ry, history and physical, Do Not) form and any laboratory ked if the bed hold reserve to the resident or the Resident (R) at the time of discharge, she ware of the documents you are ones I told you are the only					
	conducted and when Manager on Joyn-reserve policy to the time of discharge he thought that me process, but was the hospital.	O p.m., an interview was nen asked of the RN Unit er Hall if he issued the bed hold he resident or the RR at the to the hospital, he stated that ight have been an admissions not given when discharged to					
	conducted with the she said, "We do clinical record that policy to the residuscharge." "We as soon as possilosidischarge."	the Director of Nursing (DON) and not have documentation in the lit we are issuing the bed hold lent or family at time of will be training on this process	d			,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED C			
		495247	B. WING			05/1	6/2019			
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POI					STREET ADDRESS, CITY, STATE, ZIP CODE  200 WEST CONSTANCE ROAD  SUFFOLK, VA 23434					
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	iΧ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE			
F 625	informed of the fin p.m. at the pre-exi present any furthe  3. The facility staff or Resident Represent Hall, was is hold reserve policy hospital on 2/12/19  Resident #106 was an 3/12/19 with dispersent Hall with the control of the first half of the control of the control of the control of the first half of the control of	dings on 05/16/2019 at 5:15 t meeting. The facility did not r information about the findings. failed to ensure Resident #106 sentative (RR), who resided on sued a written notice of the bedy upon transfer to the local		625						
	amputation.  Resident #106's n (MDS) assessment and coded the respossible score of Mental Status (Billy was fully intact in for daily decision.	nost recent Minimum Data Set nt was a quarterly dated 4/4/19 sident with a score of 14 out of a 15 on the Brief Interview for MS) which indicated the residen the cognitive skills necessary								
	Resident #106 was hospital for surge readmitted to the There was no doo that facility staff is hold reserve policity hospital to either.  The nurse's notes resident was transdepartment (ED) in the indwelling to the nursing face	as transported to the local ry. Resident #106 was nursing facility on 2/15/19. Cumentation in the clinical record saued a written notice of the bedry upon transfer to the local the Resident or RR.  Is dated 3/14/19 indicated the sferred to the emergency for evaluation due to dark blood urinary tubing and drainage bag. to the hospital and re-admitted tility on 3/21/19. There was no the clinical record that facility								

CENTERS FOR MEDICARE		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILI		COMPLETED			
			- WING			C 05/45/0040		
	495247		B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	05/16/2019		
NAME OF P	ROVIDER OR SUPPLIER			i	0 WEST CONSTANCE ROAD			
CONCOR	DIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE	1	JFFOLK, VA 23434			
		ATEMENT OF DEFICIENCIES	ID.	1	PROVIDER'S PLAN OF CORRECTIO	Ň	(X5) COMPLETION	
(X4) ID PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREI TAG	FIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	RIATE .	DATE	
TAG	REGULATORY OF L	GO IDENTIFY THE OTHER COLUMN			DEFICIENCY)			
					•			
F 625	Continued From pa		F	625				
	staff issued a writte	en notice of the bed hold		1				
	reserve policy upor to either the Reside	n transfer to the local hospital ent or RR.						
	On 5/15/19 at 2:08	p.m., Registered Nurse (RN) outler hall stated when residents						
į	are discharged from	m the nursing facility the						
	SBAR/Interact doc	ument is sent along with a			•			
	copy of the Medica	ation Administration Record Administration Record (TAR),						
	discharge summai	ry, history and physical, Do Not						
	Resuscitate (DNR)	) form and any laboratory ked if the bed hold reserve	'					
	noticy was issued:	to the resident or the Resident						
	Representative (R	R) at the time of discharge, she						
	stated, "I am not a	ware of the documents you are ones I told you are the only						
-	ones we send."	, , , , , , , , , , , , , , , , , , ,					1	
	0. 54040 - 114	15 a.m., the Director of Nursing			·			
	(DON) said, "We o	do not have documentation in						
-	the clinical record	the clinical record that we are issuing the bed			·			
,	hold policy to the	hold policy to the resident or family at time or discharge." "We will be training on this process as	<b>.</b>					
	soon as possible."							
	•							
	identified issuance	The facility did not have a current policy that identified issuance to the resident or RR the bed hold reserve policy upon discharge to the local						
	hold reserve polic					•		
	hospital.	hospital.						
	No additional doc	No additional documentation was provided prior						
	to survey exit on 5/16/19 at 7:30 p.m. PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3)		,	F 645				
F 645			1	UTU				
SS=D		,					-	
,	§483.20(k) Pread	mission Screening for						
	individuals with a	mental disorder and individuals						

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (> AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	COM	COMPLETED	
•		495247	в. WING			1	16/2019	
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
		CARE REHAB-NANSEMOND PO	INTE		00 WEST CONSTANCE ROAD UFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL: LSC IDENTIFYING INFORMATION)	ID PREF . TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE	
F 645	with intellectual dis §483.20(k)(1) A nu or after January 1, (i) Mental disorder (i) of this section, authority has dete independent physiperformed by a pestate mental healt (A) That, because condition of the inthe level of service and (B) If the individual services, whether specialized service (ii) Intellectual disabilicanthority has dete (A) That, because condition of the inthe level of service and (B) If the individual services, whether specialized service (A) That, because condition of the inthe level of service and (B) If the individual services, whether specialized services, whether specialized service §483.20(k)(2) Exception—(i)The preadmissiparagraph(k)(1) of determination to a nursing facility being admitted to transferred for care	ursing facility must not admit, on 1989, any new residents with: as defined in paragraph (k)(3) unless the State mental health rmined, based on an ical and mental evaluation erson or entity other than the ch authority, prior to admission, of the physical and mental dividual, the individual requires es provided by a nursing facility; all requires such level of the individual requires es; or ability, as defined in paragraph ction, unless the State ity or developmental disability ermined prior to admissione of the physical and mental dividual, the individual requires es provided by a nursing facility; all requires such level of the individual requires es for intellectual disability. The individual requires in the individual requires es for intellectual disability. The proposes of this in screening program under of this section need not provide in the case of the readmission the case of the readmission that the nursing facility, was		345	This Plan of Correction is the center's credib allegation of compliance.  Preparation and/or execution of this plan of does not constitute admission or agreement by provider of the truth of the facts alleged or consect forth in the statement of deficiencies. The correction is prepared and/or executed solely it is required by the provisions of federal and been completed on resident,  1. Resident # 88 currently resident facility and Level 1 PAS been completed on resident,  2. All residents residing in the have been identified as having potential to be affected.  3. Social Worker/designee revall residents for PASSR Levassess for service that might necessary based on diagnos mental disorder. PASSR Leassessment has been completed all residents' currently residents currently residents of 5/23/2019  4. The Executive Director/designer in-serviced the Director of Services on completing PAS level 1 on all residents upon admission to the facility. All admissions will be reviewed morning meeting for PASS determination to determine appropriate recommendatio care plan addresses disability	des in SRR has #88. facility ng the iewed rel I to to be is of a vel 1 eted for iing in lignee Social SRR I I new I in R level I if ns and	06/20/2019	

Facility ID: VA0169

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		PLETED C	
		495247	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE		16/2019	
	PROVIDER OR SUPPLIER	. CARE REHAB-NANSEMOND PO	INTE					
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES YY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 645	paragraph (k)(1) of to a nursing facility (A) Who is admitted hospital, (B) Who requires condition for which the hospital, and (C) Whose attend before admission is likely to require facility services.  §483.20(k)(3) Definition section— (i) An individual is disorder if the individual is intellectual disability intellectual disability intellectual disability or is a person with described in 435. This REQUIREMING.  Based on clinical and facility docum failed to issue a Fresident Review residents (Resident #88 did PASRR to assess	sening program under f this section to the admission of an individual-ed to the facility directly from a siving acute inpatient care at the nursing facility services for the nursing has certified, to the facility that the individual less than 30 days of nursing inition. For purposes of this considered to have a mental vidual has a serious mental nursing has as defined in §483.102(b)(1). It is considered to have an ity if the individual has an ity as defined in §483.102(b)(3) in a related condition as 1010 of this chapter. ENT is not met as evidenced record review, staff interviews inentation review, the facility staff threadmission Screening and (PASRR) for 1 out of 56 int #88) in the survey sample. In the service that might be on diagnosis of a mental		345	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The p correction is prepared and/or executed solely bit is required by the provisions of federal and sit is required by the provisions of federal and sit is required by the provisions of federal and sit is reviewed and discussed by the Executive Director, reviewed analyzed by the interdisciplin Team which consist of Executive Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy at the monthly Quants Assessment and Performance Improvement meeting for the months with a subsequent plat correction as needed.	the clusions lan of lan of lecause tate law.  De le and lary tive	06/20/2019	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		00,00	
		495247	B. WING			1	6/2019
NAME OF F	ROVIDER OR SUPPLIER	453247		ST	REET ADDRESS, CITY, STATE, ZIP CODE  0 WEST CONSTANCE ROAD	, 00, 1	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
CONCOR	IDIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE		JFFOLK, VA 23434		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 645	on 7/4/18 with diag	admitted to the nursing facility noses that included bipolar ophrenia. There was no ne clinical record that a Level I	F6	345			
	(MDS) assessmen assessment which and long term men with the necessary making. The reside coded in Section I:	st recent Minimum Data Set to dated 4/13/19 was a quarterly coded the resident with short nory and severely impaired skills for daily decision ent's active diagnoses were anxiety disorder, depression, (bipolar) and psychotic renia.				•	
	conducted with the who stated, "Every Level I PASRR eith completed after the specialized service coordination of a L	p.m., an interview was Social Services Coordinator one in the facility will have a ner upon admission or one eir admission to determine if es are needed, then evel II assessment will be ne of the assessment service)."					
	11/28/17 indicated	r and procedures dated PASRR screenings are g centers having State tion.					
F 656 SS=D	Survey exit on 5/16 Develop/Implement	nt Comprehensive Care Plan	F	656			
	\$483,21(b)(1) The	rehensive Care Plans facility must develop and prehensive person-centered	THE PROPERTY OF THE PROPERTY O	į			-

#### PRINTED: 05/23/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 05/16/2019 495247 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 200 WEST CONSTANCE ROAD CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE SUFFOLK, VA 23434 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 06/20/2019 F 656 Continued From page 27 care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's This Plan of Correction is the center's credible medical, nursing, and mental and psychosocial allegation of compliance. needs that are identified in the comprehensive Preparation and/or execution of this plan of correction assessment. The comprehensive care plan must does not constitute admission or agreement by the describe the following provider of the truth of the facts alleged or conclusions (i) The services that are to be furnished to attain set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because or maintain the resident's highest practicable it is required by the provisions of federal and state law. physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and F656 (ii) Any services that would otherwise be required Residents, #44 and #50 currently 1. under §483.24, §483.25 or §483.40 but are not resides in the facility. provided due to the resident's exercise of rights Comprehensive care plan has been under §483.10, including the right to refuse completed and updated for residents treatment under §483.10(c)(6). #44 and #50. (iii) Any specialized services or specialized rehabilitative services the nursing facility will 2. All residents residing in the facility provide as a result of PASARR have been identified as having the recommendations. If a facility disagrees with the potential to be affected. findings of the PASARR, it must indicate its rationale in the resident's medical record. The DNS/Staff Development (iv)In consultation with the resident and the Coordinator (SDC)/designee inresident's representative(s)serviced Licensed Dietitian, (A) The resident's goals for admission and License Nurses & MDS desired outcomes. Coordinators and on-going to (B) The resident's preference and potential for ensure the resident's care plans are future discharge. Facilities must document

section.

by:

entities, for this purpose.

whether the resident's desire to return to the

community was assessed and any referrals to

local contact agencies and/or other appropriate

(C) Discharge plans in the comprehensive care

plan, as appropriate, in accordance with the

requirements set forth in paragraph (c) of this

This REQUIREMENT is not met as evidenced

updated to reflects residents' needs.

DNS/ADNS/UM/designee will

plans are updated to maintain

compliance.

perform random audit 3X weekly

for 1 month and then monthly x 2

months to validate that resident care

STATEMENT AND PLAN C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		C C		
		495247	B. WING			05/	16/2019
	PROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	INTE	20	REET ADDRESS, CITY, STATE, ZIP CODE 10 WEST CONSTANCE ROAD UFFOLK, VA 23434		1
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Based on staff intereview, and clinical determined that factomprehensive cain the survey samp.  1. For Resident #4 a nutritional care polar dated 12/27/17.  2. The facility staff address Resident regular call light du motion of bilateral and traumatic brain. The findings included 1. Resident #44 who should be seen to be a seen t	erview, facility document record review, it was cility staff failed to develop the re plan for two of 56 residents ole, Resident #44 and #50.  4, facility staff failed to develop lan to her comprehensive care failed to develop a care plan to #50's inability to utilize a set to decreased range of hands related to quadriplegia in injury.		656	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The progrection is prepared and/or executed solely bit is required by the provisions of federal and states and the provisions of federal and states are monthly Performance Improvementing which consist of Exerection, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, correcting action will be initiated if appropriate.	rrection the clusions lan of ecause tate law. to the ement cutive	06/20/2019

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		+ ' '		LE CONSTRUCTION	) COM	COMPLETED	
		495247	B. WING	ì	,		0 16/2019
	PROVIDER OR SUPPLIER	<u> </u>	<u></u>	2	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434	1 00,	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 656	planned.  The CAA workshed documented the four formal Status: "Functional status: "Functional limitation to perform ADLs (significant physical status and behavior with eating: Anxied and condition that nutritional status: Antipsychoticsls warranted? Yes, runmet needs."  Review of Reside that she had a ter	eets dated 12/24/18 ollowing under the area of		656	-		
	3/21/19: "Resider nursing she cons meals. She is eddenies problems regular texture dilikes/dislikes. We Significant weight quarterRecomplusContinue continue co	e was written by the dietitian on at reports good appetite. Per umes 75-100 percent of most entulous (without teeth) but chewing or swallowing the et. Discussed food preferences, ight stable this month. I loss noted this nended: Added Ensure urrent diet regimen w/ ween meals. Will continue to					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		E CONSTRUCTION	COMPLETED		
		495247	B. WING			05/16/2019		
	PROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PC	INTE	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONSTANCE ROAD UFFOLK, VA 23434	CODE		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
F 656	interventions in pla Review of Resider plan dated 12/27/ evidence a nutrition	sisting with meals and putting ace to promote weight gain.  In #44's comprehensive care 17 and revised 5/7/19, failed to onal care plan.  Iroximately 4 p.m., a copy of mprehensive care plan was	F	356				
	On 5/15/19 at app administration pre plan. Nutritional S plan on 5/15/19 (c was documented: unplanned/unexpe poor food intake. two of three meals Interventions: Alei poor for more that supplements bid (Alert nurse/dieticic basis. Monitor/Eva via meal intake reand evaluate any	proximately 10:00 a.m., asented Resident #44's care tatus was added to her care during survey). The following						
	conducted with Lf the unit manager. care plan, LPN #1 guide on how to c stated that all staf they have a quest stated that it was accurate, LPN #1	14 a.m., an interview was PN (licensed practical nurse) #1, When asked the purpose of the stated that the care plan was a rare for the resident. LPN #1 if can look at the care plan if tion regarding care. LPN #1 important for the care plan to be stated that nurses and MDS are plan with any new changes						

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	TENCH COMMENTS.						
		495247	B. WiNG			05/1	6/2019
	PROVIDER OR SUPPLIER RDIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE	20	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST CONSTANCE ROAD JFFOLK, VA 23434		
(X4) ID PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	XI:	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 656	in the condition of was responsible for comprehensive ca MDS develops the comprehensive care of care areas he was baseline care plan expect to see the factivities of would expect to see plan, LPN #1 states care area "nutrition plan. LPN #1 states current nutritional a care plan address LPN #1 looked at stated that he was a care plan in place there was any conweight, LPN #1 states concerns with Research intake was g LPN #1 stated that meals and get ups	the resident. When asked who		656			
	conducted with RN MDS coordinator. responsible for de care plan, RN #4 (MDS) was responded to admission. When areas are address plan, RN #4 states following care are	19 p.m., an interview was I (registered nurse) #4, the When asked who was veloping the comprehensive stated that her department nsible for developing the ure plan within the first few days en asked what type of care ed on the comprehensive care I that she would add the as: ADLS, pain management, ufections, diagnoses etc. When		mente de destado a como de mesto de la composição de la composição de la composição de la composição de la comp			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILC		COMPLETED			
		495247	B. WING			05/1	6/2019
	PROVIDER OR SUPPLIER		INTE	20	REET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	on the comprehent that she would. We not on Resident # especially after it to assessment, RN # responsible for dethat the dietician in RN #4 confirmed on the 12/11/18 Medocumenting that planned. RN #4 steed would be responsible for the responsive care plan.  On 5/16/19 at 12: conducted with O Dietician. When a that she would excomprehensive care plan. When a stated that she we within seven days care plan. When a stated that she we within seven days care plan. When a stated, "Seems libefore that." OSI was having weigh on supplements. have been a nutrition would have added when asked why yesterday 5/15/19 alerted that Residence plan and that care plan and that the side care plan and the side care pl	age 32 If expect to see nutritional status sive care plan, RN #4 stated then asked why nutrition was 44's comprehensive care plan riggered on her annual MDS #4 stated that MDS was not veloping the nutrition care plan, nitiates the nutrition care plan. That it was her staff's signature IDS under section V nutrition was an area to be care tated again that the dietician lible for developing a nutrition  20 p.m., an interview was SM (other staff member) #4, the sked if nutrition was a care area pect to see on a resident's are plan, OSM #4 stated that and a nutrition care plan. OSM #4 build do a nutritional assessment of admission and develop a lasked if Resident #44 had a note of the care plan was a care area asked if Resident #44 had a note of the stated that she had esterday (5/15/19). When asked no place prior to 5/15/19, OSM #4 to the stated that Resident #44 had loss and that she added her OSM #4 stated that there should those and that she added her OSM #4 stated that there should those and that she was dent #44 did not have a nutrition at she needed one.  If present a nutrition care plan is the present a nutrition care plan and the plane was dent #44 did not have a nutrition at she needed one.					

	S FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	ING _			_ 1
		495247	B. WING			1	16/2019
	ROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	INTE	20	REET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	staff member) #1, the DON (Director of the above concerns of the a	p.m., ASM (administrative he administrator and ASM #2, of Nursing) were made aware		656			

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE	CONSTRUCTION	(X3) DATE		
STATEMENT AND PLAN O	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					COMPLETED		
			5 W/N/	2		05/4	6/2019	
		495247	B. WING		REET ADDRESS, CITY, STATE, ZIP CODE	1 00/1	0/2013	
	PROVIDER OR SUPPLIER				0 WEST CONSTANCE ROAD			
CONCOR	IDIA TRANSITIONAL	CARE REHAB-NANSEMOND PC	INTE	SL	JFFOLK, VA 23434			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TAG	FIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE	
	Continued From paresident's reach. B were opened and the Resident #50 didn'  During the medicate approximately 9:57 Nurse (LPN) #4 enexplained she had resident accepted resident's windows was extremely cold and light to contact standight to contact standight, which was call light, which was the bed near the flight to the resident Review of Resident Review of Resident and the An interview was an approximately 1:4 #50 can't do anythe hands are contract.	age 34 oth of the double windows he room was very cool. t respond to questions asked.  tion pass on 5/15/19 at 7 a.m., Licensed Practical attered the resident's room and his medications, which the without problem. Again the without problem. Again the were opened and the room d. The resident's left hand was the was brought to LPN #4's windows were up, the room was defi if needed. LPN #4 asked he cold and he responded sed one window and left the he looked for Resident #50's as located behind the head on loor. LPN #4 attached the call att's gown top and left the room.  Int #50's care plan didn't reveal a sed on a specialty call light.  Conducted with Certified (CNA) #1 on 5/16/19 at 5 p.m. CNA #1 stated Resident ining for himself because his sted. CNA #1 further stated the	a f	656	DEFICIENCY			
	left hand and prior hospital in Decem room and in the o	nd moved a little better than the record to Resident #50 going to the aber, he resided in a another ther room a specialty call light ce he return from the hospital to only had a regular call light able to activate.						

NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  SUMMARY STATEMENT OF DEPOSITORIS (EACH DEPOSITONY MUST BE PRECIDED BY PULL REGILATORY OR LSC (DENTIFYING INFORMATION)  FRESH TAG  F 656  Continued From page 35  CNA #1 stated Resident #50's window is frequently opened because the resident sweats a lot, and on occasion the resident has frequently stools related to a medication he is administered and the window is often opened to help remove the odors.  An interview was conducted with LPN #4 on 51'16'19 at approximately 1:58 p.m. LPN #4 stated she had never noticed Resident #50's window staying opened for long periods of time. LPN #4 stated she had never noticed Resident #50's window staying opened for long periods of time. LPN #4 stated she was aware the resident required use of a specialty call light he could easily activate with his chin or hand because of limited hand movement but; she had not noticed he didn't have it until it was bought to her attention. LPN #4 stated she was immediately installed in the resident's current room.  An interview was conducted with the MDS Coordinators stated a care plan was developed to address the resident's musculos/cleaf status related to pain and activities of daily living but not the resident's musculos/cleaf status related to pain and activities of daily living but not the resident's musculos/cleaf status related to pain and activities of daily living but not the resident's musculos/cleaf status related to pain and activities of daily living but not the resident's musculos/cleaf status related to pain and activities of daily living but not the resident's musculos/cleaf status related to pain and activities of daily living but not the resident's musculos/cleaf status related to pain and activities of daily living but not the resident's musculos/cleaf status related to pain and activities of daily living but not the resident to contact staff; a touch pad call light was a part of the resident to contact staff; a touch pad call light was a part	STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	COMPLETED	
CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  CA) ID SUMMARY STATEMENT OF DEPTORNOISES (EAGLI JEPFOLENCY MUST BE PRECEDED BY FULL REGULATORY OR ISO IDENTIFYING INFORMATION)  FREETY TAG  F 656  Continued From page 35  CNA #1 stated Resident #50's window is frequently opened because the resident sweats a lot, and on occasion the resident has requested the air to be cut on to aid him in cooling off. CNA #1 also stated the resident has frequested and the window is often opened to help remove the odors.  An interview was conducted with LPN #4 on 5/16/19 at approximately 1:58 p.m. LPN #4 stated she had never noticed Resident #50's window staying opened for long periods of time. LPN #4 also stated she was aware the resident required use of a specialty call light he could easily activate with his chin or hand because of limited hand movement but; she had not noticed he didn't have it until it was bought to her attention. LPN #4 stated she contacted the Maintenance Director on 5/16/19, and the specialty call light was immediately installed in the resident's current room.  An interview was conducted with the MDS Coordinators on 5/16/19, at approximately 2:45 p.m. The MDS Coordinators stated a care plan was developed to address the resident's musculoskeletal status related to pain and activities of daily living but not the resident's mability to use a requiar call light MDS Coordinator #4 stated she had heard Resident #50 call out for assistance wasn't the optimal means for the resident to contact staff, a touch pad call light would be appropriate device.			495247	B. WING			05/1	6/2019
PREFIX TAG  F 656  Continued From page 35  CNA #1 stated Resident #50's window is frequently opened because the resident sweats a lot, and on occasion the resident sweats a lot, and on occasion the resident has requested the air to be cut on to aid him in cooling off, CNA #1 also stated the resident has requested and the window is often opened to help remove the odors.  An interview was conducted with LPN #4 on 5/16/19 at approximately 1:58 p.m. LPN #4 stated she had never noticed Resident #50's window staying opened for long periods of time. LPN #4 also stated she was aware the resident required use of a specialty call light he could easily activate with his chin or hand because of limited hand movement but; she had not noticed he didn't have it until it was bought to her attention. LPN #4 stated she contacted the Maintenance Director on 5/15/19, and the specialty call light was immediately installed in the resident's current room.  An interview was conducted with the MDS Coordinators on 5/16/19, at approximately 2:45 p.m. The MDS Coordinators stated a care plan was developed to address the resident's musculoskeletal status related to pain and activities of daily living but not the resident's inability to use a regular call light. MDS Coordinator #4 stated the resident calling out for assistance wasn't the optimal means for the resident to contact staff, a touch pad call light would be appropriate device.				INTE	20	00 WEST CONSTANCE ROAD UFFOLK, VA 23434		
CNA #1 stated Resident #50's window is frequently opened because the resident sweats a lot, and on occasion the resident has requested the air to be cut on to aid him in cooling off. CNA #1 also stated the resident has frequent smelly stools related to a medication he is administered and the window is often opened to help remove the odors.  An interview was conducted with LPN #4 on 5/16/19 at approximately 1:58 p.m. LPN #4 stated she had never noticed Resident #50's window staying opened for long periods of time. LPN #4 also stated she was aware the resident required use of a specialty call light he could easily activate with his chin or hand because of limited hand movement but, she had not noticed he didn't have it until it was bought to her attention. LPN #4 stated she contacted the Maintenance Director on 5/15/19, and the specialty call light was immediately installed in the resident's current room.  An interview was conducted with the MDS Coordinators on 5/16/19, at approximately 2:45 p.m. The MDS Coordinators stated a care plan was developed to address the resident's musculoskeletal status related to pain and activities of daily living but not the resident's inability to use a regular call light. MDS Coordinator #4 stated she had heard Resident #50 call out for assistance, MDS Coordinator #4 stated she had heard Resident to contact staff, a touch pad call light would be appropriate device.	PRÉFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
frequently opened because the resident sweats a lot, and on occasion the resident has requested the air to be cut on to aid him in cooling off. CNA #1 also stated the resident has frequent smelly stools related to a medication he is administered and the window is often opened to help remove the odors.  An interview was conducted with LPN #4 on 5/16/19 at approximately 1:58 p.m. LPN #4 stated she had never noticed Resident #50's window staying opened for long periods of time. LPN #4 also stated she was aware the resident required use of a specialty call light he could easily activate with his chin or hand because of limited hand movement but; she had not noticed he didn't have it until it was bought to her attention. LPN #4 stated she contacted the Maintenance Director on 5/16/19, at did the specialty call light was immediately installed in the resident's current room.  An interview was conducted with the MDS Coordinators on 5/16/19, at approximately 2:45 p.m. The MDS Coordinators stated a care plan was developed to address the resident's musculoskeletal status related to pain and activities of daily living but not the resident's inability to use a regular call light. MDS Coordinator #4 stated she had heard Resident #50 call out for assistance. MDS Coordinator #4 stated the resident to contact staff; a touch pad call light would be appropriate device.	F 656			E	656	·		
5/16/19 at approximately 1:58 p.m. LPN #4 stated she had never noticed Resident #50's window staying opened for long periods of time. LPN #4 also stated she was aware the resident required use of a specialty call light he could easily activate with his chin or hand because of limited hand movement but; she had not noticed he didn't have it until it was bought to her attention. LPN #4 stated she contacted the Maintenance Director on 5/15/19, and the specialty call light was immediately installed in the resident's current room.  An interview was conducted with the MDS Coordinators on 5/16/19, at approximately 2:45 p.m. The MDS Coordinators stated a care plan was developed to address the resident's musculoskeletal status related to pain and activities of daily living but not the resident's inability to use a regular call light. MDS Coordinator #4 stated she had heard Resident #50 call out for assistance. MDS Coordinator #4 stated the resident calling out for assistance wasn't the optimal means for the resident to contact staff; a touch pad call light would be appropriate device.		frequently opene lot, and on occas the air to be cut of #1 also stated the stools related to and the window i	d because the resident sweats a sion the resident has requested on to aid him in cooling off. CNA e resident has frequent smelly a medication he is administered					
Coordinators on 5/16/19, at approximately 2:45 p.m. The MDS Coordinators stated a care plan was developed to address the resident's musculoskeletal status related to pain and activities of daily living but not the resident's inability to use a regular call light. MDS Coordinator #4 stated she had heard Resident #50 call out for assistance. MDS Coordinator #4 stated the resident calling out for assistance wasn't the optimal means for the resident to contact staff; a touch pad call light would be appropriate device.		5/16/19 at approstated she had n window staying of LPN #4 also stated required use of a easily activate w limited hand more he didn't have it attention. LPN # Maintenance Direction of the property of the specialty call light	ximately 1:58 p.m. LPN #4 lever noticed Resident #50's opened for long periods of time. led she was aware the resident a specialty call light he could ith his chin or hand because of wement but; she had not noticed until it was bought to her 4 stated she contacted the rector on 5/15/19, and the int was immediately installed in the					
On 5/16/19 at approximately 5:00 p.m., the MDS		Coordinators on p.m. The MDS was developed to musculoskeletal activities of daily inability to use a Coordinator #4 september #50 call out for a stated the reside wasn't the optimicontact staff; a tappropriate device.	5/16/19, at approximately 2:45 Coordinators stated a care plan to address the resident's status related to pain and vilving but not the resident's regular call light. MDS stated she had heard Resident assistance. MDS Coordinator #4 ent calling out for assistance had means for the resident to rouch pad call light would be lice.					

		& MEDICAID SERVICES	()(0) 1411	TID) C	E CONSTRUCTION	(X3) DATE	SURVEY
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION		PLETED
AND PLAN O	F CORRECTION	15.51.77 157 (15.51.51.51.51.51.51.51.51.51.51.51.51.5	A. BOLL	MIACE		(	o -
	•	495247	B. WING	ì		05/	16/2019
NAME OF R	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
		THE THE PART OF TH	INITE	20	00 WEST CONSTANCE ROAD		
CONCOR	DIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE	SI	UFFOLK, VA 23434		·
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 658 SS=D	Continued From particles of resident and a problem date of resident and to a cognitive decli (name of resident) needs known on a date 6/26/19. The intervention dated bell.  The above findings Administrator and at approximately 6 Nursing stated the #50 to have a call care plan which ale available for the reservices Provided CFR(s): 483.21(b) \$483.21(b)(3) Con The services provided CFR(s): 483.21(b) Sased on resident facility document in facility staff failed of practice for one sample, Resident #7, for Resident	age 36 ded a revised care plan which ed 12/30/18, which read (name paired communication related ne, head injury. The goal read; will be able to make basic daily basis through the review interventions included a new 5/16/19, for a touch pad call s were shared with the Director of Nursing on 5/16/19 :00 p.m. The Director of expectation was for Resident light he could activate and a erted the staff to ensure it was esident's use. Meet Professional Standards (3)(i) Inprehensive Care Plans ided or arranged by the facility, comprehensive care plan, hal standards of quality. ENT is not met as evidenced at interview, staff interview and review, it was determined that to follow professional standards of 56 residents in the surveys #7. facility staff failed to obtain daily cian's order and the	<u>L</u>	658	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of a does not constitute admission or agreement be provider of the truth of the facts alleged or consection is prepared and/or executed solely it is required by the provisions of federal and F658  1. Resident #7 currently reside facility and receiving daily to per physician order.	erorrection by the moclusions plan of because state law.  es in the weights  reder for intified  coordinator l License ents on ained on their i MD as  will weights ion 3X eekly X	06/20/2019
	The findings inclu	de:					

STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		PLETED
		405047	B. WING				C 16/2019
	PROVIDER OR SUPPLIER	495247  CARE REHAB-NANSEMOND PO		ST 20	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST CONSTANCE ROAD JFFOLK, VA 23434		10/2019
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Resident #7 was a 5/22/18 and readmodiagnoses that including atrial fibrillation, chigh blood pressur Resident #7's mosset) assessment wan ARD (assessment wan ARD (assessment wan ARD (assessment #7 was considered in the ability to male out of possible 15 mental status) examples of the following order for heart failure, Modoctor) for weight day, 5 pounds in oninitiated on 7/30/18.  Review of Resider MARs (medication revealed that facility weights on the MAThere were no commod MARs.  Further review of form (medication adminor blanks for the form 4/6/19 4/7/19 4/8/19 4/21/19  Review of Resider MARs for the form 4/6/19 4/21/19	dmitted to the facility on itted on 7/27/18 with uded but were not limited to, ronic kidney disease stage 3, e, and type two diabetes. It recent MDS (minimum data as a quarterly assessment with ent reference date) of 2/12/19. Oded as being cognitively intact as daily decisions scoring 12 on the BIMS (brief interview for m.  It #7's clinical record revealed: "weight daily every day shift onitoring Alert MD (medical gain of 3 lbs (pounds) in one ne week." This order was administration records) ty staff were documenting daily. R along with a nurse signature. Incerns with the May 2019  Resident #7's April 2019 MARs distration records) revealed hole		558	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The proceeding is prepared and/or executed solely bit is required by the provisions of federal and something the provisions of federal and something the provisions of federal and something which consist of Executing wh	the clusions lan of secause tate law.  to the rement scutive	06/20/2019

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:	A. BUILE	DING _	Mary Control of the C			
		495247	B. WING			05/1	6/2019
	PROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PC	INTE	20	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST CONSTANCE ROAD JFFOLK, VA 23434		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1X ·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 658	Continued From page	age 38	F	658	•		
	PCC (point click of failed to evidence Further review of favored that on 4	at #7's April 2019 weight log on are) (electronic health record) weights for these dates.  Resident #7's April 2019 MARs /23/19 through 4/28/19 (6					
	Resident #7 weight Review of Resider	nt #7's comprehensive care					,
	documented the format of the f	ollowing: "Altered Cardiac to) history of MI (myocardial uttack), CHF (congestive heart nary artery disease, HTN (high Weigh per facility policy and/or					
	conducted with LF asked why a resid LPN #1 stated that and fluid retention stated that a resid need to be put on balance. When as LPN #1 stated that assistant) weigher the weights on the nurse. LPN #1 mark this weight	A 4 a.m. an interview was PN #1, the unit manager. When lent would need daily weights, at a resident would need daily da diagnosis of heart failure had to be monitored. LPN #1 lent receiving dialysis may also daily weight to monitor fluid sked who weighed residents, at the CNA (certified nursing d residents and then they put eir assignment sheet to give to a stated that the nurses will ther into the MAR. When asked ignatures) meant on the MAR,					
	LPN #1 stated the forgot to enter in not obtained. Who on daily weights,	at blanks meant the nurse either the weight or that the weight wa nen asked why Resident #7 was LPN #1 stated that she was on er heart failure and had a	S	-			

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILT	DING			)	
		495247	B. WING	à		05/1	6/2019	
	PROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	DINTE	200	REET ADDRESS, CITY, STATE, ZIP CODE D WEST CONSTANCE ROAD DFFOLK, VA 23434			
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	I =IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	.DBE [	(X5) COMPLETION DATE	
IAG		and the state of t	-		Dullon			
F 658	problem with retain	age 39 ning fluid. This writer showed 7's MAR. LPN #1 stated that at had happened with her		658				
	conducted with Reweighed her daily, was weighed may Resident #7 stated day. Resident #7 time getting her so observation was n	s p.m., an interview was sident #7. When asked if staff Resident #7 stated that she pe once a week but not daily. If that she was weighed that then stated that she had a hard packs on that day. An made of Resident #7's legs at was noted to her bilateral legs:						
	conducted with LF When asked the pweights, LPN #5 sweights and the nthe clinical record or document that really was not dor that happen to meremember the las a weight was obtacompleted. When	I p.m., an interview was PN #5, Resident #7's nurse. Process of obtaining daily tated that the CNAs obtain daily urse will record the weights in When asked if CNAs ever say they obtained a weight when it us, LPN #5 stated, "I have had be before." LPN #5 could not time that the aides stated that ined when it was not a sked if it was easy to weigh	/					
	Resident #7, LPN #5 stated Resident #7 in he the weight of the was believable th exactly the same in April, LPN #5 s the same all the t seen Resident #7 she had. When a #7's legs. LPN #7	I that they usually weigh in wheelchair and then subtract wheelchair. When asked if it at Resident #7's weight was "191.4" for six consecutive day tated, "Her weights are about ime." When asked if she had that shift, LPN #5 stated that sked if she had seen Resident stated that her edema was at e. When asked if she had					-	

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	\^	COMPLETED
495247		D WING		-		C 05/16/2019
		D. WING		TREET ADDRESS, CITY, STATE, ZIP (	CODE	03/10/2019
NAME OF PROVIDER OR SUPPLIEF CONCORDIA TRANSITIONAL	L CARE REHAB-NANSEMOND PO	INTE	20	00 WEST CONSTANCE ROAD UFFOLK, VA 23434		
(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC-IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	E (X5) COMPLETION TE DATE
stated that she copulled up Residen weight recorded for pounds. Her weight day) prior was at #5 then stated that with the weight gas on 5/16/19 at 5:30 staff member) #1, the DON (Director of the above conditions was presented prior address the above information was presented prior address the ab	t #7's weight that day, LPN #5 uldn't remember. This writer ut #7's May 2019 MAR. Her or 5/16/19 was a little over 200 ht recorded for 5/15/19 (the 192.0 pounds. LPN ut she would notify the physician uin of more than 5 pounds.  O p.m., ASM (administrative uthe administrator and ASM #2, ur of Nursing) were made aware erns. No further information ior to exit.  d, "Physician's Orders," did not e concerns. No further presented prior to exit. heostomy Care and Suctioning eratory care, including the and tracheal suctioning. ensure that a resident who or care, including tracheostomy I suctioning, is provided such with professional standards of prehensive person-centered sidents' goals and preferences,		695	This Plan of Correction is the center allegation of compliance.  Preparation and/or execution of this does not constitute admission or agr provider of the truth of the facts alle set forth in the statement of deficience correction is prepared and/or executit is required by the provisions of feet it is required by the provisions of feet it is residing in the fact receiving oxygen order.  2. All current Resident #13 is residing in the fact receiving oxygen order.  2. All current Resident physician orders have been identified the potential to be a facility conduct residents with or and no further owere identified.  3. The SDC/Design service the licent implementing and MD orders for order administration.  4. ADNS/Unit many will audit 10 residents and the recommended be performance Impensure oxygen in the state of the content of the conten	s plan of corre- regent by the reged or concilicies. The plan sted solely becoderal and state  currently acility and n per physi dents with s for oxygen ified as have be affected, ted audit of reder for oxy occurrences nee will in- nsed staff or nd monitor oxygen  nagers/desi sidents wee monthly x n as by the nprovement	sions n of ause e law.  cian  n ing all ygen  ing gnee kly 2

Event ID: 9C7311

		(X1) PROVIDER/SUPPLIER/ČLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495247	B. WING		and the same of th		16/2019
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	" (FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 695	For Resident #131	acility staff failed to administer ian's order and comprehensive	F	695	This Plan of Correction is the center's credi	ble	06/20/2019
	Resident #13 was 7/26/17 and 1/11/1 but were not limite (chronic obstructive blood pressure. For (minimum data sea assessment with a date) of 4/23/19. It is being mildly impaid 09 out of 15 on the Mental Status) expection O "Special Programs" as reconstruction of the following order liters/min (minute) On 5/14/19 at 12: p.m., observations oxygen concentrated Her oxygen concentrated Her oxygen concentrated the following and concentrator from appear to be in at On 5/15/19 at 12:	admitted to the facility on 8 with diagnoses that included do to heart failure, COPD re pulmonary disease) and high tesident #13's most recent MDS to assessment was a quarterly an ARD (assessment reference Resident #13 was coded as red in cognitive function scoring e BIMS (Brief Interview for am. Resident #13 was coded in all treatments, Procedures, and eiving oxygen therapy.  Int #13's clinical record revealed redated 2/28/19, "Oxygen at 2 via Nasal Cannula every shift."  42 p.m., and 5/15/19 at 12:38 as were made of Resident #13's tor with nasal cannula in use. Entrator was set to 1 liter per #13 was in bed for both could not reach the her bed. Resident #13 did not my respiratory distress.			This Plan of Correction is the center's creditallegation of compliance.  Preparation and/or execution of this plan of does not constitute admission or agreement provider of the truth of the facts alleged or a set forth in the statement of deficiencies. The correction is prepared and/or executed solel it is required by the provisions of federal and to the monthly Perform Improvement meeting consist of Executive D Medical Director, Director, Social Services Director Dietitian, C.N.A & Phifor review, corrective a will be initiated if approximations.	correction by the conclusions e plan of by because d state law.  e taken nance which irector, cotor of coment, or, armacy action	
	conducted with LI Resident #13's nu liters of oxygen R #3 looked at Resi	PN (licensed practical nurse) #3, urse. When asked how many esident #13 should be on, LPN dent #13's physician orders and young should be set to 2 liters.	-				

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ČLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPLETED	
		495247	B. WING	i		1	16/2019
	PROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	#13's room. When Resident #13 was concentrator and sturned easy." LPN concentrator easily or if it brushes up asked what should turned, LPN #3 stookygen concentrated also stated that shroom and that she in her room. When the knob on her or stated that she would be stated to compete the stated that she would be stated to congestion admit order."  On 5/16/19 at 11:: conducted with LF with Resident #13 important to follow rate, LPN #1 stated oxygen was consisted that the oxyge	ved this writer to Resident asked how many liters on, LPN #3 looked at the stated, "It says one, but it gets #3 stated that the knob on the y turns if someone bumps into it against the curtain. When d be done if the knob is easily ated that she tries to check the tor at least twice a shift. LPN #3 we was always in Resident #13's or tries to check every time she is asked if Resident #13 turns exygen concentrator, LPN #3 buildn't do that.  Int #13's comprehensive care and revised 5/8/18 buildn't do that.  Int #13's comprehensive care and revised 5/8/18 buildn't do that.  Int #13's comprehensive heart coulmonary embolism, left copp, CHF (congestive heart and allergies and nister oxygen per physician's  14 a.m., an interview was or physician's orders for oxygen and it was important because dered a medication. LPN #1 bygen flow rate will be everent levels for different asked why Resident #13 needed		695			
	heart failure and ( liters of oxygen R	tated that he believed she had COPD. When asked how many esident #13 was supposed to be I 2 liters. When asked if	The state of the s				

CENTER	12 LOU MEDIOVILE	A MEDIO/ ND CE/TO/COLO			- CONSTRUCTION	/YS) DATE	SUBVEY	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION	(DENTIFICATION ROMDELL	A. BUILE	JING _		С		
,		40.0047	B. WING			1	6/2019	
	-	495247	B. WINC		THE ADDRESS OF VICTATE ZIR CODE	05/1	0/2019	
NAME OF F	ROVIDER OR SUPPLIER		-	1	FREET ADDRESS, CITY, STATE, ZIP CODE			
	STATE AND TO A SALE	CARE REHAB-NANSEMOND PO	INTE	ł .	00 WEST CONSTANCE ROAD		1	
CONCOR	DIA THANSITIONAL	CARE REHAD-MANGEMOND!		S	UFFOLK, VA 23434	<del> ,</del>		
(X4) ID PREFIX	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	) BE	(X5) COMPLETION DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	i	DEFICIENCY)	, ,		
			<u> </u>					
F 695	oxygen concentrate know of." When as concentrator easily knobs were very easy when asked how of Resident is on the #1 stated that nurs they go into a reside purpose of the care purpose of the care care for the residence can look at the care regarding care. LP important for the care writer told LPN #1 LPN #1 was also splan. When asked her oxygen concer flow rate, LPN #1 strate was set to 1 limited to the care for the residence and the care care for the residence and the care care for the care care for the care care for the residence and the care care for the care care care care care care care car	I turn her the knob on the or, LPN #1 stated, "Not that I ked if the knobs on the turned, LPN #1 stated that the asy to turn if bumped into. Often nurses check to see if a correct amount of liters, LPN es should check every time lent's room. When asked the eplan, LPN #1 stated that the eplan was a guide on how to ont. LPN #1 stated that all staff eplan if they have a question N #1 stated that it was are plan to be accurate. This about the above observations, hown Resident #13's care if her care plan was followed if intrator was set to the incorrect stated that if her oxygen flow the per minute then the care	F .	695				
F 712 SS=D	staff member) #1, the DON (Director of the above concerned in the ab	p.m., ASM (administrative the administrator and ASM #2, of Nursing) were made aware erns.  I, "Respiratory Evaluation" and ment Care and Handling," did bove concerns.  Ition was presented prior to exit. requency/Timeliness/Alt NPP	F	712				

NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  SUBMARY SYSTEMENT OF DESCRIPTIONS  CANDIDATE SUBMARY SYSTEMENT OF CORRECTION  (EACH CORRECTIVE ACTUAL PROPOGRIATE  CONTRETION  (EACH CORRECTIVE ACTUAL PROPOGRIATE  CACH CORRECTIVE ACTUAL SOON SICULD SET OF THE STATE OF TH			(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCE) METAL PROVIDERS PLAN OF CORRECTION (EACH ORDINAL PROPERTY TAG)  F712  Continued From page 44 physician at least once every 30 days for the first 30 days after admission, and at least once every 60 thereafter.  §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.  §483.30(c)(2) A physician personally.  §483.30(c)(4) At the option of the physician visits must be made by the physician personally.  §483.30(c)(4) At the option of the physician, required wisits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical record review, it was determined that facility staff failed to ensure physican wisits for one of 56 residents in the survey sample, Resident #44.  For Resident #44, facility staff failed to ensure physician visits for one of 56 residents in the survey sample, Resident #44.  For Resident #44, facility staff failed to ensure physician visit for one of 56 residents in the survey sample, Resident #44.  For Resident #44, facility staff failed to ensure physician visit for one of 56 residents in the survey sample, Resident #44.  For Resident #44 was admitted to the facility on 1927/17 with diagnoses that included but were	AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILC	ING_			
STREET ADDIESS, CITY, STRE, 2P CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434  SUPPOLK, VA 23434  SUPPOLK, VA 23434  SUPPOLK, VA 23434  F 712  Continued From page 44 physician at least once every 30 days for the first 30 days after admission, and at least once every 60 thereafter.  \$483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.  \$483.30(c)(2) A physician personally.  \$483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical ruses specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure timely physician visits for one of 56 residents in the survey sample, Resident #44.  For Resident #44, facility staff failed to ensure timely physician visits for one of 56 residents in the survey sample, Resident #44.  For Resident #44, facility staff failed to ensure timely physician visits for one of 56 residents in the survey sample, Resident #44.  For Resident #44, facility staff failed to ensure timely physician visits for one of 56 residents in the survey sample, Resident #44.  For Resident #44 was admitted to the facility on 1/227/17 with diagnoses that included but were			495247	B. WING				- I
PREFIX TAG  SAMANTA SLAV MUST BE PRECEDED BY FULL RESULATORY ON LSG DENTIFYING INFORMATION)  F 712  Continued From page 44 physician at least once every 60 thereafter.  §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.  §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.  §483.30(c)(4) At the option of the physician, required visits in SNFs, after the Initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review, and clinical record review; it was determined that facility staff failed to ensure timely physician visits between the dates of: 5/25/18 through 9/19/18 (over 4 months) and 9/19/18 through 3/23/19 (6 months).  The findings include:  Resident #44 was admitted to the facility on 12/27/17 with diagnoses that included but were		RDIA TRANSITIONAL	CARE REHAB-NANSEMOND PO		20	00 WEST CONSTANCE ROAD UFFOLK, VA 23434	in N	. (X5)
F 712  Continued From page 44 physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.  §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.  §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.  §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This RECUIREMENT is not met as evidenced by:  Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to ensure timely physician visits between the dates of; 5/25/18 through 9/19/18 (over 4 months) and 9/19/18 through 3/23/19 (6 months).  The findings include:  Resident #44 was admitted to the facility on 19/27/17 with diagnoses that included but were	PREFIX	/EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		<ul> <li>(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF</li> </ul>	) BE	COMPLETION
not limited to Bipolar disorder, anxiety disorder, and mild cognitive impairment. Resident #44's most recent MDS (minimum data set) assessment was a quarterly assessment with an	F 712	physician at least of 90 days after admit 60 thereafter.  §483.30(c)(2) A phitimely if it occurs in date the visit was in \$483.30(c)(3) Exce (c)(4) and (f) of this visits must be made \$483.30(c)(4) At the required visits in Salternate between and visits by a phypractitioner or clinical accordance with physician visits in Salternate between and visits by a phypractitioner or clinical accordance with physician visits have also and clinical determined that fatimely physician visits between the survey sample.  For Resident #44, physician visits between the survey sample.  For Resident #44, physician visits between 3/23/19 (6)  The findings inclusion in the survey sample.  Resident #44 was 12/27/17 with diagnot limited to Bipo and mild cognitive most recent MDS	ence every 30 days for the first ssion, and at least once every eysician visit is considered to later than 10 days after the required.  The ept as provided in paragraphs is section, all required physician de by the physician personally.  The option of the physician, solved in the physician personal visits by the physician exician assistant, nurse ical nurse specialist in the aragraph (e) of this section. The is not met as evidenced everyiew, facility document all record review, it was acility staff failed to ensure exists for one of 56 residents in expectation.  The facility staff failed to ensure extrement the dates of: 5/25/18 for one of 56 residents in extrement the dates of: 5/25/18 for one of 56 residents in extrement the dates of: 5/25/18 for one of 56 residents in extrement the dates of: 5/25/18 for one of 56 residents in extrement the dates of: 5/25/18 for one of 56 residents in extrement the dates of: 5/25/18 for one of 56 residents in extrement the dates of: 5/25/18 for one of 56 residents in extrement the dates of: 5/25/18 for one of 56 residents in extrement. Resident #44's (minimum data set)		712	Preparation and/or execution of this plan of a does not constitute admission or agreement by provider of the truth of the facts alleged or co set forth in the statement of deficiencies. The correction is prepared and/or executed solely it is required by the provisions of federal and  F712  1. Resident, #44 currently reside the facility. Resident #44 was by the physician on 5/17/201  2. All residents in the facility here identified as having the potential to be affected.  3. Medical Record Clerk/design audit all current residents to timely physicians visits.  4. Medical Records Clerk/designal will audit all current residents to timely physicians visits.  4. Medical Records Clerk/designal audit all current resident charts monthly to ensure compliance with physician vischedule and update physicial log.  5. Physicians will be educated facility policy and procedure regarding frequency and time of physician visit. Medical reclerk/designee will notify Expirector of Physician(s) not	des in as seen 19.  ave  mee will ensure  gnee ts'  risit an visit  on the es eliness ecord  gecutive	06/20/2019

STATEMENT	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,		ECONSTRUCTION	COMPLETED	
		495247	B. WING	ì			16/2019
	PROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	INTE	20	REET ADDRESS, CITY, STATE, ZIP CODE 10 WEST CONSTANCE ROAD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 712	ARD (assessment Resident #44 was on the BIMS (Brief exam which indical impairment.  Review of Resident that the nurse practitions and 9/19/18 3/23/19 3/30/19 4/29/19  There was no evid visit in between 5/2 and 9/19/18 and 3  On 5/15/19 throug were made to to s visits from the passists from the passi	reference date) of 3/3/19. coded as 12 out of possible 15 Interview for Mental Status) ted moderate cognitive  It #44's clinical record revealed stitioner (NP) had visited he following dates:  lence of a physician and/or NP 25/18 and 9/19/18 (4 months); /23/19 (6 months).  h 5/16/19 several requests ee evidence of all physician		712	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The process consection is prepared and/or executed solely it is required by the provisions of federal and something performance Improvementing which consist of Executing Which consist of Exec	orrection the ticlusions tolan of because tate law.  to the rement ecutive	06/20/2019

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		COMPLETED		
AND I LAN O	. 00/11/20/10/10				· · · · · · · · · · · · · · · · · · ·	1	
		495247	B. WING			05/	16/2019
NAME OF F	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
CONCOR	DIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE	1	000 WEST CONSTANCE ROAD SUFFOLK, VA 23434		
****		ATEMENT OF DEFICIENCIES	T ID	J	PROVIDER'S PLAN OF CORRECTION	N N	(X5) COMPLETION
(X4) ID PREFIX TAG	/EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
F 712	Continued From page	age 46	F	712			
1 / 12	log that she gave t	o the physician/NP alerting			,		
	them to see the re-	sident. OSM #3 stated that					
	once the physician	/NP sees the resident, they summary that is then filed into					
	the resident's clinic	cal record. OSM #3 was asked					
	to present any phy	sician visits in between dates					
		19/18; and 9/19/18 through					
	3/23/19.						
	On 5/16/19 at app	roximately 1:30 p.m., OSM #3					
	presented the sam	ne progress summaries from an visits that this writer already					
	had Anhysician a	audit was also presented					
	documenting that	Resident #44 was seen by the					
	physician on 12/3/	18. A progress note from this Id not be presented. OSM #3					
	physician visit cou	any additional information.					
							,
	On 5/16/19 at 5:30	p.m., ASM (administrative the administrator and ASM #2,					
	the DON (Director	of Nursing) were made aware					
	of the above conc	erns. ASM #2 stated that					
	should would try to	o find the missing physician could not be found.					
	Facility policy title	d, "Monitoring Physician Visits,"					
	documents in part	t, the following: "The physician					,
	(or physician exte	nder, where states allow their sits the resident at least once	•				
	every 30 days for	the first 90 days after					
	admission, and at	least once every 60 days					
,	information into the	dure: Enter the physician visit ne PCC (point click care) systen	n				
	as follows: Revieu	w list of physician visits due fron	n				
	the PCC system	Notify physicians with visits due	<del>}</del>				
	at the beginning of	of the month, or at least one (1) date his/her first visit due.					
	Gather and organ	rize the resident's information					
	(chart, physician	orders, care plan, etc.) for					1 P 47 -45

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	DING _		С	
		495247	B. WING			05/1	6/2019
	ROVIDER OR SUPPLIER DIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	NTE	20	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST CONSTANCE ROAD JFFOLK, VA 23434		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	FACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	SHOULD BE COMP	
F 712 F 727 SS=D	physician: a. Revie of care at each req Medical Services, 2 Physical, occupation therapy, 4) Nursing interventions, and services that maint functioning. b. Writ notes at each visit progress and problem proving their mestatus; and c. sign Document in reside physician's visit. 6. the physician visits date the visits are made, enter the dasystem. 8. Call/not resident/resident has not (5) days following RN 8 Hrs/7 days/No. 2007/2007/2007/2007/2007/2007/2007/2007	uring a physician's visit, the withe resident's total program uired visit that includes: 1)  Medication Management 3)  Mal, and speech/language (Care 5) Nutritional  Social work and activity ain or improve psychosocial e, sign and date progress that include the resident's fems in maintaining or intal and physical functional and date all orders. 5. ent's progress notes the Monitor the records to be sure the residents/residents by the due. 7. When the visits are ates of the visits in PCC iffy the physician if the as not been seen by the due Executive Director if the seen the resident/resident five the date due."  VK, Full Time DON (1)-(3)		712			
	§483.35(b)(1) Exc paragraph (e) or (i	ept when waived under  of this section, the facility  ices of a registered nurse for at  e hours a day, 7 days a week.					
	paragraph (e) or ( must designate a	ept when waived under  f) of this section, the facility  registered nurse to serve as the  on a full time basis.	The state of the s	٠		·	
	§483.35(b)(3) The	director of nursing may serve					

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391 IX3) DATE SURVEY

NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  SUBMANY STATEMENT OF DEPOSICES 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434  FROUGET ON STANCE ROAD SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  SUPPLIER  SUBMANY STATEMENT OF DEPOSICES OF THE STANDARD OF CORRECTION AND THE PROCESS OF THE STANDARD OF CORRECTION AND THE PROPERTY TAG STANDARD OF COMPLETION OF THE STANDARD OF THE STANDARD OF COMPLETION OF THE STANDARD OF THE STANDAR		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		COMPLETED		
CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POINTE  SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST SEE PRECEDED BY FILL REGULATORY OR ISE PRECEDED BY FILL REGULATORY OR ISE PRECEDED BY FILL REGULATORY OR ISE DENTIFYING INFOHMATION)  F 727  Continued From page 48 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure Registered Nurse (RN) coverage for 8 hours, 7 days a week.  The facility staff failed to ensure RN coverage for 8 hours on three days 11/10/18, 12/09/18 and 01/20/19.  The findings included:  On 05/14/19 at approximately 11:00 AM, the facility has actual worked schedule was reviewed with Other Staff #7 (Nursing Scheduler) and revealed there was no RN coverage for the following days: 11/10/18, 12/09/18 and 01/20/19.  On 05/16/19 at approximately 9:45 AM, Other Staff #7 asked surveyor if she could re-check the above FIN (Registered Nurse) non-coverage dates and staffing. Other Staff #7 later continued that there was no RN coverage? She stated that usually she would know ahead of time if an RN wouldn't be able to work. She also stated that if an RN staff member was calling out after hours they would call to the unit to inform the nurse supervisor, would contact the DON (Director of Nursing) concerning staffing.  On 5/16/19 at approximately 5:09 PM an			495247	B. WING			05/	16/2019
F727 Continued From page 48 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure Registered Nurse (RN) coverage for 8 hours, 7 days a week.  The facility staff failed to ensure RN coverage for 8 hours on 1/20/19.  The findings included: On 05/14/19 at approximately 11:00 AM, the facility's actual worked schedule was reviewed with Other Staff #7 (Nursing Scheduler) and revealed there was no RN coverage for the following days: 11/10/18, 12/09/18 and 01/20/19.  On 05/16/19 at approximately 9:45 AM, Other Staff #7 asked surveyor if she could re-check the above RN (Registered Nurse) non-coverage dates and staffing. Other Staff #7 later confirmed that there was no RN coverage for the above dates. She was asked what should have been done to ensure RN coverage? She stated that if an RN staff member was calling out after hours they would call to the unit to inform the nurse supervisor that they wouldn't be coming in. The Nurse Supervisor, would contact the DON (Director of Nursing) or the ADON (Assistant Director of Nursing) concerning staffing.  On 5/16/19 at approximately 5:09 PM an			CARE REHAB-NANSEMOND PO	INTE	20	0 WEST CONSTANCE ROAD	-	
F 727 Continued From page 48 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure Registered Nurse (RN) coverage for 8 hours, 7 days a week.  The facility staff failed to ensure RN coverage for 8 hours on three days 11/10/18, 12/09/18 and 01/20/19.  The findings included:  On 05/14/19 at approximately 11:00 AM, the facility sactual worked schedule was reviewed with Other Staff #7 (Nursing Scheduler) and revealed there was no RN coverage for the following days: 11/10/14, 12/09/18 and 01/20/19.  On 05/16/19 at approximately 9:45 AM, Other Staff #7 asked surveyor if she could re-check the above RN (Registered Nurse) non-coverage dates and staffing. Other Staff #7 later confirmed that there was no RN coverage? She stated that usually she would know ahead of time if an RN wouldn't be able to work. She also stated that if an RN staff member was calling out after hours they would call to the unit to inform the nurse supervisor that they wouldn't be able to work. She also stated that if an RN staff member was calling out after hours they would call to the unit to inform the nurse supervisor that they wouldn't be able to work. She also stated that if an RN staff member was calling out after hours they would call to the unit to inform the nurse supervisor that they wouldn't be acoming in. The Nurse Supervisor, would contact the DON (Director of Nursing) or the ADON (Assistant Director of Nursing) concerning staffing.  On 6/16/19 at approximately 5:09 PM an	PREFIX	(FACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION
interview was conducted with the Director of	F 727	as a charge nurse average daily occu This REQUIREME by: Based on observa document review, the gistered Nurse (days a week.) The facility staff fails hours on three doon/20/19. The findings included the findings included the findings included the finding days: 11/10 On 05/14/19 at approximate the following days: 11/10 On 05/16/19 at approximate following days: 11/10 On 05/16/19 at approximate following days: 11/10 On 05/16/19 at approximate for the finding days: 11/10 On 05/16/19 at approximate for the finding days: 11/10 On 05/16/19 at approximate for the finding days: 11/10 On 05/16/19 at approximate for the finding days: 11/10 On 5/	only when the facility has an pancy of 60 or fewer residents. NT is not met as evidenced tion, staff interview, and facility the facility staff failed to ensure (RN) coverage for 8 hours, 7 led to ensure RN coverage for ays 11/10/18, 12/09/18 and led:  Droximately 11:00 AM, the red schedule was reviewed (Nursing Scheduler) and son RN coverage for the 10/18, 12/09/18 and 01/20/19.  Droximately 9:45 AM, Other reveyor if she could re-check the ered Nurse) non-coverage Other Staff #7 later confirmed RN coverage for the above sked what should have been a coverage? She stated that know ahead of time if an RN owork. She also stated that if her was calling out after hours the unit to inform the nurse by wouldn't be coming in. The would contact the DON (Assistant g) concerning staffing.		727	Preparation and/or execution of this plan of cordoes not constitute admission or agreement by the provider of the truth of the facts alleged or concise that in the statement of deficiencies. The placorrection is prepared and/or executed solely be it is required by the provisions of federal and states a required by the provisions of federal and states.  F727  1. Facility has Registered Nurse (coverage for 8 hours, 7 days a week.  2. All residents residing in the fact have been identified as having potential to be affected.  3. Executive Director/Director of Nursing (DNS) will ensure that facility is staffed with at least a hours/day RN coverage to ensuronment of the compliance.  4. DNS/designee educated staff scheduler on 5/24/2019 to ensure that facility is staffed with at least a hours/day RN coverage to ensuronment of the compliance.  5. DNS/designee will audit the fact the schedule 5 times weekly to ensure that facility is staffed with at least schedule 5 times weekly to ensure that facility is staffed with at least schedule 5 times weekly to ensure that facility is staffed with at least schedule 5 times weekly to ensure that facility is staffed with at least schedule 5 times weekly to ensure that facility is staffed with at least schedule 5 times weekly to ensure the schedule 5 times weekly to ensur	the flusions an of scause the law.  (RN)  cility the  fut 8  ure  ure  east 8  ure	06/20/2019

Facility ID: VA0169

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_			
						1	C
		495247	B. WING		TOTAL ADDRESS OF VICTATE 710 CODE	] 05/	16/2019
	ROVIDER OR SUPPLIER  IDIA TRANSITIONAL	CARE REHAB-NANSEMOND PO	INTE	20	REET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONSTANCE ROAD UFFOLK, VA 23434		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 727 F 812 SS=E	concerning the about that should have to above issue. The Esupervisor for weel Food Procurement CFR(s): 483.60(i)(1) \$483.60(i) Food sathe facility must -	If the facility Administrator ove issue. The DON was asked been done concerning the DON stated "I will hire an RN kend coverage."  "Store/Prepare/Serve-Sanitary 1)(2)  If the facility Administrator of the facility Ad		727 812	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The province is prepared and/or executed solely it is required by the provisions of federal and statement of federal and statement.	orrection the aclusions olan of because	06/20/2019
	approved or considerate or local authors (i) This may include from local produce and local laws or respectively. This provision of facilities from using gardens, subject to safe growing and form consuming form consuming for \$483.60(i)(2) - Store serve food in according authors (iii) This provision of the from consuming for serve food in according for the food in according to the food in accord	e food items obtained directly ors, subject to applicable State egulations.  Joes not prohibit or prevent g produce grown in facility compliance with applicable tood-handling practices.  Joes not preclude residents bods not procured by the facility.  Te, prepare, distribute and rdance with professional		The second secon	6. Results of audit will be taken monthly Performance Improvementing which consist of Exconication, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy for review, correct action will be initiated if appropriate.	vement ecutive	
	by: Based on observative record review, it we failed to dispose of one trash contractor recycle compactor.  Facility staff failed	ation, staff interview and facility as determined that facility staff f trash in a sanitary manner for ompactor and one of one to ensure one of one trash e of one recycle compactor					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,		CONSTRUCTION	COMPLETED	
AND PLAN O	FOUNTEDHON					05/	
		495247	B. WING		THE CORE THE CORE	05/	16/2019
	PROVIDER OR SUPPLIER	CARE REHAB-NANSEMOND PO	INTE	20	REET ADDRESS, CITY, STATE, ZIP CODE 0 WEST CONSTANCE ROAD JFFOLK, VA 23434		
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF	PROVEDERIC BLANLOE CORRECTION			(X5) COMPLETION DATE
F 812	Continued From particles of the findings included on 5/14/19 at 12:35 facility dumpster at (other staff member was observed that one recycle comparts observed to have the ground around it: the plastic cup. The observed to have the ground around it: plastic cup. The observed to have the ground around it: plastic cup. The observed to have the ground around it: plastic cup. The observed to have the ground around it: plastic cup. The observed to have the ground around it: plastic cup. The observed to have the ground around it: plastic cup. The observed to have the ground around it: plastic cup. The observed to have the ground around it: plastic cup. The observed to have the ground around it: plastic cup. The observed to have the observed	de:  10 p.m., observation of the rea was conducted with OSM er) #5, dietary aide and stock. It that facility had one trash and acter. The trash compactor was the following debris on the hree gloves, plastic spoon and recycle compactor was the following debris on the blastic bag, cookie wrapper, x. At that time an interview was SM #5 When asked who was aintaining the compactors in a OSM #5 stated that it was his neck the compactors at least a asked if the observed trash day (the previous Monday), at the surrounding trash was weekend storms. OSM #5 I not been able to clean up the open compactors.  10 p.m., ASM (administrative the Administrator and ASM #2, trsing were made aware of the defacility compactors.  21 ation was presented prior to exit diship Program		812	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of codoes not constitute admission or agreement by provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The progrection is prepared and/or executed solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of federal and solely bit is required by the provisions of the federal and solely bit is required by the provision of the federal and solely bit is prepared to the federal and solely bit is prepared to solely bit is prepared to solely bit is prepared to the federal and solely bit is prepared to solely bit	orrection the colusions because thate law.  of the the debris acility g the mental will vices  ces duct kly x5,	06/20/2019
1	İ						

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING				C 05/16/2019	
	495247		B. WING			i i		
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND PO			INTE	20	TREET ADDRESS, CITY, STATE, ZIP CODE 00 WEST CONSTANCE ROAD UFFOLK, VA 23434			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ULD BE	(X5) COMPLETION DATE		
F 881	Continued From participation of the facility is staff and review of the facility is staff and Prevention programed and Prevention programed in the facility is staff fail and Prevention programed in the facility is staff and prevention programed in the facility is staff fail and Prevention programed in the facility is staff fail and Prevention programed in the facility is staff and prevention programed in the facility is staff fail and prevention programed in the facility is staff fail and prevention programed in the facility in the facility in the huse was validated prescribed an apport in the facility in facility in facility in facility in facility in the facility in facility in the facility in facility	stablish an infection prevention m (IPCP) that must include, at lowing elements: Intibiotic stewardship program totic use protocols and a antibiotic use. INT is not met as evidenced erview, clinical record review, ed to have an Infection Control policy, ed to have an Infection Control ogram which monitored all tered by the facility staff.  failed to have an antibiotic am which monitored newly and nts who were prescribed ospital, to ensure indication of and the resident was ropriate antibiotic.		881	This Plan of Correction is the center's creallegation of compliance.  Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged of set forth in the statement of deficiencies. Correction is prepared and/or executed so it is required by the provisions of federal of the presented to Performance Improvement Committee of Executive Director, M. Director, Director of Nur. Development, Social Serv. Director, Dietitian, C.N.A. Pharmacy monthly for the for review, recommendat continued need for further monitoring to sustain continued to the state of the sustain continued to the sustain continued to the sustain continued to the sustain continued to sustain continued to sustain continued to sustain continued to the sustain continu	of correction not by the r conclusions The plan of clely because and state law.  ce consists edical sing, Staff vices A & ree months ion and r	06/20/2019	
	with microscopic I	had the clean catch urinalysis reflex culture on 3/3/19 revealed t indicating a large amount of , red blood cells and white blood						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
495247		495247	B. WING				C 05/16/2019	
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND POL				STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD				
' (X4) ID PREFIX TAG			ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		BE	(X5) COMPLETION DATE	
F 881	specimen. The ho antibiotic and discinursing facility 3/5, milligram every 12 stated the hospital the culture and se had no laboratory bacteria's and the including if the bas susceptible to the Two resident's recithe hospital. The roursing facility on diagnoses of UTIs bacteria's being trouring an intervier approximately 9:4 hospital doesn't set the facility and the obtaining the cultuincluded in the ad also stated without they had been unis appropriate or it antibiotic. The AD in-house acquired antibiotic prescrib the indication, does and review of laboratory and the control Program is designed. The facility's policing the control Program is designed.	d in the resident's urine spital started the resident on an harged the resident to the /19 on the antibiotic Ceftin 500 hours for 5 days. The ADON didn't provide the facility with nsitivity results therefore they data to indicate specific appropriate treatment, steria in the resident's urine was antibiotic, Ceftin.  eived clean catch urinalysis at esidents were admitted to the antibiotic therapy with but no laboratory of the		381	Preparate does not provider set forth correctio it is required.  F881  1.  2.  3.	in of Correction is the center's credible of compliance.  Ition and/or execution of this plan of constitute admission or agreement by of the truth of the facts alleged or coin the statement of deficiencies. The in is prepared and/or executed solely iried by the provisions of federal and.  Facility has updated the antile stewardship plan to include monitoring.  All residents on antibiotics he potential to be affected.  DNS/ADNS/designee will reall residents with order for antibiotics to ensure appropriate documentation/labs in place/follow up.  SDC/Designee will Inservice on antibiotics stewardship proto ensure residents on antibiotics have appropriate diagnosis, monitoring and supporting documentation.  ADNS/Unit managers/design audit 5 residents' chart weekl and then monthly x 2 and as a per recommendation of performance improvement committee to ensure compliant.	orrection of the neclusions plan of because state law. Diotics  ave the view state MD  staff ogram tics  ee will y x 4 needed	06/20/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED  C 05/16/2019	
		495247	B. WING _			
NAME OF PROVIDER OR SUPPLIER  CONCORDIA TRANSITIONAL CARE REHAB-NANSEMOND PO			INTE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 WEST CONSTANCE ROAD SUFFOLK, VA 23434	1	-
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 881.	licensed independent students, and visito a safe, sanitary and involves each department of the above findings. Administrator and E at approximately 6: Nursing stated they reviews but a review prescribed antibiotic monthly pharmacy stewardship. The D stated neither was a laboratory data from Quality Assurance of Director of Nursing Medical Director to can obtain laborator hospital and it they	esidents, staff, physicians, ent practitioners, volunteers, ers. It is maintained to promote d comfortable environment that	F 88	This Plan of Correction is the center's credible allegation of compliance.  Preparation and/or execution of this plan of condoes not constitute admission or agreement by a provider of the truth of the facts alleged or conset forth in the statement of deficiencies. The picture correction is prepared and/or executed solely be it is required by the provisions of federal and state of the performance Improvement Committee consists of Execute Director, Medical Director, Director of Nursing, Staff Development, Social Services Director, Dietitian, C.N.A & Pharmacy, monthly for three months for review, recommendation and continue need for further monitoring to sustain compliance.	rrection the clusions lan of ecause ate law.	06/20/2019