PRINTED: 07/26/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		405000		-		С	
NAME OF D	ROVIDER OR SUPPLIER	495232	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	11/2019
NAME OF FI	NOVIDER OR SUFFLIER				5520 INDIAN RIVER ROAD		
KEMPSVII	LLE HEALTH & REHAB (CENTER			VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
E 000	Initial Comments		E	000			
F 000	survey was conducte The facility was in sul CFR Part 483.73, Re- Care Facilities. No el	nergency Preparedness d 07/9/19 through 07/11/19. estantial compliance with 42 quirement for Long-Term mergency preparedness stigated during the survey.	F	000			
	standard survey was through 07/11/2019. compliance with 42 C Term Care requireme	nual Medicare/Medicaid conducted 07/09/2019 Corrections are required for FR Part 483 Federal Long ents. The Life Safety Code ow. Three complaints were be survey.					
F 583 SS=D	at the time of the survise 36 which consisted of reviews and 3 closed Personal Privacy/Cor CFR(s): 483.10(h)(1)-\$483.10(h) Privacy at	record reviews. nfidentiality of Records -(3)(i)(ii)	F	583			
		r her personal and medical					
	accommodations, me telephone communicand meetings of familiand	adical treatment, written and ations, personal care, visits, ly and resident groups, but the facility to provide a			RECEIVE	Ð	
	private room for each				AUG 0 2 201	9	
		cility must respect the sonal privacy, including the			VDH/OL	C	
LABODATODY	DIDECTORIS OF DOOLIDED	SLIDDI IED DEODESENITATIVE'S SIGNATUDE			TITLE		(YE) DATE

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

ADMINISTRATOR

07/24/2019

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING COM		
		495232	B. WING		C 07/11/2019	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 583	right to privacy in his written, and electronic the right to send and mail and other letters materials delivered to including those delive than a postal service. §483.10(h)(3) The resand confidential person (i) The resident has the of personal and medisprovided at §483.70(i federal or state laws. (ii) The facility must a Office of the State Loto examine a resident administrative records law. This REQUIREMENT by: Based on observation facility staff failed to piew during wound ca #21), of 36 residents The facility staff failed maintained during a very for Resident #21. The findings included Resident #21 was origon 03/29/19. Diagnos included but are not limed Mellitus. Resident #2 (MDS-an assessment Reference Assessment Reference and included to the service of the service	or her oral (that is, spoken), a communications, including promptly receive unopened packages and other the facility for the resident, and through a means other sident has a right to secure onal and medical records. The right to refuse the release cal records except as (2) or other applicable flow representatives of the ing-Term Care Ombudsman is medical, social, and is in accordance with State is not met as evidenced in and staff interviews the rotect resident from public are for 1 resident (Resident in the survey sample. It to ensure privacy was yound care dressing change in the survey sample in the survey sample.	F 58	 Resident #21's window blinds heen closed during her care and treatment. All resident's receiving care in the facility have the potential to be affected. The Director of Nursing or design and Department Managers will educate all staff on maintain paprivacy, particularly during paticare. The director of Nursing or design will conduct random audits to earesident privacy during care is behonored. These audits will be conducted 3x a week for 3 mon The audit will be reported to the facility's QAPI committee for discussion and necessary revisions. Corrective action will be completed 8/19//19 	tient's ent nee nsure eeing ths. e	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
						С	
		495232	B. WING _			07/	11/2019
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD		
KEMPSVII	LE HEALTH & REHAB (ENTER		•	VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 583	15 on the Brief Intervi (BIMS), indicating no addition, the MDS cor requiring extensive as personal hygiene, ext with bathing, toilet us- for Activities of Daily I condition was coded During a wound dress at approximately 10:5 Practical Nurse (LPN)	cew for Mental Status cognitive impairment. In ded Resident #21 as esistance of two with censive assistance of one e, dressing and bed mobility Living care. Section M-skin for pressure ulcer care. sing observation on 07/10/19 66 a.m., with Licensed	F S	583			
	in a private room. The remained open through change to Resident # Anyone walking outsi could view the wound performed on Reside approximately 2:50 p. conducted with LPN #	e resident's window blind ghout the entire dressing 21's left heel pressure ulcer. de of Resident #21's window I care dressing change nt #21. On the same day at .m., an interview was #6 who stated, "I should ow blinds to maintain privacy e dressing change to					
	Manager on East) on 2:55 p.m., who said to have been closed. So out then they can see privacy." On 07/11/19 at approinterview was conducted Nursing (DON) who should have been closes.	ducted with the LPN #5 (Unit 07/10/19 at approximately the window blinds should the stated, "If you can see in; that is a violation of their eximately 6:00 p.m., and sted with the Director of stated, "The window blinds sed to maintain dignity for this wound care dressing					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495232	B. WING			C 07/11/2019	
	ROVIDER OR SUPPLIER	CENTER		55	REET ADDRESS, CITY, STATE, ZIP CODE 20 INDIAN RIVER ROAD RGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3	(X5) COMPLETION DATE
F 604 SS=D	did not present any furindings. The facility's policy tit Facility Responsibilitic-Policy: It is the facility resident rights, and to to residents and their in a language that the Dignity, Respect & Courteat each resident with care for each resident with care for each resident environment that prorenhancement of his corecognizing each resident. Right to be Free from CFR(s): 483.10(e)(1). §483.10(e) Respect a The resident has a rigand dignity, including hysical or chemical purposes of discipline required to treat the riconsistent with §483. §483.12 The resident has the	rector of Nursing and Clinical Services was g during a briefing on ately 8:10 p.m. The facility arther information about the led Resident Rights and es (Revision date 11/16). ty's policy to abide by all communicate these rights designated representatives ey can understand. Ituality of Life. A facility must the respect and dignity and the in a manner and in an motes maintenance or or her quality of life, dent's individuality. The not promote the rights of the Physical Restraints (483.12(a)(2)) and Dignity. In the presentation of the error or convenience, and not esident's medical symptoms, 12(a)(2). In the promote of the free from any restraints imposed for a convenience, and not esident's medical symptoms, 12(a)(2).		583			
	neglect, misappropria	ition of resident property,					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				С
	495232	B. WNG		07/11/2019
NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB (CENTER	6	TREET ADDRESS, CITY, STATE, ZIP CODE 520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
includes but is not limited to purpose of discipline are not required to the symptoms. When the indicated, the facility alternative for the lead ocument ongoing restraints. This REQUIREMENT by: Based on observation interviews, clinical redocumentation reviewensure for 1 resident residents in the survery physical restraint. The facility staff failed #44 was free of phys The findings included Resident #44 was ad 05/15/2019. Diagnos limited to, Alzheimer' Unspecified Dementi Disturbance and Oste Minimum Data Set (as	efined in this subpart. This hited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. It that the resident is free nical restraints imposed for e or convenience and that eat the resident's medical use of restraints is must use the least restrictive st amount of time and evaluation of the need for is not met as evidenced ens, resident interview, staff cord review and facility the facility staff failed to (Resident #44) out of 36 by sample was free from to to ensure that Resident ical restraint. It is mitted to the facility on ses included but were not so Disease with Early Onset, a with Behavioral evarantitis. Resident #44's in assessment protocol) with rence Date of 05/24/2019	F 604	 Resident #44 mechanical lift s unfastened immediately on 7, CNA #44 was counseled on the restraints on 7/15.19. All residents in facility have the potential to be affected by this practice. A 100% audit of all rewas completed to identify any residents at risk for physical restraints. The Director of Nursing or deswill educate all staff on the used finition and identification of physical restraints. The Director of Nursing or deswill conduct random audits/rounds/observations to identify/ensure residents are from physical restraints. Theswill be conducted 5x weekly for months. The results of these awill be reported to the facility committee for discussion and necessary revision. Corrective action will be compa/19/19 	/11/19. e use of e use of is esidents y other signee se, if signee o free e audits or 3 audits y's QAPI

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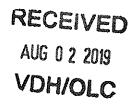
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		STRUCTION	(X3) DATE COMP	SURVEY LETED
		495232	B. WING			1	C 11/2019
	ROVIDER OR SUPPLIER	<u></u>		5520 II	T ADDRESS, CITY, STATE, ZIP CODE NDIAN RIVER ROAD NIA BEACH, VA 23464	1 011	11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 604	impaired cognitive sk In addition, the Minim Resident #44 as requ for bed mobility and the dependence of 1 for a personal hygiene and On 07/09/2019 at 1:2 observed sitting in his divided leg mechanic behind the resident in leg straps were under between his legs. The across in front of the leg strap was wrapped the back of the wheelextended across in front of the leg strap was wrapped the back of the wheelextended across in front on the leg strap handle on the back of the wheelextended across in front of the leg strap handle on the back of the wheelextended across in front of the leg strap handle on the back of the wheelextended across in front of the leg straps were under between his legs. The extended across in front on the leg strap right handle on the back of the wheelextended across in front of the leg strap right handle on the back of the wheelextended across in front of the leg strap right handle on the back of the wheelextended across in front of the leg strap right handle on the back of the wheelextended across in front of the leg strap right handle on the back of the wheelextended across in front of the leg strap right handle on the back of the wheelextended across in front of the wheelextended across in	oblems, and with severely ills for daily decision making. hum Data Set coded uiring total dependence of 2 ransfer, and total dressing, eating, toilet use, d bathing. 16 p.m., Resident #44 was swheelchair in his room. A hal lift sling was observed in his wheelchair and the sling reach leg and criss-crossed he left leg strap was extended resident and a loop on the hed around the right handle on lichair and the right leg strap ont of the resident and a was wrapped around the left of the wheelchair. 130 a.m., Resident #44 was swheelchair in his room. A hal lift sling was observed in his wheelchair and the sling reach leg and criss-crossed	F	504			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		407000	B MANG		С	
NAME OF PE	ROVIDER OR SUPPLIER	495232	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	07/11/2019	
	LE HEALTH & REHAB C	ENTER		5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 604	handle on the back of Surveyor asked CNA (RN) #2 to step into a room and CNA #4 was purpose of the criss-chooked onto the hand (Resident's name) who "To prevent him from wheelchair. His wife CNA #4 was asked, "about Resident #44 s "Yes, I told RN #2." Finot aware that the stastraps of the sling to tresident from sliding of #2 was asked, "What sling is hooked onto to keep (Resident's nahis wheelchair?" RN restraint." On 07/11/19 at 12:33 conducted with the Dithe observations were stated, "I will be doing DON was asked, "Wrstaff and restraining of stated, "I expect my st	the wheelchair. The #4 and Registered Nurse empty community area s asked, "What is the rossed leg strap being file on the back of seelchair?" CNA #4 stated, scooting, sliding down in his know's and she's ok with it." Have you told the nurse fliding?" CNA #4 stated, RN #2 stated that she was fif were looping the leg the wheelchair to prevent the down in the wheelchair. RN is this considered when the the handle of the wheelchair ame) from sliding down in #2 stated, "It is considered a p.m., an interview was frector of Nursing (DON) and the discussed. The DON that are your expectations of fif residents?" The DON staff not to restrain residents. It free."	F 60	04		
F 622	Transfer and Dischar	ge Requirements	F 6:	22		

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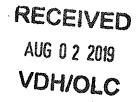
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED
		495232	B. WING		C 07/11/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	077172013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 622 SS=D	remain in the facility, discharge the resident (A) The transfer or discresident's welfare and cannot be met in the (B) The transfer or disbecause the resident's sufficiently so the resiservices provided by (C) The safety of indirendangered due to the status of the resident (D) The health of indirendangered due to the status of the resident (D) The health of indirendangered due to the status of the resident has appropriate notice, to under Medicare or Medicar	ind discharge- requirements- ermit each resident to and not transfer or at from the facility unless- scharge is necessary for the at the resident's needs facility; scharge is appropriate s health has improved ident no longer needs the the facility; viduals in the facility is e clinical or behavioral viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not paperwork for third party hird party, including l, denies the claim and the ay for his or her stay. For a s eligible for Medicaid after the facility may charge a le charges under Medicaid; s to operate. ot transfer or discharge the beal is pending, pursuant to	F 622	1. Residents #45 and #78 have re to the facility and have comprehensive care plans in pl 2. All residents that are transferre another facility have the poten be affected. 3. The Director of Nursing, or desi will educate the Licensed Nursi staff on the regulations regardi discharge/transfer notice requirements, including care pl 4. The Director of Nursing, or desi will audit all transfers and disch to the hospital or other facilitie months. These audits will be reto the facility's QAPI committee discussion and necessary revisions. Corrective action will be completed on 8/19/19	ace. ed to tial to ignee ng ans. gnee sarges s for 3 ported e for

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED C		
		495232	B. WNG		07	7/11/2019
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 622	discharge or transfer or safety of the reside facility. The facility methat failure to transfer §483.15(c)(2) Docum When the facility transesident under any of in paragraphs (c)(1)(is section, the facility mor discharge is docum medical record and a communicated to the institution or provider (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of par section, the specific met, facility attemneds, and the service facility to meet the net (ii) The documentation (2)(i) of this section in (A) The resident's phedischarge is necessar (A) or (B) of this section in (C) in formation provice must include a minim (A) Contact information responsible for the case of the case	would endanger the health ent or other individuals in the nust document the danger or discharge would pose. Identation. Internation. Intern	F 62	22		

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		495232	B. WING		۸ ا	C 7/11/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		77172013	
(X4) ID PREFIX TAG			ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 622	ongoing care, as app. (E) Comprehensive c (F) All other necessa copy of the resident's consistent with §483. any other documenta a safe and effective tr This REQUIREMENT by: Based on staff interv reviews the facility sta comprehensive care (Resident #45, Resid in the survey sample hospital. 1. The facility staff fa care plan goals for Re discharged to the hos 2. For Resident #78, evidence that the con were sent with the res hospital on 9/1/18. The findings included 1. Resident #45 was on 05/17/2019 and re 05/21/2019. Diagnos limited to, Non Traum Hemorrhage, unspec Resident #45's Minim assessment protocol) Reference Date of 05 BIMS (Brief Interview 15 indicating no cogn	tions or precautions for ropriate. are plan goals; any information, including a discharge summary, 21(c)(2) as applicable, and tion, as applicable, to ensure ransition of care. Tis not met as evidenced iews and clinical record aff failed to send plan goals for 2 residents when discharged to the spital on 05/17/19. Ifacility staff failed to esident #45 when spital on 05/17/19. Ifacility staff failed to enprehensive care plan goals sident upon transfer to the seident upon transfer to the discharged to the hospital eadmitted to the facility on the seincluded but were not eatic Intracranial ified and Hypertension. Inum Data Set (an existence with a second with a for Mental Status) score of	F	622			

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		495232	B. WING		C 07/11/2019
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	, 0/////2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 622	622 Continued From page 10		F 622		
F 022	#45 as requiring exte bed mobility and trans 1 with dressing, toilet and physical help in passistance of 1. On 07/10/2019 docur evidencing Resident plan goals were sent discharged to the host conducted with the D Director of Nursing we evidence that the conwere sent to the hosp discharged. The Director of Nurses usually send care plan goals with the discharged to the hosp had went out for an aup going directly to the weren't thinking. We	nsive assistance of 2 with sfer, extensive assistance of use and personal hygiene part of bathing with mentation was requested #45's comprehensive care when the resident was spital. O p.m., an interview was irector of Nursing. The as unable to provide an unable to provide an unable to provide an unable to provide and the residents when they are spital but since the resident pointment and then ended the hospital I guess we know now and will send the	F 622		
	to the hospital going				
	pre-exit meeting the A Nursing and the Regi Services were inform facility did not presen about the findings. 2. For Resident #78, evidence that the con	proximately 8:10 p.m., at the Administrator, Director of onal Director of Clinical ed of the findings. The tany further information facility staff failed to apprehensive care plan goals sident upon transfer to the			
		mitted to the facility on d on 6/20/19 with diagnoses			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	IPLE CONSTRUCTION		E SURVEY PLETED	
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		495232	B. WNG_		07	//11/2019	
	ROVIDER OR SUPPLIER LLE HEALTH & REHAB (CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	weakness, anemia, heart failure. Residen (minimum data set) a change assessment or reference date) of 6/2 coded as being intact 15 out of possible 15 for Mental Status) exceeded as being intact 15 out of possible 15 for Mental Status) exceeded as being intact 15 out of possible 15 for Mental Status) exceeded as the set of Resident # that she had been traffractured leg on 9/1/1 note was written: "Reresults back shows a cannot exclude a fiburial to see if we can storom) for brace and see Both on call and DON aware of x-ray results. The next note dated following: "Resident standard will send out to Ereport. Will let on common to include the serior of the hospital conducted with LPN (#2, Resident #78's not documents were sent transfer to the hospital transfer transfer to the hospital transfer transfer transfer transfer transfer transfer t	e not limited to muscle igh blood pressure, and it #78's most recent MDS ssessment was a significant with an ARD (assessment it8/19. Resident #78 was in cognitive function scoring on the BIMS (Brief Interview am. 78's clinical record revealed insferred to the hospital for a instead and a ray done and cute tibial fracture and la fracture (sic). waiting on itend out to ER (emergency stronger pain medication. If (Director of Nursing) made is." 9/1/18 documented the iten called and updated that showed FX (fractured) tibia if Hospital (sic) also called ining shift know sent out." ce that all the required ude the comprehensive sent with the resident upon al. m., an interview was (Licensed Practical Nurse) urse. When asked what it with Residents upon al, LPN #2 stated that she situation, background,	F6				

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Facility ID: VA0179

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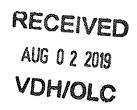
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED		TIPLE CONSTRUCTION NG	K	(X3) DATE SURVEY COMPLETED	
		495232	B, WING			С	
NAME OF P	ROVIDER OR SUPPLIER	455232	D. Valle	STREET ADDRESS, CITY, STATE, ZIP COL	<u> </u> DE	07/11/2019	
KEMPSVII	LLE HEALTH & REHAB (ENTER		5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIAT	(X5) COMPLETION DATE	
F 622	Transfer Interact Form orders, bed hold policiasked if she documer with the resident upor the clinical record, LP document. LPN #2 state off list that alerts their send. When asked withis list, LPN #2 state could not recall if she care plan goals to the recall that far back. On 7/11/19 at approximate interview was conducted manager. When asked sent with Residents under the fact of the sent with recall that cate being sent after the fact when asked if she couplan goals were sent 9/1/18 transfer to the	n, all current physician ry, and the care plan. When hits what items were sent in transfer to the hospital in N #2 stated that she will hated that she has a check hourse what documents to hen the staff starting using d, "It's been awhile." LPN #2 had sent Resident #78's hospital. LPN #2 could not	F	622			
F 623 SS=D	member (ASM) #1, the the DON (Director of of the above concerns Notice Requirements CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice Before a facility transpendent, the facility m (i) Notify the resident representative(s) of the solution of the the property of the the property of the propert	Before Transfer/Discharge (6)(8) before transfer. fers or discharges a nust-	F	623			

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Event ID: 35T111

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	4	(XS) DAT	<u>O. 0938-039</u> E 6URVEY PLETED
		496232	B. WING				C
1	PROVIDER OR SUPPLIER VILLE HEALTH & REHAB (ENTER		STREET ADDRESS, CITY, STA 6520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23		07	/11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT (IF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S I (EACH CORRECTED CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	E	COMPLETION . (X5)
~	language and manner facility must send a co representative of the C Long-Term Care Ombit (ii) Record the reasons discharge in the reside accordance with paragand (iii) Include in the notice paragraph (c)(5) of this \$483.15(c)(4) Timing of (i) Except as specified if (c)(8) of this section, the discharge required und made by the facility at least the f	they understand. The py of the notice to a office of the State udsman. It is for the transfer or unt's medical record in traph (c)(2) of this section; where the items described in a section. If the notice, in paragraphs (c)(4)(ii) and we notice of transfer or er this section must be east 30 days before the or discharged, when as soon as practicable arge when leads in the facility would aragraph (c)(1)(i)(C) of uals in the facility would aragraph (c)(1)(i)(D) of the improves sufficiently to transfer or discharge, (b)(B) of this section; or or discharge is a urgent medical needs, (c)(A) of this section; or sided in the facility for 30 of the notice. The written raph (c)(3) of this section g:	F 623	1. The State Omboof resident #83 7/10/19. The State Of resident #83 7/10/19. The State Of residents that the facility have affected. 3. The Administrate Director of Social Worker of regarding discharge quirements, in Ombudsman no 1/16 Director of Social Worker of requirements, in Ombudsman no 1/16 Director of Social Worker of Social Worker of Social Worker of requirements, in Ombudsman no 1/16 Director of Social Worker of Soc	i's discharge on tate Ombudsman dent #45's discharged for the potential to the tor will educate the al Services and the on the regulations arge and transfer including the State estification. Social Services will ges for 3 months the sare being reported to the facility or discussion and	was ge from be ee	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495232	B. WING_			C 07/11/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	········	0771112015	
(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 X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 623	(ii) The effective date (iii) The location to what transferred or discharative) A statement of the including the name, a and telephone number receives such request to obtain an appeal for completing the form a hearing request; (v) The name, address telephone number of Long-Term Care Ombour (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and addevelopmental disability of the Developmental disability of the Developmental disability. (vii) For nursing facility disorder or related disemail address and telephone number of the protection and addevelopmental disability. (viii) For nursing facility disorder or related disemail address and telephone number of the agency responsible for advocacy of individual established under the for Mentally III Individual §483.15(c)(6) Change If the information in the effecting the transfer of must update the reciping as practicable once the becomes available.	of transfer or discharge; nich the resident is ged; oresident's appeal rights, ddress (mailing and email), or of the entity which its; and information on how orm and assistance in and submitting the appeal is (mailing and email) and the Office of the State budsman; or residents with intellectual sabilities or related grand email address and the agency responsible for evocacy of individuals with ities established under Part ital Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and gresidents with a mental eabilities, the mailing and ephone number of the or the protection and lis with a mental disorder Protection and Advocacy unals Act.	F	623			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495232	B. WING		C 07/11/2019	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	011112013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLÉTION	
F 623	the administrator of the written notification pricto the State Survey Adstate Long-Term Care the facility, and the rewell as the plan for the relocation of the resident 483.70(l). This REQUIREMENT by: Based on resident reand facility document notify the Office of the Ombudsman in writing 2 of 36 residents (Ressurvey sample. 1. The facility staff fail State Long-Term Care #83 discharge to the left of the condition of the condi	closure, the individual who is the facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at § is not met as evidenced cord review, staff interviews review, the facility failed to e State Long-Term Care g of hospital discharges for sident #83 and #45) in the led to notify the Office of the e Ombudsman of Resident hospital on 05/06/19. led to notify the Office of the e Ombudsman of Resident e hospital on 05/17/2019. cadmitted to the facility on for Resident #83 included ebral Infarction. Ing to the facility's lent #83 complained of #83 was transported to the cy Medical Services (EMS).	F 62:	3		

CENTERS FOR MEDICARE & MEDICAID SERVICES

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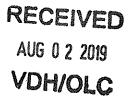
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			7. DOLDING		С	
		495232	B. WING		07/11/	2019
	ROVIDER OR SUPPLIER LLE HEALTH & REHAB C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	discharged to the hos same day at approxim Director of Social Services that was faxed to 07/10/19 at approximation included Resident #83 on 05/06/19 but only a surveyor. An interview was cond Social Services on 07 12:30 p.m. She said I when I notified the om 06/03/19 with all of the for May 2019. The Administrator, Dir Regional Director of Coinformed of the finding 07/11/19 at approximation did not present any fur findings. The facility's policy title Letter Policy). Procedure included by Social Services or de original discharge/tran resident or guardian/s -Copies will be sent to Ombudsman Office an and/or scanned into P	al was reviewed on ately 10:25 a.m. The slude Resident #83 who was pital on 05/06/19. On the nately 1:53 p.m., the vices presented another to the Ombudsman on ately 1:36 p.m., which is discharge to the hospital after requested from the ducted with the Director of //11/19 at approximately Resident #83 was missed abudsman via fax on a discharges to the hospital elector of Nursing and clinical Services was a during a briefing on ately 8:10 p.m. The facility rither information about the ed (Discharge/Transfer at not limited to: signee will assure the asfer letter is given to the	F 62:	3		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495232	B. WING				C
NAME OF D	ROVIDER OR SUPPLIER	470232	D. 771170_	~	TREET ADDRESS CITY STATE 7/D CODE	<u> 07/</u>	11/2019
NAME OF F	NOVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 520 INDIAN RIVER ROAD		
KEMPSVII	KEMPSVILLE HEALTH & REHAB CENTER				IRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	N SHOULD BE EAPPROPRIATE	
F 623	-For emergency trans the Ombudsman at the 2. Resident #45 was on 05/17/2019 and re 05/21/2019. Diagnos limited to, Non Traum Hemorrhage, unspecification of 07/10/2019 docume vidence that the Om the resident was disclosed on 07/10/2019 at 4:00 conducted with the Distated, "The Social Wombudsman of reside each month, however the Ombudsman of R The Ombudsman was On 07/11/2019 at app pre-exit meeting the A Nursing and the Registeristics were informed facility did not present about the findings.	fers, one list can be sent to be end of the month. discharged to the hospital admitted to the facility on es included but were not atic Intracranial fied and Hypertension. Inentation was requested to budsman was notified when harged to the hospital. Dip.m., an interview was rector of Nursing and she forker usually notifies the ent discharges at the first of the sident #45's discharge.		623	DEFICIENCY)		
	CFR(s): 483.15(d)(1)(
	nursing facility transfe the resident goes on t	rovide written information to					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
					С	
		495232	B. WNG		07/11/2019	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 520 INDIAN RIVER ROAD /IRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 625	any, during which the return and resume refacility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facilit bed-hold periods, whi paragraph (e)(1) of the resident to return; and (iv) The information sof this section. §483.15(d)(2) Bed-hour the time of transfer of the hospitalization or their facility must provide to resident representative specifies the duration described in paragrap This REQUIREMENT by: Based on staff intervitation and clinical redetermined that facility written bed hold notificing the survey sample, 1. For Resident #78, for the Resident and/or Revitten bed hold notification of the survey sample, 2. For Resident #45 to provide the Resident #45 to provide the Resident and plants.	e state bed-hold policy, if resident is permitted to sidence in the nursing ayment policy in the state of this chapter, if any; y's policies regarding ch must be consistent with is section, permitting a dipecified in paragraph (e)(1) and notice upon transfer. At a resident for apeutic leave, a nursing the resident and the rewritten notice which of the bed-hold policy of (d)(1) of this section. Is not met as evidenced ew, facility document cord review, it was y staff failed to provide cation for 2 of 36 residents Residents #78 and #45. Facility staff failed to provide desident Representative a cation upon transfer to the cand/or Resident ten bed hold notice when	F 625	 Residents #78 and #45 have retited to the facility. All residents that are transferred discharged from the facility have potential to be affected. The Director of Nursing or design will educate the Licensed Nursing staff on the regulations regarding discharge and transfer notice requirements, including the facilities had hold policy. The Director of Nursing or design will audit all transfers and disched to the hospital or other facilities months to ensure compliance with the regulation. These audits will reported to the facility's QAPI committee for discussion and necessary revision. Corrective action will be completed #19/19 	d or e the sinee ng sility sinee arges sith silith	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMPED		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						С	
		495232	B. WING _		0'	7/11/2019	
	ROVIDER OR SUPPLIER	CENTER	•	STREET ADDRESS, CITY, STATE, ZIF 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
F 625	Continued From page	ə 19	F6	325			
	6/2/17 and readmitted that included but were weakness, anemia, heart failure. Resider (minimum data set) a change assessment of reference date) of 6/2 coded as being intact 15 out of possible 15 for Mental Status) extractured leg on 9/1/1 note was written: "Referesults back shows a cannot exclude a fiburcall to see if we can stroom) for brace and street weakness.	178's clinical record revealed insferred to the hospital for a 8. The following nursing esident had x-ray done and cute tibial fracture and alla fracture (sic), waiting on send out to ER (emergency stronger pain medication.					
	The next note dated of following: "Resident of X-ray came back and and will send out to E report. Will let on continuous transfer to the hospital of 7/11/19 at 3:16 p. conducted with LPN of #2, Resident #78's nu documents were sent followed.	9/1/18 documented the son called and updated that I showed FX (fractured) tibia IR Hospital (sic) also called ning shift know sent out." ce that written bed hold with the resident upon al.					

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED	
		495232	B. WING_			C 7/11/2019	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		, 0,74,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 625	will send the SBAR (sassessment, and reconsiders, bed hold policy asked if she document with the resident upon the clinical record, LF document. LPN #2 stoff list that alerts the send. When asked withis list, LPN #2 state could not recall if she to the hospital on 9/1. On 7/11/19 at approximaterview was conduct manager. When asked sent with Residents of LPN #5 stated that the being sent after the fawhen asked if she could policy was sent sent with residents of hold policy was sent sent with far back. On 7/11/19 at 5:05 p. member (ASM) #1, the DON (Director of of the above concerns of the above concerns of the sent sent with the policy was sent sent with far back. On 7/11/19 at 5:05 p. member (ASM) #1, the policy that far back. On 7/11/19 at 5:05 p. member (ASM) #1, the policy was sent sent with far back. On 7/11/19 at sent sent sent sent sent with far back. On 7/11/19 at sent sent sent sent sent sent sent sen	situation, background, ommendation) form, m, all current physician by, and the care plan. When ants what items were sent in transfer to the hospital in the state of the staff starting using d, "It's been awhile." LPN #2 inhad sent Resident #78's out with LPN #5, the unit in the dwhat documents were upon transfer to the hospital, in the bed hold policy was now accility changed their policy. Bould find evidence that bed with Resident #78 for her hospital, LPN #5 stated that its not sending the bed hold in the staff in the administrator, ASM #2, Nursing) were made aware selected but were not not catic Intracranial iffied and Hypertension.	F 6	25			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495232	B. WNG		1	C /11/2019
			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	1 07	711/2019
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE	
BIMS (Brief Interview 15 indicating no cogn addition, the Minimum #45 as requiring external bed mobility and trans 1 with dressing, toilet and physical help in processistance of 1. On 07/10/2019 docume vidence that the written sent when the resider hospital. On 07/10/2019 at 4:00 conducted with the Didirector of Nursing we evidence that the written sent to the hospital with discharged. The Director of Nurses usually send to Care Plan goals with discharged to the hospital with discharged to the hospital going directly to the hospital going forward on 07/11/2019 at appre-exit meeting the A Nursing and the Regions Services were informed facility did not present about the findings.	for Mental Status) score of itive impairment. In Data Set coded Resident nsive assistance of 2 with sfer, extensive assistance of use and personal hygiene part of bathing with the mentation was requested to ten Bed Hold Notice was not was discharged to the set unable to provide ten Bed Hold Notice was then Resident #45 was cotor of Nursing stated, "The the Bed Hold Notice and the residents when they are pital but since the resident popintment and ended up ospital I guess we weren't ow and will send the Care in Bed hold Notice to the d." Proximately 8:10 p.m., at the administrator, Director of conal Director of Clinical end of the findings. The tany further information				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR IS Continued From page BIMS (Brief Interview 15 indicating no cogn addition, the Minimum #45 as requiring exter bed mobility and trans 1 with dressing, toilet and physical help in p assistance of 1. On 07/10/2019 docum evidence that the writt sent when the resider hospital. On 07/10/2019 at 4:00 conducted with the Di Director of Nursing wa evidence that the writt sent to the hospital will discharged. The Dire Nurses usually send to Care Plan goals with discharged to the hos had went out for an a going directly to the h thinking. We know no Plan goals and writter hospital going forward On 07/11/2019 at app pre-exit meeting the A Nursing and the Regio Services were informed facility did not present about the findings. Develop/Implement C	ROVIDER OR SUPPLIER LE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #45 as requiring extensive assistance of 2 with bed mobility and transfer, extensive assistance of 1 with dressing, toilet use and personal hygiene and physical help in part of bathing with assistance of 1. On 07/10/2019 documentation was requested to evidence that the written Bed Hold Notice was sent when the resident was discharged to the hospital. On 07/10/2019 at 4:00 p.m., an interview was conducted with the Director of Nursing. The Director of Nursing was unable to provide evidence that the written Bed Hold Notice was sent to the hospital when Resident #45 was discharged. The Director of Nursing stated, "The Nurses usually send the Bed Hold Notice and Care Plan goals with the residents when they are discharged to the hospital but since the resident had went out for an appointment and ended up going directly to the hospital but since the resident had went out for an appointment and ended up going directly to the hospital I guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital going forward." On 07/11/2019 at approximately 8:10 p.m., at the pre-exit meeting the Administrator, Director of Nursing and the Regional Director of Clinical Services were informed of the findings. The facility did not present any further information about the findings. Develop/Implement Comprehensive Care Plan	A BUILDING 495232 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 BIMS (Brief Interview for Mental Status) score of 15 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #45 as requiring extensive assistance of 2 with bed mobility and transfer, extensive assistance of 1 with dressing, toilet use and personal hygiene and physical help in part of bathing with assistance of 1. On 07/10/2019 documentation was requested to evidence that the written Bed Hold Notice was sent when the resident was discharged to the hospital. On 07/10/2019 at 4:00 p.m., an interview was conducted with the Director of Nursing. The Director of Nursing was unable to provide evidence that the written Bed Hold Notice was sent to the hospital when Resident #45 was discharged. The Director of Nursing stated, "The Nurses usually send the Bed Hold Notice and Care Plan goals with the residents when they are discharged to the hospital but since the resident had went out for an appointment and ended up going directly to the hospital I guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital going forward." On 07/11/2019 at approximately 8:10 p.m., at the pre-exit meeting the Administrator, Director of Nursing and the Regional Director of Clinical Services were informed of the findings. The facility did not present any further information about the findings. Develop/Implement Comprehensive Care Plan	ROUNDER OR SUPPLIER LE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 21 BIMS (Brief Interview for Mental Status) score of 13 indicating no cognitive impairment. In addition, the Minimum Data Set coded Resident #45 as requiring extensive assistance of 2 with bed mobility and transfer, extensive assistance of 1 with dressing, toilet use and personal hygiene and physical help in part of bathing with assistance of 1. On 07/10/2019 documentation was requested to evidence that the written Bed Hold Notice was sent when the resident was discharged to the hospital when Resident #45 as requiring extensive assistance of 2 with bed with the Director of Nursing stated, "The Director of Nursing stated," The Nurses usually send the Bed Hold Notice was sent to the hospital but since the resident had went out for an appointment and ended up going directly to the hospital I guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital guess we weren't thinking. We know now and will send the Care Plan goals and written Bed hold Notice to the hospital serv	A BULDING 495232 B. WING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE \$520 INDIAN RIVER ROAD VIRGINA BEACH, VA 23464 SUMMARY STATEMENT OF DEPUBLICIES SUMMARY STATEMENT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED	
		495232	B. WING		C 07/11/2019	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	0771112013	
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F 656	§483.21(b) Comprehe §483.21(b)(1) The faci implement a comprehe care plan for each restresident rights set for §483.10(c)(3), that in objectives and timefrom medical, nursing, and needs that are identificassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, includit reatment under §483.3 (iii) Any specialized so rehabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the reside (iv) In consultation with resident's representat (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Faci whether the resident's community was assess local contact agencies entities, for this purpo (C) Discharge plans in	ensive Care Plans cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's I mental and psychosocial ied in the comprehensive hensive care plan must I - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 1.10(c)(6). ervices or specialized I the nursing facility will PASARR a facility disagrees with the RR, it must indicate its nt's medical record. In the resident and the sive(s)- als for admission and ference and potential for littles must document is desire to return to the esed and any referrals to es and/or other appropriate	F 656	 Resident #6 has been dischafrom the facility All residents using fall mats facility have the potential to affected The Director of Nursing or designee will educate the mistaff on the implementation care plan interventions, specifically related to the usifall mats with residents and placement. The Director of Nursing or designee will conduct random audits/observations of resid with fall mats and the place of fall mats in resident room. These audits will be conducted to the same audits will be reported the facility's QAPI committee for discussion and necessary revision. Corrective action will be complete on 8/19/19 	in the o be ursing of of there oment on s. ted	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD /IRGINIA BEACH, VA 23464			
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F 656	section. This REQUIREMENT by: Based on observation document review and was determined that frimplement the compression of 36 residents in the #6. For Resident #6, facil her plan of care and explace to prevent injury. The findings include: Resident #6 was adm 6/1/2015 with diagnos not limited to Chronic high blood pressure, thypothyroidism and B #6's most recent MDS assessment was a sign assessment was a sign assessment with an Adate) of 4/22/19. Resicognitive impairment; assistance from one spersonal hygiene and assist with two plus standing including and transfers. Review of Resident #6 (Physician Order Sum following orders: "Fall	in paragraph (c) of this is not met as evidenced in, staff interview, facility clinical record review, it facility staff failed to chensive care plan for one survey sample, Resident ity staff failed to implement chasure a fall mat was in from falls. itted to the facility on test that included but were Kidney Disease Stage 3, type two diabetes, ipolar disorder. Resident is (Minimum Data Set) prificant change RD (assessment reference dent #6 was coded with no requiring extensive that member with toileting, dressing; and extensive aff members with bed is current July 2019 POS		656			

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Review of Resident #6's comprehensive care

Event ID; 35T111

Facility ID: VA0179

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 656	the following for her fis at risk for injury, modeconditioning, psychincontinence, bowel i problem related r/t (re (right) ankle fracture. #6) will have no fall re review. Interventions: (Date Initiated: 5/31/2 On 7/9/19 at 12:44 p. made of Resident #6. back. A fall mat was is side of her bed. At this asked this writer to ge readjusted in bed. On 7/9/19 at 1:49 p.m of Resident #6. She was ide. A fall mat was in the side of the bed. On 7/10/19 at 8:15 a. observed to be on the the resident was in bed bed table in front of his table was to the right was folded up at the On 7/10/19 at 9:57 a. Assistant) #1, (Reside breakfast tray and was room. Resident #6's coff to the right of Resident #6's coff to the right	d revised 5/3/19 documented falls: "(Name of Resident #6) ultiple risk factors related to noactive drug use, bladder nocontinence, functional elated to) hx (history) R Goal: (Name of Resident elated injuries through next: "Fall matt (sic) to bedside. 2019)" m., an observation was. She was lying in bed on her not observed down on the is time Resident #6 had et the nurse so she could be had et the nurse so she could be had et the nurse to be down on the is time Resident #6 had et the nurse so she could be had et the nurse s	F 65	56			

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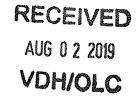
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464			
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F 656	Continued From pag On 7/10/19 at 10:10 Resident #6 was obsher fall mat in place. On 7/10/19 at 10:40 Practical Nurse) #2, observed entering Remedication. LPN #2 This surveyor made that Resident #6's blefloor to her right side On 7/10/19 at 10:47 conducted with LPN just put Resident #6's floor, LPN #2 confirm asked if it had been amorning, LPN #2 state the floor and that the they deliver Residen stated that the over the fall mat and the When asked if staff's back down once Resmeals, LPN #2 state asked if Resident #6 stated that Resident but that she had not LPN #2 stated the means the material stated that the sident with that she had not LPN #2 stated the means contains the material stated that Resident with that she had not LPN #2 stated the means contains the material stated that Resident with that she had not LPN #2 stated the means contains the material stated that Resident with that she had not LPN #2 stated the means contains the material stated that Resident with the material stated the means contains the material stated that Resident with the material stated the means contains the material stated the material stated the means contains the material stated the means contains the material stated the material stated the material stated the means contains the material stated the materia	e 25 a.m. and 10:25 a.m., served lying in bed without a.m., LPN (Licensed Resident #6's nurse, was esident #6's room with her exited her room shortly after. an observation at 10:45 a.m., ue fall mat was now on the					
	conducted with CNA #1 confirmed that sh #6 on 7/10/19 and th been the aide that re	a.m., an interview was #1, Resident #6's aide. CNA e was assigned to Resident at she had probably had moved her breakfast tray. cess (what staff should do), if					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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F 656	room and the resider that she would put the ground. CNA #1 was made on 7/10/19. CN should have put the Resident #6 had com asked how CNAs kneeds in place such CNA #1 stated that source or she can look each resident. Review of Resident #1 revealed that it did not care plan, LPN was used to guide not for a patient. When a the care plan to be a was. When asked if the care plan to be a was. When asked if the care plan to be followed. When asked if the care plan to be for Resident #6 when while she was in bed not being followed. On 7/11/19 at 5:05 p. member (ASM) #1, to the DON (Director of of the above concern Facility policy titled, "part, the following: "A always know, unders Resident's Care Plant Resident Re	at is folded up in a resident's at is in bed, CNA #1 stated e fall mat back on the told about the observations NA #1 confirmed that she fall mat back down once apleted her meal. When ow what things each resident as fall mats, devices etc. The will get report from the k at a nursing Kardex for the will get report from the k at a nursing Kardex for the will get report from the k at a nursing Kardex for the will get report from the k at a nursing Kardex for the will get report from the k at a nursing Kardex for the will get report from the was the purpose of the will get report from the care plan was on how to properly care sked if it was important for ccurate, LPN #2 stated that it was important for the care LPN #2 stated that it was the plan was being followed in her fall mat was folded up the LPN #2 stated that it was the fall mat was folded up t	F	56		

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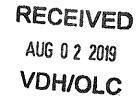
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		•	(X3) DATE SURVEY COMPLETED	
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F 657 SS=D	the Care Plan change Care Plan Timing and CFR(s): 483.21(b)(2)(2) §483.21(b)(2) A compbe- (i) Developed within 7 the comprehensive as (ii) Prepared by an intincludes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the react the resident and the react the resident for the pand their resident reprinct practicable for the resident's care plan. (F) Other appropriate disciplines as determined as requested by the (iii) Reviewed and revisteam after each assess comprehensive and quassessments. This REQUIREMENT by: Based on resident inticlinical record reviews	his can be documented or ad if necessary." Revision (i)-(iii) ensive Care Plans brehensive care plan must adays after completion of assessment. erdisciplinary team, that ited to—sician. e with responsibility for the and nutrition services staff. ticable, the participation of asident's representative(s). The included in a resident's participation of the resentative is determined development of the staff or professionals in med by the resident's needs a resident. Sed by the interdisciplinary assment, including both the uarterly review is not met as evidenced erview, staff interviews, and facility documentation is failed to invite 1 of 36		656	 Resident #54 will be invited to next scheduled care plan meet? All residents that have care plan scheduled in the facility have the potential to be affected by this practice. The Administrator or designed educate the Director of Social Services and the Social Worker presenting and documenting resident's invitation to care plan meetings. A copy of all resident invitations to care plan meeting be kept in the Social Services department. The Director of Social Services designee will perform an audit care plan invitations to ensure the resident have received the proposition of their care plan meeting. These audits will be reported to the facility's QAPI committee for discussion and necessary revision. Corrective action will be completed 19/19 	ing. n ne will on ss will or of all the	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	<u></u>		5520	EET ADDRESS, CITY, STATE, ZIP CODE INDIAN RIVER ROAD SINIA BEACH, VA 23464		07/11/2019
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F 657	The findings included Resident #54 was act 11/11/16. Diagnoses but not limited to, Dia Obstructive Pulmona The current Minimum assessment with an A (ARD) of 06/14/19, cout of a possible scounterview for Mental acognitive impairment During the initial tour approximately 1:09 pronducted with Residual to the inguitation and it is receive a let meeting." An interview was corn Worker (SW) on 07/1 a.m. The SW review invitation book. After invitation book the St locate the original invitation book or record." He stated "usually get the reside form, down load it in	e plan meeting (Resident imple. d: d: d: d: d: d: d: d: d: d	F	557			
	asked, "When was the attended his care plated "I am only able to loc	n meeting?" The SW stated, ate care plan invitations for 19." The SW presented a					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 657	Continued From page		F 65	57		
	plan meeting on 05/10 stated, "I am unable to	cheduled to have a care 6/19 at 11:15 a.m. The SW o provide evidence that the or that he attended the care				
		Clinical Services was				
	April 6, 2017). Policy: An interdiscip established for every accordance with state requirements and on states where pre-adm this will be coordinate	led Care Plan (Revision: linary plan of care will be resident and updated in and federal regulatory an as needed basis. In hission screening applies, d with the facility must be measurable and				
	Procedure include bu	t not limited to:				
F 658 SS=D	to each resident who an invitation to attend requested participation the resident at least find conference. A designer to each residen maintained for reference.	eet Professional Standards	F 65	58		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		SURVEY PLETED
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F 658	as outlined by the cormust- (i) Meet professional at This REQUIREMENT by: Based on resident in clinical record review review the facility staff professional standard #1) in the survey same. The facility staff failed ongoing assessment Resident #1 who attended three days per week of Friday; And, the facility weights on Resident #1 care plan and physicist The findings included Resident #1 was origin on 04/19/17. Diagnosto, End Stage Renal I irreversible kidney fail receiving hemodialysis week every Monday, an outpatient dialysis. The current Minimum assessment with an Assessment with a Assessment with a Assessment with a Assessment with a Assessment wit	ehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. T is not met as evidenced terview, staff interviews, and facility documentation of failed to maintain lis for 1 resident (Resident uple of 36 residents. I to communicate an with the dialysis center for inded outpatient dialysis on Monday, Wednesday and ty staff failed to obtain of 1 per the comprehensive an's order. I mally admitted to the facility ses included, but not limited Disease (ESRD) (Chronic lure). The resident was to treatments three times a Wednesday and Friday at center. Data Set (MDS) a Quarterly assessment Reference Date ded the resident with a 13	F 69		gnee gnees of the second as a second sec	
	Interview for Mental S cognitive impairment.	tatus (BIMS), indicating no In addition, under section nents, Procedures and		and document that information the resident's medical record.		

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F 658	Resident #1's Care P protocol and as need and universal precaut Resident #1's physici following orders: (1) E Wednesday and Frida from the dialysis site as needed. (3) Monito symptoms of infection weights upon return filbs is noted one time Wednesday and Frida assessment in the ev Wednesday and Frida A review of Resident of May showed the follow 105/14/19 resident wei 05/14/19 resident wei 05/16/19 resident wei 05/20/19 resident wei No other weighs were June. A review of Resident: June showed the follow 06/19/19 resident wei No other weighs were June. A review of Resident: July showed the follow 07/05/19 resident wei 07/10/19 resident wei No other weights were No other weights were No other weights were No other weights were An interview was considered.	and the was coded for dialysis. Ilan included: weigh per ed. Use aseptic technique tions. In orders contained the Dialysis on Monday, ay. (2) If bleeding occurs apply pressure and call 911 or Dialysis port for signs and a for every shift. (4) Obtain from dialysis. Notify MD if 3+ a day every Monday, ay. (5) Dialysis return ening every Monday, ay. #1's weights for the Month Ilowing: ghed 106 lbs. ghed 103.4 lbs. ghed 105.5. ghed 108.2 lbs. #1's weight for the Month of wing: ghed 106.4 lbs. a recorded for the month of wing: ghed 105 lbs, ghed 105 lbs, ghed 105 lbs, ghed 105 lbs, ghed 105.5 lbs.	F 658	5.	will audit the dialysis communication book for each resident for appropriate concorrespondence 3x a week for months. Additionally, the Dir Nursing or designee will audialysis patient's weight upofrom dialysis 3x a week for 3 months. The results of these will be reported to the facility committee for discussion and necessary revision.	thent and or 3 rector of it each n return audits y's QAPI	

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	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		172010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	could view Resident # Book. LPN #1 stated permission from the re her communication becommunication sheet receiving dialysis at (I Monday, Wednesday There were no commodity of the very received that resident is of Monday because s residents. She had to Resident told nurse si sheet in the transports asked what should ha "They should have ca received the notes." An interview was cone (Licensed Practical Ni Wing) on 07/11/19 at stated that the resident sometimes. LPN #5 we been done. She said returns after dialysis t document resident's v returns to the facility to PM. and if she refuses (Power of Attorney/recalled. On 07/11/19 at approx was held with the Adm Nursing, the Regional Services. The administrations.	m. She was asked if she f1's Dialysis Communication that she would have to get esident because she has pok with her at all times. The listed that resident was Name) Dialysis Center on and Fridays at 11:00 AM. unication notes from munication notes in the 7/19-06/10/19. LPN #5 attending a new facility as the was disruptive to other change dialysis centers. The left the communication ation van. LPN #5 was the been done. She said liled the dialysis place and diucted with LPN #5 urse) Unit Manager (East approximately 5:20 PM. She are will refuse to be weighed that when the resident he 3-11 (PM) shift should weight because she usually between 4:30 PM and 5:00 as to be weighed her POA sponsible party) should be kimately, 3:14 PM a briefing ministrator, Director of	F6	558		

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Event ID: 35T111

Facility ID: VA0179

If continuation sheet Page 33 of 70



CENTERS FOR MEDICARE & MEDICAID SERVICES

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	COMP	LETED
			1			(c
		495232	B. WNG				11/2019
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
VF34bova		n, and a, p and law.		5	520 INDIAN RIVER ROAD		
VEWISAN	LLE HEALTH & REHAB (JENIEK		١	/IRGINIA BEACH, VA 23464		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
17.0					DEFICIENCY)		
		1 1 1 11 11 11 11 11 11 11 11 11 11 11					
F 658	Continued From page	33	F (658			
	0= 07/44/40 =4 =====						
	On 07/11/19 at approx interview was conduc	•					
	I	ning her weights when she					
		Resident was asked if she					
		eighed when she comes					
		ne stated "No," "That's a lie."					
	She was also asked it						
		to keep for her when she					
	returns from dialysis.	She stated "No." "because					
	they lost it one time."	"I keep it myself."					
	On 07/11/19 at approx	ximately 7:35 PM the					
		rsing Assistants (CNAs)					
		cerning weighing resident					
	when she returns fron	n dialysis.					
		resident #1 is assigned to					
		urns from dialysis and does					
		eights. She stated "No."					
		nally work the 11 (PM)-7					
	(AM) shift; If I come ii weigh her."	n early, no one tells me to					
	_	(Resident #1) come in					
		vital signs and weigh her. I					
		and her weight on a piece of					
		me and give the information					
	to the nurse to record						
	The facility's policy titl	led Hemodialysis Care					
	Policy-Effective date-						
	-Policy statement Th	ne licensed nursing staff will					
	use the following crite						
		prehensive assessment to					
		not to proceed with care					
		omplications unique to each					
		e documented on the					
	individualized plan of	care. The general					
		ency guidelines The goal					

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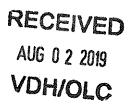
TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
					С	
	495232	B. WING			07/	11/2019
ROVIDER OR SUPPLIER	ENTER		55	20 INDIAN RIVER ROAD		
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	x			(X5) COMPLETION DATE
should provide: 1. The 2. Maintain patency of Prevent infection or mof Care Protocol: Prevery visit provided by The above issues well Administrator, Director Director of Clinical Seapproximately 3:14 Pl	e specialized care needed. If the shunt/central line, 3, sedical complications, Plan and post dialysis weight for a dialysis center. The addressed with the ref Nursing and Regional rvices on 07/11/19 at	Fe	658			
-	went/Heal Pressure I licer	_ E	202	F 696		
		FC	900	F 686		
§483.25(b) Skin Integ §483.25(b)(1) Pressur Based on the compret resident, the facility m (i) A resident receives professional standard: pressure ulcers and d ulcers unless the individemonstrates that the (ii) A resident with pre- necessary treatment a with professional stan- promote healing, prev- new ulcers from devel This REQUIREMENT by: Based on staff intervi- and clinical record rev- to conduct a thorough pressure ulcer prior to unstageable pressure evidence that a barrier	rity e ulcers. hensive assessment of a ust ensure that- care, consistent with s of practice, to prevent bes not develop pressure ridual's clinical condition by were unavoidable; and ssure ulcers receives and services, consistent dards of practice, to sent infection and prevent oping. is not met as evidenced ew, facility document review few, the facility staff failed skin assessment of a it advancing to an ulcer, and failed to ream was implemented			the facility. The Director of Nursi reviewed the physician's order for wound treatment for resident #2 with the LPN on 7/10/19. 2. The facility completed a 100% resort of current resident's skin assess to identify residents at high risk is skin break down to insure that interventions are in place. Additionally, all residents that ar receiving wound treatments are risk to be affected. 3. The Director of Nursing or design will educate the Licensed Nurses following physician's orders for wound treatments, as well as, prevention of skin break down, including assessment, intervention	ng or view nents for e at	
	ROVIDER OR SUPPLIER LLE HEALTH & REHAB OF CACH DEFICIENCY REGULATORY OR LESSION AND PROVIDED TO THE PROVIDED	A95232 ROVIDER OR SUPPLIER LLE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 should provide: 1. The specialized care needed. 2. Maintain patency of the shunt/central line. 3. Prevent infection or medical complications. Plan of Care Protocol: Pre and post dialysis weight for every visit provided by dialysis center. The above issues were addressed with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/11/19 at approximately 3:14 PM. No additional information was presented. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b) Skin Integrity symmetry sym	ROVIDER OR SUPPLIER LLE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 should provide: 1. The specialized care needed. 2. Maintain patency of the shunt/central line. 3. Prevent infection or medical complications. Plan of Care Protocol: Pre and post dialysis weight for every visit provided by dialysis center. The above issues were addressed with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/11/19 at approximately 3:14 PM. No additional information was presented. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b) Skin Integrity sydes.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to conduct a thorough skin assessment of a pressure ulcer prior to it advancing to an unstageable pressure ulcer, and failed to evidence that a barrier cream was implemented per the plan of care, for one of 36 residents in the	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 should provide: 1. The specialized care needed. 2. Maintain patency of the shunt/central line. 3. Prevent infection or medical complications. Plan of Care Protocol: Pre and post dialysis weight for every visit provided by dialysis center. The above issues were addressed with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/11/19 at approximately 3:14 PM. No additional information was presented. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) \$483.25(b) Skin Integrity \$483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to conduct a thorough skin assessment of a pressure ulcer prior to it advancing to an unstageable pressure ulcer, and failed to evidence that a barrier cream was implemented per the plan of care, for one of 36 residents in the	ROYNDER OR SUPPLIER LLE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH CEPTICIENCY MUST BE PRECEDED BY PULL REGULATORY OR IS DEMITIYING INFORMATION) COntinued From page 34 should provide: 1. The specialized care needed, 2. Adulatian patency of the shunt/central line, 3. Prevent Infection or medical complications. Plan of Care Protocol: Pre and post dialysis weight for every visit provided by dialysis center. The above issues were addressed with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/11/19 at approximately 3:14 PM. No additional information was presented. Treatment/Svox to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(r)(ii) \$483.25(b) (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that-(f) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers and does not develop pressure ulcers and constitution demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility y staff failed to conduct a thorough skin assessment of a pressure ulcer reprint to it advancing to an unstageable pressure ulcer, and failed to evidence that a barrier cream was implemented per the plan of care, for one of 35 residents in the	A SULDING A STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STORMARY STATEMENT OF DEFICIENCES EACH DEPOCISION OF BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 34 should provide: 1. The specialized care needed. 2. Maintain patency of the shunt/central line. 3. Prevent Infection or medical complications, Plan of Care Protocol. Pre and post dialysis weight for every visit provided by dialysis center. The above issues were addressed with the Administrator, Director of Nursing and Regional Director of Clinical Services on 07/11/19 at approximately 3:14 PM. No additional information was presented. Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(11)(iii) \$483.25(b) Skin Integrity \$483.25(b)(11)(iii) \$483.25(b)(11) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This RECUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to conduct a thorough skin assessment of a pressure ulcer running, prevent infection and prevent new ulcers from developing. This RECUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to conduct a thorough skin assessment of a pressure ulcer, and failed to conduct a thorough skin assessment of a pressure ulcer, and failed to conduct a thorough skin assessment of a pressure ulcer, and failed to conduct a thorough skin assessment of a pressure ulcer prior to it advancing to an unstageable pressure ulcer, and failed to conduct a thorough skin assessment of a pressure ulcer prior to it advancing to an unstageable pressure ulcer, and failed to conduct a thorough skin assessment of a pressure ulcer prior to it advancing to an un

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1,	E CONSTRUCTION ,	(X3) DATE SURVEY COMPLETED
		495232	B. WING		C 07/11/2019
			5	STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	(%5)
TAG	-	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI	l I
F 686	failed to follow physicicare dressing for one #21. The findings include: 1. For Resident #6, the conduct a thorough she provide evidence that implemented once recibeing observed on 4/2 sacrum. Resident #6 was adme 6/1/2015 with diagnost not limited to Chronic high blood pressure, the hypothyroidism and Bersessment was a sign assessment with an Adate) of 4/22/19. Resicognitive impairment; assistance from one spersonal hygiene and assist with two plus stemobility and transfers. Section Merchant (Skin Conductive of Resident #6 assessments revealed sacral area until 4/10/1 identified. The followir documented on 11-7 stesident have current Sacrum, Description:	an's orders for a wound of 36 residents, Resident of 36 resident of 36 resident of 37 resident of 37 resident of 38 resident of	F 686	4. The Director of Nursing or design will audit physician's order and to ensure treatments are being as ordered. This audit will be conducted 3x w week for 3 more. The Director of Nursing or design will audit/observe wound care treatments to ensure proper technique and that physician's care being followed. This audit we conducted 3x a week for 3 mone. The Director of Nursing or design will audit the bi-weekly skin che ensure they are completed and accurate. This audit will random review 10 residents, 3x per weekly some and the properties of these and the properties of the second treatments. The results of these and the properties of the second treatments. The results of these and the properties of the second treatments are revision. 5. Corrective action will be completed and the properties of the second treatments. Corrective action will be completed and the properties of the second treatments.	TARs done oths. gnee orders fill be ths. gnee ecks to oly k for audits QAPI
		to determine a possible			

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495232	B. WING	B. WING		C 07/11/2019	
	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 5620 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		11/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 686	Score for Pressure U was on 3/12/19. Resibeing a low risk for of with a Braden score of Review of Resident # (physician order sum order for barrier crean prior to 4/10/19. Reviintegrity care plan da 7/3/19, documented to dated 1/11/19: "Preveream/ointment after needed." There was a clinical record that shoream. Further review of Resident following supplement found on 4/10/19: "1) ProStat (3)- two times a day on 12/14/18. (This on 12/14/18. (This on 12/14/18 and resolved) 2) "MV-One (Multi-Vitmouth one time a day was initiated on 12/18 into place for a left here	edness. 6's most recent Braden loer Risk (2) prior to 4/10/19 dent #6 was documented as otaining pressures sores of 14. 6's April 2019 POS mary) failed to evidence an m (skin protective cream) ew of Resident #6's skin ted 1/11/19 and revised the following intervention entative barrier incontinence care as no evidence in Resident #6's e was receiving barrier	F	686			

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PRINTED: 07/26/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495232 B. WING 07/11/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5520 INDIAN RIVER ROAD KEMPSVILLE HEALTH & REHAB CENTER** VIRGINIA BEACH, VA 23464 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 686 Continued From page 37 F 686 Further review of Resident #6's April 2019 POS revealed that Resident #6 was on a pressure reduction mattress and had an order to turn and reposition the resident every two hours prior to the 4/10/19 sacral redness. There was no evidence that an intervention was put into place to prevent further skin breakdown after Resident #6's sacral redness was identified on 4/10/19.

Review of Resident #6's skin integrity care plan dated 1/11/19 and revised 7/3/19, failed to evidence that a new intervention was put into place or that her care plan was reviewed after redness was found on 4/10/19.

The next skin assessment documented in the clinical record was conducted during the overnight shift 4/13/19-4/14/19 (11 PM-7 AM shift). The following was documented: "Does the resident have current skin issues: Yes. Site 53) Sacrum, Description: redness." Further review of the the nursing notes failed to evidence a thorough assessment to determine a possible cause of the sacral redness. There was no evidence that an intervention was put into place for Resident #6's sacral redness identified again on 4/14/19.

The next skin assessment dated 4/14/19 at 10:03 a.m., revealed that an unstageable pressure ulcer was found to Resident #6's sacral area. The following was documented by the DON (Director of Nursing):
UTD (unable to determine)
Wound Location: Sacrum

Width (cm) 0.8
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Length (cm (centimeters))2

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495232	B. WING		С	
NAME OF P	ROVIDER OR SUPPLIER	777672		STREET ADDRESS, CITY, STATE, ZIP CODE	07/11/2019	
VEMPOVO	I F HEALTH & SELLAS	>-x-x		5520 INDIAN RIVER ROAD		
KEMPSVILLE HEALTH & REHAB CENTER				VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 686	Continued From page	≥ 38	F 68	6		
	Depth (cm)0					
	Area is in house acqu					
		not present on admission.				
	04/14/2019 Drainage					
		mall amount) Drainage				
	Wound bed appearant	ound) appearance is Pink."				
	r chwodia (arodia w	ound) appearance is Filik.				
	A skin assessment co	onducted by the LPN				
	(Licensed Practical N					
		nted the following on a				
		Interact form on 4/14/19:				
	"Skin evaluation: Pres					
		e sore: New onset Grade 2				
		cer, OR progression of				
	pressure ulcer despite	e interventions. nd details: 2.0 x 0,8 x 0,0				
		ssue), surrounding tissue,				
	pink and intact."	sous, surrounding tissue,				
	•	4/14/19 documented the				
		noted to sacral region				
	during ADL (activities	.8 x 0.0, MD (medical				
		onsible party) notified,				
		APS (turning and positioning)				
		educated on importance of				
		anding, will cont. to monitor				
	and note changes."	-				
	Review of Resident #	6's April 2019 physician				
		ollowing treatment orders				
		ound: "Santyl (5) Ointment				
		genase). Apply to sacrum				
		ift for wound care cleanse				
		n normal saline, pat dry,				
	apply santyl to wound	bed, followed by moistened				
		rith dry drsg (dressing),				
	change QD (every da	y) and prn (as needed) until	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495232	B. WING	B. WING		C 07/11/2019	
	ROVIDER OR SUPPLIER	ENTER		5	TREET ADDRESS, CITY, STATE, ZIP CODE 520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	1	11/2010
(X4) ID PREFIX TAG			ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	4/21/19 continued to a pressure ulcer as an a measurements were or." Review of Resident # that the wound care p #6 on 4/24/19. The fo "Patient presents with She has an unstageal sacrum for at least 1 a moderate serous exurverbalizes pain with s Medication affecting wedication found to b clinical context. Unstance (dead tissue) (Sacrum Wound Size: 3.0 x 1.0 adherent devitalized r (percent). Granulation dressings: santyl appl Dakins (7) solution appl 1/4 strength dakins m Dressing: Foam silico for 30 days. Plan of C Addressed: Off-load we facility protocol, Gel colow mattress (LAL), V (supplement) twice days.	ssment conducted on identify Resident #6's sacral unstageable. The following documented: "2.5 x 1.0 x 0 6's clinical record revealed shysician assessed Resident llowing was documented: a wound on her sacrum, ble (due to necrosis) days in duration. There is dates (6). The patient core of 5 out of 10, wound healing: No e affecting wound healing in ageable due to necrosis n): etiology: Pressure, o x not measurable. Thick necrotic tissue: 90 % n tissue: 10 %. Primary by once daily for thirty days; oply once daily for 30 days. oistened gauze. Secondary ne border apply once daily are Reviewed and wound, Reposition per ushion to wheelchair, low air	F	686			
	that the above recommodule wound care physician	6's clinical record revealed mendations made by the were put into place and re completed. The following					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495232	B. WING _			C 07/11/2019	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 6620 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	F 686 Continued From page 40 interventions were added to her skin integrity care		F 6	86			
	(4/23/19), Suppleme	"LAL (low air loss) mattress nt as ordered (4/26/19)."					
	wound care physicia remained an unstage	eable. The following s made: "Would recommend					
	Foley catheter was p following order was c	#6's clinical record revealed a laced on 5/9/19. The locumented: "FOLEY Foley Cath Size (16)Fr nl (milliliter) Balloon."					
	physician notes reve improved to a stage of deteriorated (worsen The following was do pressure wound sacr generalized decline of	um- deteriorated due to					
	Resident #6's wound resident was in too m	a.m., an observation of was attempted. The nuch pain despite given the resident did not want to					
	conducted with ASM member) #2. It was a writer could not find a put into place after sa 4/10/19. Additional e	m., an interview was (administrative staff explained to ASM #2 that this evidence that anything was acral redness was found on vidence was requested. ASM the the staff see redness they					

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '			SURVEY LETED	
		495232	B. WING _			C 11/2019	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	OULD BE COMP		
F 686	there was evidence the being used, ASM #2 sommally write orders she could not provide implementing the barrier was found. ASM #2 sommally has a barrier of use if needed. ASM #1 had been using barrier barrier cream was in predness, if she would treatment if it was not think it was working." resident would also somethink it was working." resident would also contributed with a sked if she would have expected blanchable or non-blanchable sommall in the pressed which means lying on the area for contributed in the pressure ulcer. On 7/11/19 at 1:40 p.1 administrator and ASI aware of a concern for the conducted with LPN (#2, the nurse who dis 4/14/19. When asked	er cream. When asked if at this barrier cream was stated that they didn't for it. ASM #2 stated that evidence that staff were fier cream once the redness tated that every resident cream and that the staff will 2 stated that Resident #6 or cream. When asked if the place prior to the sacral consider changing effective, ASM #2 stated, "I ASM #2 stated that the trup in her chair all day long put to her pressure sore. Find the sacral redness fier asked if she frence between blanchable kin, ASM #2 stated that she to see if the skin was nichable. When asked if she frence between blanchable kin, ASM #2 stated that the trurn to normal color after the redness was caused by certain amount of time or just PN #2 stated that could indicate a stage one	F6	586			

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
					С		
		495232	B. WING	· · · · · · · · · · · · · · · · · · ·	07/11/2019		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
VEMBer#	LE MEATTH & DELLAD A			5520 INDIAN RIVER ROAD			
KEMPSVILLE HEALTH & REHAB CENTER				VIRGINIA BEACH, VA 23464			
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		N	
F 686	86 Continued From page 42		F 6	86			
	skin assessment, LPN	I #2 stated that if there was					
	redness she would im	plement a barrier cream					
	and try to turn and rep	position the resident every 2					
	hours and offload the	resident off the area. LPN					
		as the skin was not open,					
		barrier cream. When asked					
	if a physician's order \	was required to use barrier					
		ere needed to be an order					
		out it on. When asked if she					
		ness further, LPN #2 stated					
	that she would assess						
		ole or non-blanchable etc.					
		n-blanchable skin could					
	-	cer. LPN #2 stated that					
	whether the skin was						
		d be included in the skin					
	assessment. LPN #2						
		nent or interventions should				ı	
	put into place. When a						
		mpleted, LPN #2 stated that					
		re completed bi-weekly on					
		is a new skin condition.					
		could remember about					
		vound, LPN #2 stated that it					
		y the aide on 4/14/19, that w skin area. LPN #2 could					
		e wound had looked like					
		al assessment, LPN #2					
		's physician orders and					
	stated that if she had	· · ·					
		d must of had slough. LPN					
	,	e wound must have been an					
		stated that the DON usually					
	comes behind her to s						
		ed that Resident #6 had an					
		e wound but that they had					
		to a LAL (low air loss)					
		und was found. When asked					
		ossible for a wound to					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		SOFARTIFICATION NUMBER.) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495232	B. WING _			C 07/11/2019	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		0713174045	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 686	#2 stated that it may Resident #6 because chair for a very long the was also diabetic white LPN #2 stated that 4/ aide had reported a sign was not aware of 4/10/19. On 7/11/19 at 3:48 p. conducted with ASM member) #4, the physical possible for a resident impairments and ther unstageable, ASM #4 it's going to be rare." was a gap of time before Resident #6 for the fill how Resident #6 for the fill how Resident #6 for the fill how Resident #6 was a documented. ASM #4 her sacral wound was but that Resident #6 wanted to sit in her diabet that the staff also had incontinence and that eventually placed for Further review of Resident #6's nonconther wheelchair to office The 11-7 nurse who if the sacral redness or the sacral	ing to an unstageable, LPN have been common for she liked to stay up in her ime and that Resident #6 ch affected wound healing. 14/19 was the only day the kin area. LPN #2 stated that if any sacral redness on m., an interview was (administrative staff sician. When asked if it was at to have no skin a wound be found at an a stated, "It does happen, but ASM #4 stated that there fore she was able to see set time so she could not say bund first presented. ASM #4 the had documented sacral hen that sacral redness sessed further and to could not say for certain if a avoidable or unavoidable was non-compliant and hair all day. ASM #4 stated to combat moisture due to to a Foley catheter was healing. sident #6's comprehensive 19, failed to evidence inpliance with getting out of	F 6	86			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	· ·		(X3) DATE SURVEY COMPLETED	
495232	B. WING		C 07/11	1/2019	
rer		6520 INDIAN RIVER ROAD	V 1	112010	
SUMMARY STATEMENT OF DEFICIENCIES X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			1	(X5) COMPLETION DATE	
an interview was he nurse who identified cond time on 4/14/19, he process if she were to at was not previously hat if the resident had a could continue the hent in place such as he oseptine (barrier cream he would check to see if her non-blanchable, LPN helanchable, the he one pressure. When Resident #6, LPN#1 th Resident #6 every has shown her skin helanchable the helanchable th	F 686				
THE THE TOTAL STREET OF STREET OF STREET	A95232 TER ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) an interview was the nurse who identified cond time on 4/14/19, the process if she were to at was not previously at if the resident had a could continue the ent in place such as to side, offloading the oseptine (barrier cream the would check to see if the one pressure. When Resident #6, LPN the Resident #6, LPN#1 th Resident #6 every was shown her skin (14/19 on 11-7 shift. The ses meant to Resident stated that when she is sment she looked at that barrier cream was und the wound and just ses. LPN #1 confirmed the ses the wound because the and she did not want the confirmed the ses the wound because the and she did not want the confirmed the ses the wound because the and she did not want the confirmed the ses the wound because the and she did not want the confirmed the confirmed the confirmed that the confirmed tha	A BUILDING 495232 B. WING B. WING F 686 An interview was the nurse who identified cond time on 4/14/19, the process if she were to at was not previously at if the resident had a could continue the condition of the would check to see if the non-blanchable, the cone pressure. When Resident #6, LPN#1 th Resident #6 every was shown her skin (14/19 on 11-7 shift. the siment to Resident stated that when she is meant to Resident stated that when she is meant to Resident was und the wound and just sets the wound because the and she did not want the concerns. ASM #1, the the poon of Clinical Services above concerns. It is a Pressure Ulcer, "coving: "Pressure Ulcers bending on the severity in the condition of the severity in the severity	A BUILDING 495232 STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464 ENT OF DEFICIENCIES STEE PRECEDED BY FULL SENTIFYING INFORMATION) F 686 A BUILDING PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) F 686 F 686 F 686 F 686 F 686 F 687 F 688 TAG PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) F 688 TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) F 688 TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) F 688 TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) F 686 THE TOTAL PLAN OF CORRECTION THE APPROPRIA DEFICIENCY F 688 TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY F 688 TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY F 688 F 686 F 688 F 688	A BUILDING A 995232 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE \$20 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464 ENT OF DEFICIENCIES ST BE PRECEDED BY PULL PREFIX TAG TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 686 An interview was the nurse who identified cond time on 4/14/19, e e process if she were to at was not previously at if the resident had a bould continue the ent in place such as o side, offloading the oseptine (barrier cream the would check to see if or non-blanchable. LPN h-blanchable, the one pressure. When Resident #6, LPN#1 The Resident #6 every ras shown her skin 114/19 on 11-7 shift. ss" meant to Resident stated that when she isment she looked at that barrier cream was und the wound and just ss. LPN #1 confirmed ses the wound because e and she did not want m. ASM #1, the e DON, and Corporate of Clinical Services above concerns. It is a Pressure Ulcer, "bowing: "Pressure Ulcers benefing on the severity"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495232	B. WING_			C 07/11/2019	
	ROVIDER OR SUPPLIER	ENTER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		0111120:0	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	discoloration (or reduced complex as dead, blawith exposure of under and boneIf you notice discoloration or skin by prominence, you should immediately." Facility policy titled, "Seculity policy pol	ess) of the skin or as ck tissue (called necrosis) erlying structures like muscle ce any suspicious preakdown over a bony ald notify your doctor. Skin and Wound Care dress the above concerns. Sure ulcer*- Full thickness be base of the ulcer is ellow, tan, gray, green or (tan, brown or black) in the escription: Until enough is removed to expose the etrue depth, and therefore rmined. Stable (dry, aut erythema or fluctuance) erves as "the body's natural of should not be removed. For Advisory Panel website erg/pr2.htm. In inflammation or sore on prominence (e.g., shoulder tocks, or heel), resulting the area, usually of bed. Most frequently seen included by frequently change of the water or air mattress. Also sure sores. Barron's Terms for the Non Medical. Rothenberg, M.D. and	F6	86			

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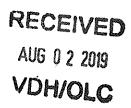
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495232	B. WING_			C 7/11/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, GITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	<u></u>	771172013
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 686	Continued From page	46	F6	86		
	Sore Risk is a clinical nurses and other hea score a patient/client's pressure ulcers. easedocs/current/LNC (3) Prostat is a supple are a critical factor in protein stores and acreation patients with pressure was obtained from https://www.cwimedico-stat-awc-sugar-freed-protein-ps-awc-sf. (4) Sanguinous Drainliquid part of blood (so obtained from The Nathtps://www.ncbi.nlm. 17498/. (5) *SANTYL® Ointmactive enzymatic thermoves necrotic tiss microscopic level. The bed of microscopic cegranulation to proceed occur. (http://www.scitation.com/ (6) Serous exudate is This information was Institutes of Health.	ement high amino acids that replenishing depleted celerating tissue healing in a ulcers. This information al.com/liquid-supplement/pr-advanced-wound-care-liqui age is the blood and the erum). This information was stional Institutes of Health. hih.gov/pmc/articles/PMC47 ent is an FDA-approved apy that continuously use from wounds at the his works to free the wound ellular debris, allowing d and epithelialization to antyl.com/about>) thin, clear, watery drainage. obtained from The National mih.gov/pmc/articles/PMC47				

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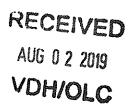
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495232	B. WING _			C 07/11/2019	
	ROVIDER OR SUPPLIER	CENTER	1	STREET ADDRESS, CITY, STATE, ZIP COI 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 686	of the skin and tissue obtained from The Na https://dailymed.nlm.im?setid=9906e5fe-7l 5. (8) A wound vacuum Closure) is a device to by applying localized the edges of the wou wound healing" This information was Fundamentals of Nur Perry, 2005. Page 1st. 2. The facility staff fair orders for a wound can Resident #21's left health 7/10/19. Resident #21 was or on 03/29/19. Diagno included but are not 1 Mellitus. Resident #2 (MDS-an assessment Referenthe resident with a 1st 15 on the Brief Interv (BIMS), indicating no addition, the MDS co assistance of two with extensive assistance use, dressing and be Daily Living care. Unwas coded for pressure.	prevent and treat infections This information was ational Institutes of Health. Inih.gov/dailymed/drugInfo.cf Inf5-4d99-8107-c048bb5e42d (Wound Vacuum Assisted In that assists in wound closure Inegative pressure to draw Ind togetheraccelerates obtained from Ising 6th Edition, Potter & India to follow physician In deel *pressure ulcer on India to Type II Diabetes It is Minimum Data Set It protocol) with an Ince Date of 05/04/19 coded Is out of a possible score of It iew for Mental Status It cognitive impairment. In It ded Resident #21 extensive In personal hygiene, In of one with bathing, toilet It did mobility for Activities of Index section M-skin condition	F	886			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495232	B. WING_	D. MANO		С	
NAME OF PE	ROVIDER OR SUPPLIER	450232	I D. VIIIVO —	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	/11/2019	
				5520 INDIAN RIVER ROAD			
KEMPSVII	KEMPSVILLE HEALTH & REHAB CENTER			VIRGINIA BEACH, VA 23464			
(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 CORRECTI ((EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 686	to left heel. The goal:	e 48 resident will have intact as, blisters or discoloration	F6	586			
	by/through next review intervention/approach	w. Some of the les to manage goal					
	monitor for effectivene	treatments as ordered and ess of treatment and update				:	
		and assess/document/report ed with changes in skin					
	Administration Record	21's July 2019 Treatment J (TAR) consisted of the ng on 06/28/19-cleanse left					
	alginate and dry dress	e, pat dry, apply *calcium sing every day shift for p around peri-wound (skin					
		ximately 10:56 a.m., served lying in bed in supine ent supplies consisted of 4 x					
	4 gauzes, normal sali Calcium Alginate and	ne, dry adhesive dressing, hand sanitizer. The LPN 18 seconds then donned a					
	set of gloves. The wo	ound was cleaned twice with e, pat dry, the LPN cut a					
	wound, placed the cu wound bed then secu	t Calcium Alginate to the red the Calcium Alginate in					
	place with the dry adh her gloves then wash seconds.	nesive dressing, removed ed her hands for 19					
	interview was conduc read Resident #21's to	ximately 2:58 p.m., an ted with LPN #5. The LPN reatment order for the					
	asked, "Should you ha	left heel. The surveyor ave used skin prep to the heel ulcer." The LPN					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		40.000	2 11010	P MANC		С	
		495232	B. WING_			07/	11/2019
	NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 520 INDIAN RIVER ROAD FIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	then stated, "Yes, I sharound the left heel waround the left heel waround the left heel was con Nursing (DON) on 07 p.m. The DON read to order for the pressure surveyor asked, "Sho skin prep around the heel wound" the DON simple, yes." The surthat LPN #5 did not upressure ulcer wound nurse should have us the physician. The supurpose of using skin keep the dressing in protection." The Administrator, Dir Regional Director of Conformed of the finding 07/11/19 at approximation of the findings. The facility's policy titt Guideline (Revised-Swound and Dressing to: -Dressing/treatment cophysician's order for the treatment. Definitions: *A pressure injury is left.	ducted with the Director of //11/19 at approximately 6:00 Resident #21's treatment e ulcer to the left heel. The full the nurse have applied skin surrounding the left I replied, "That's pretty reveyor informed the DON se skin prep during the left I care. The DON said the field skin prep as ordered by surveyor asked, "What is the prep" she replied, "To help polace and also used for skin rector of Nursing and Clinical Services was g during a briefing on ately 8:10 p.m. The facility arther information about the led) Skin and Wound care eptember 2014). Care include but not limited	F	686			

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OF DEFICIENCIES CORRECTION	EDENTIFICATION NI IMPED			(X3) DATE SURVEY COMPLETED	
495232 B. WNG			C 07/11/2019		
NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		112010
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	3E	(X5) COMPLETION DATE
prominence or related device. The injury car open ulcer and may be as a result of intense or pressure in combinatolerance of soft tissue may also be affected perfusion, co-morbiditissue (http://www.npuap.org-clinical-resources/npi-*Calcium alginate is at that can be cut to fit wheavy exudate while renvironment (wounds *Skin prep is a thin liquit that, upon application protective film to help removal of tapes and (http://www.smith-nepucts/advanced-wound Free of Accident Haza CFR(s): 483.25(d)(1)(1) §483.25(d) Accidents The facility must ensu §483.25(d)(2) Each resupervision and assist accidents. This REQUIREMENT	It to a medical or other in present as intact skin or an interpolar procurs and/or prolonged pressure station with shear. The interpolar pressure and shear by microclimate, nutrition, ties and condition of the soft states and state				
Based on observation	n, staff interview, clinical				
	CORRECTION ROVIDER OR SUPPLIER LE HEALTH & REHAB OF SUMMARY STATE (EACH DEFICIENCY REGULATORY OR INTERPRETATION OF INT	ROVIDER OR SUPPLIER LE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) *Calcium alginate is a sterile primary dressing that can be cut to fit wounds with moderate to heavy exudate while maintaining a moist wound environment (woundsource.com). *Skin prep is a thin liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films (http://www.smith-nephew.com/professional/prod ucts/advanced-wound-management/skin-prep/). Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and \$483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	A BUILDING 495232 ROVIDER OR SUPPLIER LE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 50 prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (Inttp://www.npuap.org/resources/educational-and -clinical-resources/npuap-pressure-injury-stages/) *Calcium alginate is a sterile primary dressing that can be cut to fit wounds with moderate to heavy exudate while maintaining a moist wound environment (woundsource.com). *Skin prep is a thin liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films (http://www.smith-nephew.com/professional/prod ucts/advanced-wound-management/skin-prep/). Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(2) Each resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	TOURIDER OR SUPPLIER LE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DETICIONICES (SCAT OBSTRICEMENT ON DETICIONICES) (SCAT OBSTRICEMENT OF DETICIONICES) (F 686) CONTINUED FROM page 50 Prominence or related to a medical or other devolve. The injury can pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/inpuap-pressure-injury-stages/) *Calcium alginate is a sterile primary dressing that can be cut to fit wounds with moderate to heavy exudate while maintaining a moist wound environment (woundsource, com). *Skin prep is a thin liquid film-forming dressing that, upon application to intact skin, forms a protective film to help reduce friction during removal of tapes and films (http://www.nsith-nephew.com/professional/products/advanced-wound-management/skin-prep/). Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) \$483.25(d)(2)[Each resident receives adequate supervision and assistance devices to prevent accidents. This RECURREMENT is not met as evidenced by:	COMPLET ON IDENTIFICATION NUMBER: 495232 A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CADE FROM DISCRAMENT CODE ADDRESS A

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495232	B. WNG		С	
			07/11/2019			
NAME OF P	ROVIDER OR SUPPLIER	•	1	STREET ADDRESS, CITY, STATE, ZIP CODE		
KEMPSVI	LLE HEALTH & REHAB (CENTER		5520 INDIAN RIVER ROAD		
			VIRGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION	
F 689	determined that facilitinterventions to reduce accidents/hazards for survey sample, Resident #6, facilifall mat was placed or bed per physician's or The findings include: Resident #6 was adm 6/1/2015 with diagnos not limited to Chronic high blood pressure, thypothyroidism and B #6's most recent MDS assessment was a sign assessment with an Adate) of 4/22/19. Resirequiring extensive as member with toileting dressing; and extensimember with bed mot Review of Resident #6 (Physician Order Sumfollowing orders: "Fall when resident is in be on 5/30/18. Review of Resident #6 (Physician Order Sumfollowing orders: "Fall when resident is in be on 5/30/18.	cility document review, it was by staff failed to implement be the potential for one of 36 residents in the lent #6. Lity staff failed to ensure her on the floor while she was in order to prevent injuries. Litted to the facility on sees that included but were Kidney Disease Stage 3, type two diabetes, tipolar disorder. Resident S (minimum data set) gnificant change LRD (assessment reference ident #6 was coded as assistance from one staff personal hygiene and we assist with two plus staff coility and transfers.	F6		tential nee n s, ment nee h to e as oleted sults to the	
	incontinence, bowel in	oactive drug use, bladder ncontinence, functional lated to) hx (history) R				

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Event ID: 35T111

Facility ID: VA0179

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	495232 B. W		B. WING			C	
NAME OF PI	ROVIDER OR SUPPLIER	*30202	D. VIIIIO _	STREET ADDRESS, CITY, STATE, ZIP CODE	07/1	1/2019	
	KEMPSVILLE HEALTH & REHAB CENTER			5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	#6) will have no fall re review. Interventions: (Date Initiated: 5/31/2) On 7/9/19 at 12:44 p.made of Resident #6. back. A fall mat was ride of the bed. At this asked this writer to ge readjusted in bed. On 7/9/19 at 1:49 p.m of Resident #6. She will be was not the bed. On 7/10/19 at 8:15 a.m observed to be on the the resident was in bed. On 7/10/19 at 8:57 a.m observed up in bed ebed table in front of he table was to the right was folded up at the form of 1/10/19 at 9:57 a.m assistant) #1, (Reside breakfast tray and wa room. Resident #6's coff to the right of Resinot come back to put	Goal: (Name of Resident blated injuries through next "Fall matt (sic) to bedside (019)." m., an observation was She was lying in bed on her not observed to be at the stime Resident #6 had at the nurse so she could be at the nurse so she could be at the nurse to be at the side was lying in bed on her right of observed to be at the side at the side of her bed while ed. m., a blue fall mat was a right side of her bed while ed. m., Resident #6 was atting breakfast with her over the base of the over bed of Resident #6. The fall mat foot of her bed. m., CNA (certified nursing ent #6's) aide, removed her alked out of Resident #6's over bed table was pushed dent #6's bed. CNA #1 did the fall mat back down.	F 6	89			
	On 7/10/19 at 10:40 a.m., LPN (Licensed						

		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION VG	(X3	(X3) DATE SURVEY COMPLETED	
		495232	B. WING_			C 07/11/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	DE .	0//11/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	observed entering F Morphine. LPN #2 e This surveyor made that Resident #6's b floor to her right side On 7/10/19 at 10:47 conducted with LPN just put Resident #6 floor, LPN #2 confin asked if it had been morning, LPN #2 sta the floor and that the they deliver Resider stated that the over of the fall mat and ti When asked if staff back down once Re meals, LPN #2 state asked if Resident #6 stated that Resident but that she had not LPN #2 stated the n to prevent injury froi resident received a On 7/11/19 at 10:27 conducted with CNA #1, Resident #6's ai she was assigned to that she had probab removed her breakf process (what staff mat that is folded up resident is in bed, C put the fall mat back told about the obser	Resident #6's nurse was desident #6's room with her exited her room shortly after. an observation at 10:45 a.m., lue fall mat was now on the ea. a.m., an interview was a.m., an interview was a fall mat back down on the med that she did. When on the floor earlier that ated that it was originally on the staff usually pick it up when on the floor earlier that ated that it was originally on the staff usually pick it up when on the floor earlier that ated that it was originally on the staff usually pick it up when on the floor earlier that ated that it was originally on the staff usually pick it up when on the floor earlier that staff usually pick it up when the staff usually pick it up when on the floor earlier that was a fall risk, LPN #2 that it should be. When the swas a fall risk, LPN #2 that any falls in some time. The falls especially while the	F	989			

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495232	B. WING		C 07/11/2019	
	NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	1 077172013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		N
F 689	Continued From page		F 68	9		
	know what things eac such as fall mats, dev she will get report from at a nursing Kardex for	When asked how CNAs h resident needs in place ices etc. CNA #1 stated that n the nurse or she can look or each resident.				
	Review of Resident # revealed that it did no	6's current nursing Kardex t address fall mats.				
	that her last recorded minor injury. The care	6's clinical record revealed fall was on 9/28/18 with a plan was updated with the "Encourage resident to eat r) for meals."				
	revealed that her last conducted on 9/28/18	ident #6's clinical record fall risk assessment was . The risk assessment did stem to determine her risk				
	member (ASM) #1, th	m., administrative staff e administrator, ASM #2, Nursing) were made aware s.	+			
	Facility policy titled, "Facility policy po	Resident Safety," did not ncern.				
F 698 SS=D	Dialysis	was presented prior to exit.	F 69	8		
	§483.25(I) Dialysis. The facility must ensu require dialysis receiv with professional stan	e such services, consistent				

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Event ID: 35T111

Facility ID: VA0179

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	AND PLAN OF CORRECTION SPENTISH AT AN AN IMPORT.			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
			1			С	
		495232	B. WING	B. WING			11/2019
	ROVIDER OR SUPPLIER	ENTER		56	TREET ADDRESS, CITY, STATE, ZIP CODE 620 INDIAN RIVER ROAD 'IRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	the residents' goals at This REQUIREMENT by: Based on resident intercept of the control of the c	n-centered care plan, and and preferences. is not met as evidenced serview, staff interviews, and facility documentation of failed to communicate an after one resident (Resident the survey sample for ations after dialysis to check weights on the communicate an with the dialysis center for added outpatient dialysis on Monday, Wednesday and to obtain weights on the returned from dialysis on the	F	398	 Resident #1 has a Dialysis Communication book and a physician's order to be weighe when returning from dialysis. All Dialysis patients in the facili have the potential to be affect this practice. The Director of Nursing or desi will educate the Licensed Nursi staff on following physician's o and appropriate communicatio with the dialysis center regardi the facility's patients. A communication note book will provided to each dialysis reside take to dialysis. This will be use communication tool between the dialysis center and the facility. I event that the note book is not complete upon return from the dialysis center, the Licensed Nur will contact the dialysis center to receive any necessary informati and document that information the resident's medical record. 	ty ed by gnee ng rders n ng be nt to d as a ne n the	

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MANE OF PROMIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER (24) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (24) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (24) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (24) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (24) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (25) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (24) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (24) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (24) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (25) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (25) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (25) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (25) TRAIN RIVER ROAD (26) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (26) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (26) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (26) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (26) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHAN RIVER ROAD (26) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHT RIVER ROAD (26) D STREET ADDRESS, CITY, STAYLE, ZIP CODE 5620 NIGHT RIVER ROAD (26) D STREET ADDRESS, CITY, STAYLE, ZIP CADE (26) CARCHAN CORNERS ROAD (26) D REMOVE COMMENT OF COMMENT RIVER ROAD (26) CARCHAN COPPER RIVER ROAD (26) C STREET ADDRESS, CITY, STAYLE, ZIP CADE (26) CARCHAN COPPER RIVER ROAD (26) C STREET ADDRESS, CITY, STAYLE, ZIP CADE (26) CARCHAN COPPER RIVER ROAD (26) C STREET ADDRESS REPERENCE DOES COMMENT RIVER ROAD (26) C STREET ADDRESS REPERENCE TO SHOULD BE COMMENT ROAD (26) C STREET ADDRESS REPERENCE TO SHOULD BE COMMENT ROAD (26) C STREET ADDRESS REPERENCE TO SHOULD BE COMMENT ROAD (26) C STREET ADDRESS REPER PROPERTY ROAD (26) C STREET ADDRESS REPERENCE TO SHOULD BE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER (A) D SUMMARY STATEMENT OF DEFICIENCIES FREETER SUMMARY STATEMENT OF DEFICIENCIES FREETER FREETER FROM CONTINUED FOR PROPROCES TO THE APPROPRIATE FREEDLATORY OR LISC IDENTIFYING INFORMATION) F 698 Continued From page 56 (O) for Special Treatments, Procedures and Programs, the resident was coded for dialysis. Resident #1's Care Plan included: weigh per protocol and as needed. Use asseptic technique and universal precautions. Resident #1's physician orders contained the following orders: (1) Dialysis on Monday, Wednesday and Friday. (2) If bleeding occurs from the dialysis ste apply pressure and call 1911 as needed. (3) Montor Dialysis port for signs and symptoms of infection for every shift. (4) Obtain weights upon return from dialysis. Notify MDI 3-lbs is noted one time a day every Monday, Wednesday and Friday. A review of Resident #1's weights for the Month of May showed the following: 06/19/19 resident weighed 105.5. 05/20/19 resident weighed 105.6. Ibs. No other weighs were recorded for the month of June showed the following: 06/19/19 resident weighed 105. Ibs. 7/10/19 resident weighed 105. Ibs. O7/10/19 resident weighed 105. Ibs. O7/10/19 resident weighed 105. Ibs. O7/10/19 resident weighed 105. Ibs.			40700					С
SSZO NOIAN RIVER ROAD VIRGINIA BEACH, VA 23444 SACH DEFICIENCY SUSTEMBRING PERFECT TAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE PREFIX TAGE PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE PROVIDER'S FLAN OF CORRECTION (EACH DEFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 698	NAME OF P				07	/11/2019		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 698 Continued From page 56 (O) for Special Treatments, Procedures and Programs, the resident was coded for dialysis. Resident #1's Care Plan included: weigh per protocol and as needed. Use aseptic technique and universal precautions. Resident #1's physician orders contained the following orders: (1) Dialysis on Monday, Wednesday and Friday. (2) If bleeding occurs from the dialysis site apply pressure and call 911 as a needed. (3) Monitor Dialysis port for signs and symptoms of infection for every shift. (4) Obtain weights upon return from dialysis. Notify MD if 3+ lbs is noted one time a day every Monday, Wednesday and Friday. (5) Dialysis return assessment in the evening every Monday, Wednesday and Friday. (5) Dialysis return assessment in the weighed 103.4 lbs. 05/16/19 resident weighed 103.4 lbs. 05/16/19 resident weighed 108.2 lbs. A review of Resident #1's weight for the Month of June showed the following: 06/19/19 resident weighed 108.4 lbs. No other weighs were recorded for the month of June showed the following: 07/05/19 resident weighed 105 lbs. 07/10/19 resident weighed 105.5 lbs.			CENTER		5520 II	NDIAN RIVER ROAD		
(O) for Special Treatments, Procedures and Programs, the resident was coded for dialysis. Resident #1's Care Plan included: weigh per protocol and as needed. Use aseptic technique and universal precautions. Resident #1's physician orders contained the following orders: (1) Dialysis on Monday, Wednesday and Friday. (2) If bleeding occurs from the dialysis site apply pressure and call 911 as needed. (3) Monitor Dialysis port for signs and symptoms of infection for every shift. (4) Obtain weights upon return from dialysis. Notify MD if 3+ lbs is noted one time a day every Monday, Wednesday and Friday. (5) Dialysis return assessment in the evening every Monday, Wednesday and Friday. A review of Resident #1's weights for the Month of May showed the following: 05/01/19 resident weighed 106.5. 05/20/19 resident weighed 108. No other weighs were recorded for the month of June showed the following: 06/19/19 resident weighed 105. Ibs. 07/10/19 resident weighe	PREFIX	(EACH DEFICIENC	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION	
An interview was conducted with Licensed	**	(O) for Special Treatmerograms, the resident Programs, the resident Resident #1's Care Piprotocol and as needed and universal precaute Resident #1's physicial following orders: (1) Die Wednesday and Fridate from the dialysis site as needed. (3) Monitod symptoms of infection weights upon return from the significant with the every wednesday and Fridate assessment in the every wednesday and Fridate Areview of Resident #105/14/19 resident weight 05/14/19 resident weight 05/16/19 resident weight wei	nents, Procedures and nt was coded for dialysis. Ian included: weigh per ed. Use aseptic technique ions. Ian orders contained the Dialysis on Monday, ay. (2) If bleeding occurs apply pressure and call 911 or Dialysis port for signs and of for every shift. (4) Obtain form dialysis. Notify MD if 3+ a day every Monday, ay. (5) Dialysis return ening every Monday, ay. If it's weights for the Month flowing: ghed 106 lbs. ghed 103.4 lbs. ghed 105.5. ghed 108.2 lbs. If it's weight for the Month of wing: ghed 106.4 lbs. recorded for the month of ving: ghed 105 lbs. ghed 105.5 lbs. e obtained.	F6		will audit the dialysis communication book for each resident for appropriate contectorrespondence 3x a week for months. Additionally, the Dire Nursing or designee will audit dialysis patient's weight upon from dialysis 3x a week for 3 months. The results of these a will be reported to the facility' committee for discussion and necessary revision. Corrective action will be comp	nt and 3 ctor of each return udits s QAPI	

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Event ID: 35T111

Facility ID: VA0179

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION MUMBED:		TIPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
		495232	B. WING			C 07/11/2019	
	NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP COU 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	E		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CC X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 698	approximately 9:45 at could view Resident #Book. LPN #1 stated permission from the resident free communication sheet receiving dialysis at (IMonday, Wednesday). There were no commodown were dated 06/0 stated that resident is of Monday because sometimes. She had to Resident told nurse sometimes what should ha "They should have careceived the notes." An interview was con (Licensed Practical N Wing) on 07/11/19 at stated that the resident sometimes. LPN #5 where done. She said returns after dialysis to document resident's worth the facility IPM, and if she refuse (Power of Attorney/recalled. On 07/11/19 at approwas held with the Adr Nursing, the Regiona Services. The adminitive communication of the sources. The adminitive control of the sources was held with the Adr Nursing, the Regiona Services. The adminitive communication of the sources was held with the Adr Nursing, the Regiona Services. The adminitive communication of the sources was held with the Adr Nursing, the Regiona Services. The adminitive communication of the source of the s	m. She was asked if she this Dialysis Communication that she would have to get esident because she has book with her at all times. The listed that resident was Name) Dialysis Center on and Fridays at 11:00 AM, unication notes from munication notes in the to 17/19-06/10/19, LPN #5 attending a new facility as the was disruptive to other change dialysis centers, the left the communication tation van, LPN #5 was tave been done. She said tilled the dialysis place and ducted with LPN #5 urse) Unit Manager (East approximately 5:20 PM. She that will refuse to be weighed was asked what should have that when the resident the 3-11 (PM) shift should weight because she usually between 4:30 PM and 5:00 s to be weighed her POA sponsible party) should be	F	698			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495232	B. WING		C 07/11/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 011	11/2013	
KEMPSVII	LLE HEALTH & REHAB (ENTER		5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	I SHOULD BE COME		
F 698	Continued From page telephone or fax." On 07/11/19 at approximaterview was conduct concerning staff obtaireturns from dialysis. Was refusing being we back from dialysis. She was also asked it communication book returns from dialysis. they lost it one time." On 07/11/19 at approximate following Certified Nuwere interviewed conswhen she returns from CNA #2 was asked if her when resident retishe obtain resident we CNA #5 stated "I norm (AM) shift; If I come it weigh her." CNA #6 stated "When from dialysis I get her record the vital signs paper with the date, to the nurse to record. The facility's policy titt Policy-Effective date-	e 58 Eximately 7:30 PM an ted with Resident #1 ning her weights when she Resident was asked if she eighed when she comes he stated "No," "That's a lie." If she gives staff her to keep for her when she She stated "No." "because "I keep it myself." Eximately 7:35 PM the raing Assistants (CNAs) cerning weighing resident in dialysis. The resident #1 is assigned to curns from dialysis and does eights. She stated "No." Inally work the 11 (PM)-7 in early, no one tells me to in (Resident #1) come in rivital signs and weigh her. I and her weight on a piece of time and give the information in the system." The ded Hemodialysis Care June 16, 2017.	F 69	DEFICIENCY)			
	use the following crite patient/resident's com determine whether or planning. Risks and c	nprehensive assessment to not to proceed with care complications unique to each se documented on the					

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/26/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495232		B, WING		C 07/11/2019	
	NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	LD BE COMPLETION	
F 698	should provide: 1. The 2. Maintain patency o Prevent infection or m	ency guidelines The goal e specialized care needed. f the shunt/central line. 3. nedical complications. Plan and post dialysis weight for	F 69	98		
F 745 SS=D	The above issues we Administrator, Director of Clinical Se approximately 3:14 Pl was presented.	re addressed with the or of Nursing and Regional ervices on 07/11/19 at M. No additional information or Related Social Service	F 74	15		
	§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, staff interviews and facility documentation review, the facility staff failed for one (Resident #181) of 36 residents in the survey sample, to assist with transportation arrangements in order to attend an appointment with an outside physician. The findings included: The facility staff failed to ensure Resident #181 attended her scheduled physician appointment on 07/09/18. Resident #181 was admitted to the facility on 07/02/18. Being the resident was no longer in the facility a closed record review was conducted. Diagnoses for Resident #181 included but not					

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Event ID: 35T111

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495232	B. WING		C 07/11/2019	
	NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5620 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 745	limited to Atherosclero Infarction (stroke) and resident's Minimum D was not due. Review Admission Evaluation alert and oriented x 4. level of functioning ind assist of two with amb transfers, assist of on and dressing for Activ Review of Resident # summary dated 07/02 doctor's appointment: to discuss *WATCHM 1:00 p.m. Review of Resident # conducted 07/09/19 a and revealed the follo had an appointment to resident stated to can had not set up transport An interview was cone Practical Nurse (LPN) on 07/10/19 at approx #5 stated, "The facility have reviewed Reside summary for any upco explained the nurse is Transportation Form f the completed form to	otic Heart Disease, Cerebral Chronic COPD. The ata Set (MDS) assessment of Resident #181's coded Resident #181 as Under ADL/Mobility for cluded the following: the outlation, toileting and e with bed mobility, bathing lities of Daily Living care. 181's hospital discharge /18 included the following Follow up with Dr. (Name) AN device on 07/09/18 at 181's clinical record was the approximately 12:22 p.m. wing information: "Resident oday, family came and cell appointment. Resident ortation." ducted with Licensed #5 (Unit Manager on East) imately at 9:00 a.m., LPN is admitting nurse should ent #181's discharge oming appointments." She to complete the or appointments then give Social Services (SS). SS tion for the resident. The is not responsible for sportation; the Social nsible for making the	F7	1. Resident #181 was discharged the facility 2. All residents with scheduled appointments have the potent be affected. 3. The Director of Nursing, or des will educate the Licensed Nursi staff of identifying Physicians appointments on the hospital discharge summary, scheduling appointments and completing transportation request that wil given to the Social Services department. 4. The Director of Nursing or designed will review all new admissions a scheduled appointments. The Director of Nursing or designed audit the appointment date/tin transportation request complete and given to social services. This will be completed Monday. The with Friday, Saturday and Sund being completed on Monday for months. The results of these audit will be reported to the facility's committee for discussion and necessary revision. 5. Corrective action will be completed 8/19/19	gnee ng the a l be gnee or will ne, ed s audit ursday, ay r 3 dits QAPI	

CENTERS FOR MEDICARE & MEDICAID SERVICES

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	495232	B. WING_		C 07/11/2019
NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP C 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE COMPLÉTION HE APPROPRIATE DATE
On 07/11/19 at approxinterview was conduct. The SW reviewed Redischarge. After he redischarge the SW state scheduled appointment to discuss watchman p.m." He said "The near completed transport Resident #181 whether resident or not." He statement of transportation arrange the resident should happysician appointment. The Administrator, Director of Conformed of the finding 07/11/19 at approximate.	ximately 9:10 a.m., an ted with the Social Worker. sident #181's hospital eviewed the hospital ted, "Resident #181 had a nt follow up with Dr. (Name) device on 07/09/18 at 1:00 urse should have given me tation request form for er the family was taking the said they would have amily to make sure ements were made and that ave never missed her at. Tector of Nursing and Clinical Services were g during a briefing on ately 8:10 p.m. The facility	F7	745	
implant designed to k from entering your blocausing a stroke (uch Complaint deficiency. Infection Prevention & CFR(s): 483.80(a)(1)(§483.80 Infection Cor The facility must established to know the state of the sta	eep harmful blood clots ood stream and potentially ealth.org). Control (2)(4)(e)(f) htrol blish and maintain an nd control program	F 8	380	
	SUMMARY ST/ (EACH DEFICIENCY REGULATORY OR LE Continued From page On 07/11/19 at approximaterview was conduct The SW reviewed Redischarge. After he redischarge the SW state scheduled appointment of discuss watchman p.m." He said "The near completed transport Resident or not." He standered to resident or not." He standered to resident should he physician appointment. The Administrator, Director of Conformed of the finding 07/11/19 at approximated in the present any further findings. Definitions: *WATCHMAN device implant designed to ke from entering your block causing a stroke (uch Complaint deficiency. Infection Prevention & CFR(s): 483.80(a)(1)(1) §483.80 Infection Cor The facility must estate infection prevention as the control of the control of the control of the control of the causing a stroke (uch Complaint deficiency). Infection Prevention & CFR(s): 483.80(a)(1)(1)(1)	ROVIDER OR SUPPLIER LE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 61 On 07/11/19 at approximately 9:10 a.m., an interview was conducted with the Social Worker. The SW reviewed Resident #181's hospital discharge. After he reviewed the hospital discharge the SW stated, "Resident #181 had a scheduled appointment follow up with Dr. (Name) to discuss watchman device on 07/09/18 at 1:00 p.m." He said "The nurse should have given me a completed transportation request form for Resident #181 whether the family was taking the resident or not." He said they would have followed up with the family to make sure transportation arrangements were made and that the resident should have never missed her physician appointment. The Administrator, Director of Nursing and Regional Director of Clinical Services were informed of the finding during a briefing on 07/11/19 at approximately 8:10 p.m. The facility did not present any further information about the findings.	A BUILDIN ROYIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 61 On 07/11/19 at approximately 9:10 a.m., an interview was conducted with the Social Worker. The SW reviewed Resident #181's hospital discharge. After he reviewed the hospital discharge the SW stated, "Resident #181 had a scheduled appointment follow up with Dr. (Name) to discuss watchman device on 07/09/18 at 1:00 p.m." He said "The nurse should have given me a completed transportation request form for Resident #181 whether the family was taking the resident or not." He said they would have followed up with the family to make sure transportation arrangements were made and that the resident should have never missed her physician appointment. The Administrator, Director of Nursing and Regional Director of Clinical Services were informed of the finding during a briefing on 07/11/19 at approximately 8:10 p.m. The facility did not present any further information about the findings. Definitions: *WATCHMAN device is a permanent, one-time implant designed to keep harmful blood clots from entering your blood stream and potentially causing a stroke (uchealth.org). Complaint deficiency. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	A STREET ADDRESS, CITY, STATE, ZIP C SEZO INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES DE Y FUIL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 61 Continued From page 61 Continued From page 61 Continued From page 61 F 745 Continued From page 61 Continued From page 61 F 745 Continued From page 61 F 745 F 745

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495232	B. WING		C
NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	07/11/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 880	comfortable environd development and tradiseases and infection program. The facility must estand control program a minimum, the followard for the facility must estand control program a minimum, the followard for the facility must estand communicable of the facility for the faci	ment and to help prevent the insmission of communicable ons. prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: mem for preventing, identifying, ng, and controlling infections diseases for all residents, tors, and other individuals ander a contractual upon the facility assessment to \$483.70(e) and following andards; mentandards, policies, and regram, which must include, illiance designed to identify ble diseases or your can spread to other or; mentandards policies, and regram, which must include, illiance designed to identify ble diseases or your can spread to other or; mentandards policies, and regram, which must include, illiance designed to identify ble diseases or your can spread to other or; mentandards policies, and regram, which must include, illiance designed to identify ble diseases or your spread to other or; mentandards policies, and regram, which must include, illiance designed to identify ble diseases or your spread to other or; mentandards policies, and regram, which must include, illiance designed to identify ble diseases or your spread to other or; mentandards policies, and regram, which must include, illiance designed to identify ble diseases or your spread to other or; mentandards policies, and regram, which must include, illiance designed to identify ble diseases or your spread to other or; mentandards policies polici	F 880	1. CNA #1 for resident #33 w educated on the Infection policy on 7/31/19. The LPN resident #21 was educated Infection Control policy on The facility reviewed the Ir Prevention and Control Po 7/16/19. 2. All residents in the facility potential to be affected by practice. 3. The Director of Nursing or will educate all staff on the Prevention and Control pol Additionally, Licensed Nurseducated on Infection cont practice during treatments the facility QAPI committee review the Infection Prever Control policy and amend the as necessary. This annual rebe documented in the comminutes. 4. The Director of Nursing or committees. 5. Corrective audits will be reported in the seaudits will be reported in the committee for these audits will be committee for discussion and necessary residents.	Control I for I on the 7/10/19. Infection Ilicy on Inave the this designee Infection Icy. Icy. Infection Icy. Infection Icy. Infection Icy. Icy. Icy. Icy. Icy. Icy. Icy. Icy.

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		495232	B. WING_				C 11/2019
NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			55	REET ADDRESS, CITY, STATE, ZIP CODE 20 INDIAN RIVER ROAD RGINIA BEACH, VA 23464			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit the contact will transmit the contact will transmit the vijThe hand hygiene by staff involved in directions taken will be staff involved in directions. §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual reversion that the facility will condulated the infection. §483.80(f) Annual reversion that the facility will condulated the infection control praction the survey sample and facility staff failed the infection control procession of the survey sample and facility staff failed the infection control procession of the survey sample and facility staff failed the infection control procession of the survey sample and facility staff failed the infection control procession of the survey sample and facility staff failed the infection control procession of the survey sample and facility staff failed the infection control procession of the survey sample and facility staff failed the infection control procession of the survey sample and facility staff failed the infection control procession of the survey sample and facility staff failed the infection control procession of the survey sample and facility staff failed the infection control procession.	s under which the facility ses with a communicable sin lesions from direct or their food, if direct ne disease; and procedures to be followed rect resident contact. In for recording incidents scility's IPCP and the en by the facility. It, store, process, and to prevent the spread of In the store of t	F	880			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, l''			(X3) DATE SURVEY COMPLETED	
			A. BUILDING		С		
		495232	B. WING_			1	11/2019
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			5	520 INDIAN RIVER ROAD			
KEMPSVII	LE HEALTH & REHAB C	ENIER		٧	IRGINIA BEACH, VA 23464		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
170					DEFICIENCY)		
F 880	Continued From page	64	F8	80			
	0 70 6 70 4 66 6						
		iled to ensure the Infection					
	Prevention & Control annually.	policy was reviewed					
	ariridally.						
	The findings include:						
	1. Resident #33 was a	admitted to the facility on					
	10/6/18 and readmitte	·					
	diagnoses that include	ed but were not limited to					
	high blood pressure, I	neart failure, muscle					
		hyroidism. Resident #33's					
	most recent MDS (mir						
		arterly assessment with an					
	•	erence date) of 5/15/19.					
	Resident #33 was coo	ring 13 out of possible 15					
	_	erview for Mental Status)					
		vas coded as requiring					
	limited assistance with	· •					
	On 7/10/19 at 9:00 a.r	m. observation of breakfast					
		resident rooms. At 9:06					
	a.m., CNA #1 was obs	served walking out of room					
		eal cart. CNA #1 grabbed					
		dent #33 and walked into					
		., CNA #1 placed her meal					
	-	nt #33 and removed the lid					
		then walked out of Resident					
		d up the hall to room 614.					
		walked out of room 612 er hand. CNA #1 then					
		#33's room, placed the					
		33's shirt and began cutting					
		al. CNA #1 was also not					
	observed to wash or s						
		out of all three rooms.					
	On 7/11/19 at 10:27 a	.m., an interview was					

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					,	c	
		495232	B. WING_			07/	11/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
KEMPSVII	LLE HEALTH & REHAB C	ENTER			5820 INDIAN RIVER ROAD		
					/IRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	HOULD BE COMPLÉTION	
F 880	maintain infection con resident rooms, CNA sanitize or wash her hand prior to starting caresident. When asked towel from a residents another resident, CNA okay to do. When ask above observation, C don't recall." CNA #11 cross contamination. On 7/11/19 at 5:05 p.r member (ASM) #1, the DON (Director of I of the above concerns Facility policy titled, "I address the above concerns facility on 03/29/19. It included but are not liming Mellitus. Resident #2 (MDS-an assessment Assessment Reference the resident with a 15 15 on the Brief Intervice (BIMS), indicating no addition, the MDS concerns assistance of two with extensive assistance use, dressing and bed	#1. When asked how to strol going in and out of #1 stated that she would hands after leaving a room are and/or assisting the next of if it was okay to grab a so room to be used on A #1 stated that was never red if she could recall the NA #1 stated, "Honestly I then stated, "I know that is I know you can't do that." m., administrative staff e administrator, ASM #2, Nursing) were made aware so. Infection Control," did not necerns. I was presented prior to exit. originally admitted to the Diagnosis for Resident #21 mited to *Type II Diabetes 1's Minimum Data Set protocol) with an one Date of 05/04/19 coded out of a possible score of ew for Mental Status cognitive impairment. In ded Resident #21 extensive in personal hygiene, of one with bathing, toilet dimobility for Activities of der section M-skin condition	F	880			
	Resident #21's revise	d comprehensive care plan					

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PRINTED: 07/26/2019 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ C 495232 07/11/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5520 INDIAN RIVER ROAD KEMPSVILLE HEALTH & REHAB CENTER** VIRGINIA BEACH, VA 23464 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 880 Continued From page 66 F 880 on 04/15/19 documented Resident #21 with area to left heel. The goal: resident will have intact skin, free from redness, blisters or discoloration by/through next review. Some of the intervention/approaches to manage goal included: administer treatments as ordered and monitor for effectiveness of treatment and update physician as needed and assess/document/report to physician as needed with changes in skin status. Review of Resident #21's July 2019 Treatment Administration Record (TAR) consisted of the following order: starting on 04/17/19-apply bilateral *prevalon boots while in bed every shift. On 07/10/19 at approximately 10:56 a.m., Resident #21 was observed lying in bed in supine position with prevalon boot to left heel. The LPN washed her hands x 18 seconds then donned a

x 19 seconds.

set of gloves. The LPN removed Resident #21's left heel from a prevalon boot; left pressure ulcer observed without a dressing with small amount of serosanguineous drainage present. The LPN placed the left foot back inside the prevalon boot. The LPN removed her gloves, used hand sanitizer, donned a new pair of gloves, removed the left heel from the prevalon boot, cleaned the wound x 2 with a saline soaked gauze, pat dry, then placed the left foot (left heel pressure ulcer without dressing) back inside the prevalon boot. The LPN cut a piece of Calcium Alginate to fit the left heel pressure ulcer wound. The LPN removed the left foot from the prevalon boot, placed the cut Calcium Alginate to the wound bed then covered with a dry adhesive dressing. The LPN removed her gloves then washed her hands

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		495232	B. WING_				C 11/2019
NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		11/2010	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IVE ACTION SHOULD BE ED TO THE APPROPRIATE	
F 880	07/10/19 at approxim "I should have not plathe prevalon boot to portion of infection." She said elevated off the bed with performed. On 07/10/19 at approximate was conducted an agent on East). The back inside the prevalue control problem. She contaminated from the have been clean agent pressure ulcer. She sheen put in place; the bed or be placed back the LPN stated, "The cause cross contaminated are consumed in the cause cross contaminated from the cause cross contaminated are contaminated in the prevalon by the said inside the prevalon by the said inside the proposed the foot on a clean sure of hands to hold the foot on a clean sure of hands to hold the foot on control issued. The Administrator, Direction control issued. The Administrator, Direction of the finding of the fi	ducted with LPN #6 on ately 2:50 p.m., who stated, ced the left foot back inside prevent the potential spread of the left heel should have while wound care was being a similar to the LPN #5 (Unit he LPN said placing the foot lon boot is an infection said the wound is now a boot so the wound should no before dressing the said a barrier should have wound should not touch the considerable the prevalon boot. The boot is not clean so it can sation." I ducted with the Director of the first approximately 5:25 the nurse should have never the pressure ulcer back soot after cleaning the wound. The DON said the nurse the foot with the boot or laid reace or have an extra pair boot while wound care was a DON said this is an according to the previous said the	F	380			

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		495232	B. WING		07/11/2019
NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
F 880	Definitions: *A pressure injury is I and underlying soft tiprominence or related device. The injury car open ulcer and may be as a result of intense or pressure in combinate tolerance of soft tissue may also be affected perfusion, co-morbiditissue (http://www.npuap.org-clinical-resources/np. *Prevalon boots give protection against he drop. Prevalon helps and shear on your parankles. By elevating theel from the mattress pressure relief (http://www.sageprod.cfm). *Calcium alginate is a that can be cut to fit were related.	led (Infection 2015). residents and staff by d of infection. ocalized damage to the skin seue usually over a bony d to a medical or other in present as intact skin or an present and or pressure and shear by microclimate, nutrition, ties and condition of the soft gresources/educational-and uap-pressure-injury-stages/) patients the most advanced all pressure ulcers and foot minimize pressure, friction tient's feet, heels and the foot and separating the s, it delivers total heel luctsglobal.com/en/prevalon.	F8	80	

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NAME OF PROVIDER OR SUPPLIER KEMPSVILLE HEALTH & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5520 INDIAN RIVER ROAD VIRGINIA BEACH, VA 23464	Unitizatio	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 880	3. On 07/11/2019 at conducted with the Direview the facility's In Program and observe Prevention Control Prwas dated April 10, 20 reviewed. The DON sto the Administrator to policy that was dated On 07/11/2019 at app DON was unable to p documentation. On 07/11/2019 at app interview was conducted and he was asked, "V of the facility staff reviewed in Control Pr Administrator stated, policy immediately. I reviewed annually or The Administrator, Director of Cinformed of the finding approximately 8:10 p.	5:00 p.m., an interview was rector of Nursing (DON) to fection Prevention Control of that the Infection evention Program Policy D17 as the last date stated that she would speak a see if he had a copy of the more recent. Troximately 5:30 p.m., the rovide any further Troximately 7:00 p.m., an ted with the Administrator what are your expectations rewing the facilities Infection togram Policy?" The "The facility will review the expect all policies to be more often as needed."	F 88		

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

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