PRINTED: 09/26/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	S	(X3) DATE SURVEY COMPLETED		
	495299	B. WING		C 09/05/2019		
NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEAI	TH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD CORRECTED C GLEN ALLEN, VA 23060			
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
hospital must impler power systems base forth in paragraph (a policies and procedu paragraphs (b)(1)(i) §483.73(e), §485.62 (e) Emergency and start the emergency and start the emergency planthis section. §482.15(e)(1), §483 Emergency generate must be located in a requirements found Code (NFPA 99 and Amendments TIA 12 12-5, and TIA 12-6), and Tentative Interin 12-2, TIA 12-3, and when a new structure structure or building 482.15(e)(2), §483.7 Emergency generate [hospital, CAH and I the emergency power and maintenance rehealth Care Facilitie Safety Code. 482.15(e)(3), §483.7 Emergency generate LTC facilities] that me	standby power systems. The ment emergency and standby ed on the emergency plan set a) of this section and in the ures plan set forth in and (ii) of this section. 25(e) Standby power systems. The CAH] must implement adby power systems based on set forth in paragraph (a) of 273(e)(1), §485.625(e)(1) or location. The generator ccordance with the location in the Health Care Facilities Tentative Interim 2-2, TIA 12-3, TIA 12-4, TIA Life Safety Code (NFPA 101 in Amendments TIA 12-1, TIA TIA 12-4), and NFPA 110, are is built or when an existing is renovated. 23(e)(2), §485.625(e)(2) or inspection and testing. The LTC facility] must implement er system inspection, testing, quirements found in the scode, NFPA 110, and Life 23(e)(3), §485.625(e)(3) or fuel. [Hospitals, CAHs and aintain an onsite fuel source	E 04	correction are not an admission and do not constitute an agree with the alleged deficiencies here are to be corrected by the date or dates indicated. E041 1. The facility is following the emergency preparedness plar generator checks are being conducted and logged. 2. No other concerns identified as Maintenance staff will be educated on the generator checks are being conducted and logged. 4. Audits will be conducted by Administrator/ Designee to eather the date of the content of the generator checks are being the generator checks are being conducted and logged.	ement erein. all the g to be The tion of encies and the encies and the encies are the encies ed.		
LABUKATORY DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	? F	TITI F	(X6) DATE		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

3/22/10

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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 495299 09/05/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **3600 MOUNTAIN ROAD** CORRECTED COPY **ELIZABETH ADAM CRUMP HEALTH AND REHAB** GLEN ALLEN, VA 23060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) conducted and logged weekly times E 041 | Continued From page 1 E 041 four weeks then monthly times three to power emergency generators must have a plan for how it will keep emergency power systems months. Results of the audits will be operational during the emergency, unless it reviewed at the monthly QAPI evacuates. meeting for three months to sustain *[For hospitals at §482.15(h), LTC at §483.73(g), compliance. and CAHs §485.625(g):] The standards incorporated by reference in this 5. Compliance Date: 10/5/19 section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of federal regulations/ibr locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013.

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(vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition,

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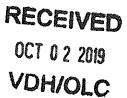
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION		DATE SURVEY COMPLETED
		495299	B. WING				C
NAME OF B	ROVIDER OR SUPPLIER	433233			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	09/05/2019
NAME OF F	ROVIDER OR SUPPLIER						
ELIZABET	TH ADAM CRUMP HEAL	TH AND REHAB			3600 MOUNTAIN ROAD CORRECTED (GLEN ALLEN, VA 23060	JUPY	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 041	Continued From pag	ge 2	E	041	1		
	issued August 11, 20 (viii) TIA 12-1 to NFI 2011. (ix) TIA 12-2 to NFP 2012. (x) TIA 12-3 to NFP 2013. (xi) TIA 12-4 to NFP 2013. (xiii) NFPA 110, Star Standby Power Sys TIAs to chapter 7, is This REQUIREMEN by: Based on staff inter review, it was detern						
	The findings include	:	10 mm er				
	9/5/19 at approxima administrative staff r director of nursing. A she could not provide stated that they had walls, the maintenar papers were destroy director kept all of h	e for the generator logs on tely 1:00 p.m. from member (ASM) #1, the At 1:55 p.m., ASM #1 stated le the generator logs. She had a flood between the noce office was hit, and the yed. The former maintenance is records on paper in s got wet with the flood.					
	member) #1, the ne 9/5/19 at 2:05 p.m. (day of employment how often is the ger it's tested weekly for monthly it's run for c	nducted with OSM (other staff w maintenance director on OSM #1 states it was his third at the facility. When asked herator tested, OSM #1 stated or about 30 minutes and then one to one and a half hours. the gauges have to be checked	THE PARTY NAMED IN THE PARTY OF STREET, WHICH TH				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		ATE SURVEY OMPLETED
							С
		495299	B. WING				09/05/2019
NAME OF P	ROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLIZADET	U ADAM COUMO HEALT	THE AND DELLAD		:	3600 MOUNTAIN ROAD CORRECTED CO)PY	Į.
ELIZABE	H ADAM CRUMP HEALT	H AND REHAB		١ ،	GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD IT TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
E 041	got wet in the flood are Therefore, he could in documentation of the stated the previous milke the computer systemaintenance. There is maintenance document computer program. The document preser program for maintenance "Exercise generator (routine checks, and concept the computer program for maintenance startup and operations of the computer program for maintenance startup and operations of the computer program for maintenance startup and operations of the computer program for maintenance startup and operations of the computer program for maintenance startup and operations of the transfer switch task should be used it scheduled tests in who (load should be at lead capacity). The concept of the following gravity checked if equipped, test the first of the computer of the computer of the computer of the computer of the concept of the con	stated the generator logs and are unreadable. The are unreadable are unreadable. The present any logs since 8/7/19. He also train term in place for so a program for antation and duties in the arted from the computer ance documented in part, with no load), perform areate entry in logbook. Week. A Power Generators for exercising (with no load), and only verifies engine and it does not verify that the for supporting your facility or these are working. 2. This in conjunction with regularly sinch the generator is loaded and into the generator for an oload. Execute prestart and incomponents of engine. The check for all fittings are tight, specific and, visually inspect fuel tank; well leak, detection system. The system are the system, as discharged away from	E	041			
	building,. 6. Perform I battery."	pattery test on generator	AAAAA BIRKANA KAAAAA BAAAAA				•

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		
		495299	B. WING		09	C //05/2019
NAME OF P	ROVIDER OR SUPPLIER	***************************************		STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD CORRECTED COPY GLEN ALLEN, VA 23060 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or is planning to take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or are to be corrected by the date or dates indicated. F600 1. Residents #7 and #8 are now safe from abuse. 2. Each resident has the potential of being affected. 3. Staff will be re-educated on facility abuse policy and procedures to ensure residents are free from		
ELIZABET	H ADAM CRUMP HEAL	TH AND REHAB			TED COPY	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
E 041	Continued From page	e 4	ΕO	41		
F 600	the following, "Emerg Maintenance Departr emergency equipmer operable at all times." ASM #1 was made at on 9/5/19 at 2:53 p.m. INITIAL COMMENTS An announced Medic survey was conducte complaints were invectorections are required. CFR Part 483 Federal requirements. The census in the 18 164 at the time of the consisted of eight cur (Residents #1 throug Free from Abuse and CFR(s): 483.12(a)(1)	ware of the above concern care/Medicaid abbreviated d 9/4/19 through 9/5/19. Two stigated during the survey. red for compliance with 42 al Long Term Care certified bed facility was survey. The survey sample rrent Resident reviews, h #8).	F 0	correction are not an admiss and do not constitute an ag with the alleged deficiencie To remain in compliance wi federal and state regulation center has taken or is plann take the actions set forth in following plan of correction following plan of correction constitutes the center's alleged deficited have been or are to be corrected by the date or daindicated. F600 Residents #7 and #8 are resident constitutes for the date or daindicated.	sion to reement s herein. th all as, the ing to the . The regation of iciencies e tes	10/5/19
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit	involuntary seclusion and ical restraint not required to edical symptoms.		2. Each resident has the pobeing affected.3. Staff will be re-educated abuse policy and procedure	on facility s to	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495299	B. WING				C 05/2019
	ROVIDER OR SUPPLIER I'H ADAM CRUMP HEAL	TH AND REHAB		36	TREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD CORRECTED CO LEN ALLEN, VA 23060		03/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	(X5) COMPLETION DATE
F 600	by: Based on staff intervand clinical record refacility staff failed to in the survey sample Residents #7 and #8 grabbed Resident #7 pushed Resident #8 injuries noted. The findings include: The "Facility Reported documented in part, Resident's involved (#8). Injuries: (A cheonext to)"Yes." (Residestratches to neck an Incident: Resident to (Resident #7) and (Resident #7) pushed (Residerno injuries noted. Reseparated. (Residerunit/room." The "Final Report" dipart, "This is the Final FRI of allegation of a (Resident #7) and (Resi	oral punishment, or i; T is not met as evidenced view, facility document review eview, it was determined the ensure two of eight residents were free from abuse, c. On 8/6/19, Resident #8 "s arm. Resident #7 then and Resident #8 fell with no ed Incident date: 8/6/19. Resident #7) and (Resident k mark was documented ent #7) noted with red d foreheadDescribe resident altercation between desident #8). (Resident #8) and got upset at (Resident to on the phone. (Resident to the sident #8) fell with	F	600	4. Audits will be conducted to enstaff understanding that resident have the right to be free of abust weekly times four weeks then monthly times three months. Roof the audits will be reviewed at monthly QAPI meeting for three months to ensure compliance. Compliance Date: 10/5/19	ts e esults the	
	resident altercation b (Resident #8) was re	etween (Resident #7) and ported. (Resident #8) was got upset at (Resident #7)	Annual of the An	A SECTION AND AND AND AND AND AND AND AND AND AN			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							c
		495299	B. WING			09/0	05/2019
NAME OF P	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
EI IZADET	H ADAM CRUMP HEALT	CH AND DELIAD			3600 MOUNTAIN ROAD CORRECTED C	OPY	
ELIZADET	H ADAM CROWL BEALI	H AND KEHAD			GLEN ALLEN, VA 23060		Į.
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
F 600	Continued From page	e 6	F	600	0	!	
		the phone. (Resident #8)	4				
		7)'s arm and (Resident #7)	The second second				
). (Resident #8) fell with no	A A A A				
	injuries noted. Resid	•	4				
		t #8) moved to a different					
		#7) was noted to have red					
	scratch marks on her	•					
	(Resident #8) was no	t noted with any injuries.					
	Staff report that they		2				
	incidentUpon furthe	er interview with (Resident					
	#7) by Social Worker	; stated (Resident #8) does					:
,	not like it when she is	on her cell phone. When	20				
		nto the room, she started	1				
	pacing around and m	ocking (Resident #7),	B. B. W.				
	, •	ras saying. (Resident #7)	1				:
		(Resident #8) went into a			4		
		told (Resident #7) she	**				
		the room and she told her	AMMON IN .				
		abbed (Resident #7)'s arm	- AMARIEM III.				
		out and away from her. By	4				
	_	on the floor. Upon further	4				
:		ent #8) by Social Worker,	. 444				
		was in their room trying to	A Addition of the Control of the Con				
		(Resident #7) suddenly					<u> </u>
		ed (Resident #8) down, and	***				
		esident #7) and (Resident					
	, ,	reviewed and revised. Both					
	behavior. The resider	ad a change in mood or					
		s in mood or behaviors and			- 14		
	_	h the physician as needed.	And Adams		1		and the same of th
		n the investigation, the	W.m.				
		iates a resident to resident					
	-	petween the residents per	SE-AWWAY PERSON				!
		ents. (Resident #8) was	A. Phase was				
	moved to another uni		C				8
		ervices met with (Resident	Anam Anno Pan		2011		
) to ensure no apparent			* BY C C C C C C C C C C C C C C C C C C		1
		Social Services will continue	***************************************				
	- • • • • • • • • • • • • • • • • • • •						

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING				C 05/2019	
NAME OF PI	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	00.2010	
					3600 MOUNTAIN ROAD CORRECTED C	OPY		
ELIZABET	H ADAM CRUMP HEAL	TH AND REHAB			GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 7 Isocial harm and follow up as	F	600	0		And the second s	
	Resident #7 was adn 10/5/18 with diagnos limited to: dementia, pressure and history The most recent MD assessment, a quarte assessment reference resident as scoring a interview for mental stresident was capable decisions. The reside independent or only from the staff for her The nurse's note date documented in part, physical altercation of [Resident #8]. Assess scratches along her or discomfort express ROM (range of motion limits). Response: Two and police report was MD/NP (medical documented in part). The care plan dated "Focus: I sometimes include: interfering we Closing door to room be open. Making fals anxious, and refusal living] (showers). I sometimes	nitted to the facility on es that included but were not depression, high blood of suicidal ideations. S (minimum data set) erly assessment, with an the date of 5/7/19, coded the till "14" on the BIMS (brief status) score, indicating the the of making daily cognitive tent was coded as being requiring limited assistance activities of daily living. ed, 8/6/19 at 10:38 p.m. "Situation: Resident was in a with another resident sment: Resident has several meck and forehead. No pain sed. Able to ambulate and on) WNL (within normal for residents were separated is filed in (name of county). tor/nurse practitioner) and						

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		CONSTRUCTION		SURVEY PLETED
		495299	B. WING				C
MANE OF D	ROVIDER OR SUPPLIER	455255	10		TOPET ADDRESS OFTWO CRATE 710 CODE	1 09	/05/2019
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 500 MOUNTAIN ROAD CORRECTED C	·OBV	
ELIZABET	TH ADAM CRUMP HEAL	TH AND REHAB			LEN ALLEN, VA 23060	.OF 1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 600	begin. Give me my mordered. Let my phy are interfering with mam not in pain or und to my psychologist/pto me unhurriedly an "Interventions" dated not seat me around ome to avoid situation upsetting to me." Resident #8 was admitted to: anxiety disorder, ipressure, dementia,	rventions before my behavior nedications as my doctor has sician know if my behaviors by daily living. Make sure I comfortable. Please refer me sychiatrist as needed. Speak d in a calm voice." The 1,8/7/19, documented, "Docthers who disturb me. Help is or people that are so repeated to the facility on 8/3/18 included but were not limited insomnia, high blood and bipolar disorder (a acterized by episodes of	F	600			
	assessment, a quarter assessment reference resident as scoring a interview for mental aresident was capable decisions. In Section resident was coded a her activities of living hygiene and bathing. The nurse's note dat documented in part, a physical altercation [Resident #7]. Assest flushed red. No appositis time States shows able to ambulate (range of motion) Williams.	S (minimum data set) erly assessment, with an ex date of 5/7/19, coded the "13" on the BIMS (brief status) score, indicating the ex of making daily cognitive of - Functional Status, the as being independent in all of of except toileting, personal ed, 8/5/19 at 10:31 p.m. "Situation: Resident got into on with another resident exment: Resident's face was arent injuries were found at the was pushed to the floor but the with no issues and ROM NL (within normal limits). Iliscomfort. Response:					

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING				C 05/2019	
NAME OF PE	ROVIDER OR SUPPLIER	L.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 007	00/2010	
ELIZABET	H ADAM CRUMP HEAL	TH AND REHAB			3600 MOUNTAIN ROAD CORRECTED C GLEN ALLEN, VA 23060	OPY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E :	(X5) COMPLETION DATE	
F 600	moved to (room num filed in (Name of cou and RP (responsible). The care plan dated, 8/6/19, documented in have behaviors which down hallway, makin anxiety. I enjoy the companions, pacing/aggression, not easily my personal items in showers, refusal to hoto remove my wande arguments with other physical." The "Intervidocumented, "Give in doctor has ordered, behaviors are interfer Please refer me to mas needed. Speak to calm voice." The "Introdocumented, "Do not disturb me. Help me that are upsetting to a resident striking an stated, "First you sepnotify the charge num. An interview was compractical nurse) #3, that 12:14 p.m. When a state of the country of the charge num.	rated. (Resident #8) was ber) and a police report was nty). MD (medical doctor) party) made aware." 9/18/18 and revised on n part, "Focus: I sometimes include walking up and g false statements, increase company of male paranoia/increase y redirected. I tend to leave the bathroom, refusal of ave linens changed. I tend in guard. I sometimes have residents that can become rentions" dated, 9/18/18, the my medications as my Let my physician know if my ring with my daily living. I seat me around others who to avoid situations or people me." Inducted with CNA (certified on 9/5/19 at 9:10 a.m. is staff follows if they observe other resident. CNA #1 carate the residents then se."	F	600	0			
		ent strike another resident, ould first separate them,						

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Facility ID: VA0083

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CEIVILIA	O I OIT MEDICAILE	X MILDICAID SERVICES				JIVILL IVO	. 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE S COMPL	
		495299	B. WING			С	l l
		495299	D. WHYG			09/0	5/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABET	H ADAM CRUMP HEA	LTH AND REHAB		l	00 MOUNTAIN ROAD CORRECTED CO LEN ALLEN, VA 23060	PΥ	
	OLUBANOVA CONTRACTOR	CTATELIEUE OF OFFICIALISM					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From pa	ae 10	<u></u>	600			
				000		; ;	
		lent. Notify the director of	}				
	-	inistrator. We'd have to notify					
	•	actitioner and the responsible		3			
	party."			-			
				-			
	An interview was co	onducted with administrative				\$	
	staff member (ASM) #1, the director of nursing,		-			
	on 9/5/19 at 12:45 p	o.m., regarding the process		:			
	staff follows when a	resident strikes another		į			
	resident. ASM #1 st	tated the residents are					
	separated. Both ar	e assessed for injury. The	9	***	•	1	
	director of nursing a	and/or administrator is	-	1		:	
	notified."		-MAW III III III III III III III III III I			:	
				-		:	
	The facility policy, "	Resident Abuse" documented	4	:		:	
		nt in the nature and dignity of		į			
	each resident at Fa	cility that he/she be afforded				:	
		, including the right to be free	1				
		t mistreatment, and/or					
		property. The facility policy,		į		1	
		sident" documented in part,		1			
		of be subjected to about by		1			
		out not limited to facility staff,		!		i	
	, ,	nsultants or volunteers, staff of		-			
				4			
		ving the individual, family		į		,	
		uardians, friends or other		ĺ		-	
	individuals."					 	
	ASM #1 the director	or of nursing, was made aware				!	
		rn on 9/5/19 at 2:53 p.m.					
	:	111 On 3/3/13 at 2.30 p.iii.				i	
	No further informati	ion was provided prior to exit.	a little dies a	31 Aug 31			
	(1) Barron's Diction	ary of Medical Terms for the	A			;	
		er, 5th edition, Rothenberg and	1000	1	FC00		
	Chapman, page 72		A 100 mm m m m m m m m m m m m m m m m m	1	F609		10/5/19
E 600	Reporting of Allege		-	609			
			F	oua	1. Allegations involving abuse of	r	
SS=D	CFR(s): 483.12(c)(1)(4)			result in serious bodily will be		
					resure in serious boung will be		:

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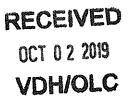
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING COMPLETED			
			/A. BOILB				
		495299	B. WING		The state of the s	1	05/2019
NAME OF P	ROVIDER OR SUPPLIER			S1	REET ADDRESS, CITY, STATE, ZIP CODE		
ELIZARET	H ADAM CRUMP HEAL	TH AND REHAB		3€	600 MOUNTAIN ROAD CORRECTED CO)PY	
LLILADE	THE PROPERTY OF THE PARTY OF TH			G	LEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRÉCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From pag	e 11	F	609	reported to the administrator of the facility and other officials no later		
	§483.12(c) In respon	se to allegations of abuse,			than 2 hours after the allegation	is	
		or mistreatment, the facility		1	made, or no later than 24 hours	if the	
	must:				events that cause the allegation	do	
	8483.12(c)(1) Ensure	e that all alleged violations	W. W		not involve abuse and do not re		
	involving abuse, neg		IN ANY AND AND ANY AND AND AND ANY AND		in serious bodily injury.		
		opriation of resident property,	141		2. Each resident has the potent	ial of	
		ately, but not later than 2			being affected.		
		ation is made, if the events ation involve abuse or result in			being uncerea.		
	. •	or not later than 24 hours if			3. Staff will be re-educated on		:
		e the allegation do not involve			reporting allegations involving a	buse	
		sult in serious bodily injury, to	***		or result in serious bodily injury		
		the facility and to other the State Survey Agency and	1		later than 2 hours after the alleg		
		ices where state law provides	Section 1		is made, or no later than 24 hou	-	
		g-term care facilities) in					: :
		te law through established			the events that cause the allega		:
	procedures.		No. of State		do not involve abuse and do no		
	§483.12(c)(4) Repor	t the results of all	1		result in serious bodily injury to	the	
	. •	administrator or his or her	ERROR III FOR		administrator of the facility and		
		tative and to other officials in	PAAL PRINCES AND		other officials.		
		te law, including to the State	Are Areas				
		in 5 working days of the	***************************************		4. Audits will be conducted to e		
		lleged violation is verified ve action must be taken.	1		allegations involving abuse or re	esult	
		T is not met as evidenced			in serious bodily injury will be		8
	by:		Banka Am. Links		reported no later than 2 hours a	after	
	1	view, facility document review	***************************************		the allegation is made, or no lat		
	1	eview, it was determined the ensure an allegation of			than 24 hours if the events that		
		nt residents in the survey			cause the allegation do not invo		
	sample, (Residents	#7 and #8), was immediately			abuse and do not result in serio	_	
	reported to the state	agency.					
	: On 8/6/19, Resident	#8 grabbed Resident #7's	AL ALE VALUE AND THE STATE OF T		bodily injury to the administrate)), Ol	

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Event ID: YPPK11

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495299	B. WING	alay ya ilika kupuya didika kapi ana kata ka ugu ugu aya kupuya kupu a dika ka jih ka juka ka ka ka ka ka ka k	C 09/05/20	19
NAME OF PE	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
FI IZABET	H ADAM CRUMP HEALT	TH AND REHAR		3600 MOUNTAIN ROAD CORRECTE	D COPY	
LLILITER	(,,,o,,,,, o,,o,,,, ,,e,,,,,,,,,,,,,,,,,			GLEN ALLEN, VA 23060		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON OF THE APPROPRIEM OF	LD BE COM	(X5) PLETION DATE
F 609	Continued From page	2 12	F 60	the facility and other officials		
	arm. Resident #7 the	n pushed Resident #8 and	a sala	times four weeks then mont	=	
		o injuries noted. The facility	An annual Person	three months. Results of the		
		ately, report the physical Resident #7 and Resident #8		will be reviewed at the mont	hly QAPI	
		The allegation was not	Parket and the same and the sam	meeting for three months to	ensure	
	reported until 8/7/19.			compliance.	:	
	The findings include:		11 mm 17 Mil 17 17 17 17	Compliance Date: 10/5/19		
	limited to: dementia, pressure and history The most recent MDs assessment, a quarte assessment reference resident as scoring a interview for mental stresident was capable decisions. The resident independent or only a from the staff for her The nurse's note date documented in part, physical altercation was scratches along her are or discomfort express ROM (range of motion limits). Response: Two and police report was	es that included but were not depression, high blood of suicidal ideations. 6 (minimum data set) erly assessment, with an e date of 5/7/19, coded the "14" on the BIMS (brief status) score, indicating the of making daily cognitive ent was coded as being requiring limited assistance activities of daily living. ed, 8/6/19 at 10:38 p.m. "Situation: Resident was in a with another resident sment: Resident has several neck and forehead. No pain sed. Able to ambulate and son) WNL (within normal to residents were separated is filed in (name of county). tor/nurse practitioner) and				
	"Focus: I sometimes	1/3/19, documented in part, have behaviors which ith other residents care.				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		495299	B. WING				C 09/05/2019
NAME OF PI	ROVIDER OR SUPPLIER	-1		;	STREET ADDRESS, CITY, STATE, ZIP CODE		00,00,2010
CLIZADET	H ADAM CRUMP HEAL	TU AND DEMAG		:	3600 MOUNTAIN ROAD CORREC	CTED COPY	<i>'</i>
ELIZABE	H ADAM CROWL HEAL	IN AND REMAD		,	GLEN ALLEN, VA 23060		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(XS) COMPLETION DATE
F 609	Continued From pag	e 13	F	609	9		
	Closing door to room be open. Making fals anxious, and refusal living] (showers). Is with other resident the "Interventions" of 1/3/19, "Attempt interbegin. Give me my nordered. Let my phy are interfering with mam not in pain or und to my psychologist/p to me unhurriedly an "Interventions" dated	when roommate request it is allegations, becoming of ADL [activities of daily ometimes have arguments at can become physical." locumented and dated rentions before my behavior nedications as my doctor has sician know if my behaviors by daily living. Make sure I comfortable. Please refer me sychiatrist as needed. Speak d in a calm voice." The 1, 8/7/19, documented, "Do others who disturb me. Help					
	with diagnoses that ito: anxiety disorder, pressure, dementia, mental disorder charmania and depression. The most recent MD assessment, a quart assessment reference resident as scoring a interview for mental resident was capable decisions. In Section resident was coded a	and bipolar disorder (a acterized by episodes of on) (1). S (minimum data set) erly assessment, with an ee date of 5/7/19, coded the "13" on the BIMS (brief status) score, indicating the e of making daily cognitive G - Functional Status, the as being independent in all of except toileting, personal					
	documented in part,	ed, 8/5/19 at 10:31 p.m. "Situation: Resident got into with another resident	A PRINTE LITERAL AND THE AND A PRINTE LITERAL AND ADDRESS OF THE A		Company of the Compan		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION			SURVEY PLETED
		######################################						С
		495299	B. WING				09	/05/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT	E, ZIP CODE		
ELIZABET	TH ADAM CRUMP HEAL	TH AND DEHAR			3600 MOUNTAIN ROAD	CORRECTED C	OPY	
CLICADE	TH ADAM CRUME HEAD	TH AND KEHAD			GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD I ED TO THE APPROPR FICIENCY)	BE	(X5) COMPLETION DATE
		(m. 1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1			TI VI		***	
F 609	Continued From pag	je 14	F	609	9			
	[Resident #7]. Asset	ssment: Resident's face was			ACCUSED ON A SECOND			
	flushed red. No app	parent injuries were found at						
	this time. States she	e was pushed to the floor but			44			
		te with no issues and ROM						- trib
	(range of motion) W	NL (within normal limits).						
	Denies any pain or o	discomfort. Response:						
	Residents were sep	arated. (Resident #8) was	1		A Paris			
	moved to (room nun	nber) and a police report was						
	filed in (Name of cou	unty). MD (medical doctor)	1		A AND BELL			1
	and RP (responsible	e party) made aware."			A PARTY CONTRACTOR OF THE PART			
	The care plan dated	I, 9/18/18 and revised on	4					:
	•	in part, "Focus: I sometimes						
		ch include walking up and						
		ng false statements, increase						:
	anxiety. I enjoy the	=			1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
	companions, pacing							:
		ily redirected. I tend to leave			a reprintant			
		n the bathroom, refusal of			acres on			\$
	,	have linens changed. I tend	Ì		v-intermed to			
	,	er guard. I sometimes have			and the state of t			
	1	er residents that can become			** III - ****			
		ventions" dated, 9/18/18,			***			
	documented, "Give	me my medications as my						
	doctor has ordered.	Let my physician know if my						
	behaviors are interfe	ering with my daily living.						
	Please refer me to r	ny psychologist/psychiatrist						
	as needed. Speak to	o me unhurriedly and in a			Annual America			1
	calm voice." The "In	terventions" dated 8/6/19,			V VALUE AND A STATE AND A STAT			
	documented, "Do no	ot seat me around others who	4		200			
	disturb me. Help me	e to avoid situations or people			a common A const			
	that are upsetting to	me."	and the second s					
	The "Facility Report	ed Incident" dated, 8/7/19,	11.		V V			
	· · · · · · · · · · · · · · · · · · ·	"Incident date: 8/6/19.	1					
		(Resident #7) and (Resident	ļ.		A solution of the solution of			
		ck mark was documented			and the state of t			
		dent #7) noted with red						
		nd foreheadDescribe						

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-	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION			(X3) DATE COMP	SURVEY LETED
		40-000					(c
		495299	B. WING				09/	05/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS.	CITY, STATE	, ZIP CODE		
FI IZARET	H ADAM CRUMP HEALT	TH AND REHAR		3600 MOUNTAIN R	OAD	CORRECTED CO	PY	
	The state of the s	THE NAME OF THE PARTY OF THE PA		GLEN ALLEN, VA	23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	CORRECTIVE REFERENCE	AN OF CORRECTION /E ACTION SHOULD B ID TO THE APPROPRI/ ICIENCY)		(X5) COMPLETION DATE
F 609	Continued From page	e 15	F6	09				:
	Incident: Resident to	resident altercation between	To the state of th					
	(Resident #7) and (Re	esident #8). (Resident #8)	,					:
1	was reading a book a	nd got upset at (Resident		an or of a definition				
:		on the phone. (Resident		4				
	#8) grabbed (Resider	nt #7)'s arm and (Resident		100				
		t #8). (Resident #8) fell with	1	de allerande.				
:	no injuries noted. Res			AND ADDRESS.				:
		t#8) moved to a different						
	unit/room."							
	The "Final Deport" do	atod 9/0/10 documented in						: :
	-	ited, 8/9/19, documented in I Report regarding the initial						:
	•	ouse/mistreatment regarding						
:		sident #8) reported August						
		Summary: Resident to						:
		etween (Resident #7) and						
		oorted. (Resident #8) was		; !				:
		ot upset at (Resident #7)						
		the phone. (Resident #8)		r.				!
:	grabbed (Resident #7	')'s arm and (Resident #7)						
	pushed (Resident #8)). (Resident #8) fell with no		A 1				:
	injuries noted. Resid							
:		t #8) moved to a different		A Committee of the Comm				
		#7) was noted to have red		er cannow was				
	scratch marks on her			d.				:
		t noted with any injuries.		a a a a a a a a a a a a a a a a a a a				
	Staff report that they	aid not withess the r interview with (Resident		Was made				
		stated (Resident #8) does	!	8				İ
		on her cell phone. When		A 100				
:		nto the room, she started		a AA				
4	pacing around and m			Andrew 71				:
		as saying. (Resident #7)	and the second s	ens source				:
		(Resident #8) went into a		10.00 m				:
	'rage.' (Resident #8) t		The state of the s	A AMustiness A.				
		he room and she told her		- Para -				
		abbed (Resident #7)'s arm	App.	200				4
	· · ·	ut and away from her. By	4	1.00				1
		n the floor. Upon further	1	N LANGUAGE				

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495299	B. WING			ļ	C /05/2019	
NAME OF PE	ROVIDER OR SUPPLIER		L	T	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	703/2019	
, , , , , , , , , , , , , , , , , , , ,					3600 MOUNTAIN ROAD CORRECTED C	OPV		
ELIZABET	H ADAM CRUMP HEAL	TH AND REHAB			GLEN ALLEN, VA 23060	OF I		
(VA) ID	SUMMARYST	ATEMENT OF DEFICIENCIES	QI .	<u></u>	PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE	
F 609	Continued From page	e 16	F	60	09			
:	interview with (Resid	ent #8) by Social Worker,	1		i de la companya de l		:	
	•	was in their room trying to			The state of the s			
		(Resident #7) suddenly					1	
		ed (Resident #8) down, and						
	· ·	tesident #7) and Resident	ŀ				: :	
	#8)'s care plans were	reviewed and revised. Both						
	residents have not ha	ad a change in mood or			A THE ANALYSIS			
	behavior. The reside	nts will continue to be						
:	_	es in mood or behaviors and			e many year		:	
		th the physician as needed.						
		n the investigation, the	4					
	-	tiates a resident to resident						
		between the residents per ents. (Resident #8) was						
	moved to another un	•						
		Services met with (Resident					:	
:	•	b) to ensure no apparent						
		Social Services will continue						
	•	social harm and follow up as						
	needed."	·						
:	An interview was con	nducted with CNA (certified			To the second se			
		on 9/5/19 at 9:10 a.m.,					:	
		s staff follows if they observe					4	
		other resident. CNA #1						
		parate the residents then						
	notify the charge nur	se."	11111					
			4					
		nducted LPN (licensed						
	•	he unit manager, on 9/5/19					Ì	
		asked what she would do if					i I	
		lent strike another resident, ould first separate them,					i t	
		nt. Notify the director of					ļ.	
		nistrator. We'd have to notify	1				*	
	-	ctitioner and the responsible	4.0		t op a management		ŧ	
		f she were involved with	- Amazan				:	
		of abuse to the state agency,					:	
		she reports to the DON						

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
							С
		495299	B. WING		**************************************		09/05/2019
NAME OF PE	ROVIDER OR SUPPLIER		~d~~~~~~~	Π	STREET ADDRESS, CITY, STATE, ZIP CODE		
					3600 MOUNTAIN ROAD CORRECTED	COPY	l
FLIZABET	H ADAM CRUMP HEALT	H AND REHAB			GLEN ALLEN, VA 23060		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG	• • • • • • • • • • • • • • • • • • • •	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 609	Continued From page	s 17	· E	60	10		:
. 000	, -	> 11		UU			:
	(director of nursing)."		WH CH		An Administra		
	staff member (ASM)	ducted with administrative #1, the director of nursing, n. regarding the process	ACCUPATION OF STATE O				
;	staff follows when a re	esident strikes another	-		the continues to the co		:
:	resident. ASM #1 stat		A seeman		1994 199		
		assessed for injury. The	WAR 15.54 AMS		Annual of the state of the stat		:
:	director of nursing an		*****				
		d why the incident between ident #8, was not reported	A - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 -		4 4		
		#1 stated she believed that	A response				:
		nent was only for when	-				:
	serious injuries occur	_					i
1	The facility policy, "Re	esident Abuse" documented					•
	•	in the nature and dignity of					:
		lity that he/she be afforded					i e
:		ncluding the right to be free			1		
:	from abuse, neglect r						:
		roperty. Procedure for			\$:
	_	All incidents of resident rted immediately to the					:
	•	arge, Director of Nursing, or	10 JOHN 1 SERVICE		THE PROPERTY OF THE PROPERTY O		:
		ce reported to one of those					
		escribed forms are to be	4 1 14 common 200 C		*		
	•	red to the Abuse coordinator	American Artistan				
	or his/her designee for	or an investigation. B. The	W 444				1
	Abuse Coordinator of	Facility will endeavor to	The second secon				:
		esidents and employees.					
		cognized that preliminary					·
:	•	sometimes be clouded by	A THE PERSON NAMED IN COLUMN 1				!
		ors that are relevant and	ļ				
:	•	during a full investigation in					
		r picture of what actually					
:	happened. Thus, wh				Transcension to		:
		suspend a suspect pending n suspension is not to be	W and a		and desired		4
:		sment of guilt3. Review of	Canada Rain				1
		and a guitano. Neview of			§		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		ATE SURVEY OMPLETED
							С
		495299	B. WING			(09/05/2019
NAME OF PE	ROVIDER OR SUPPLIER			Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
13 4 DET	** AD 445 OD(130 LIFEA)	TIS AND DELLAD			3600 MOUNTAIN ROAD CORRECTED	COPY	
ELIZABET	H ADAM CRUMP HEAL	IH AND REHAB			GLEN ALLEN, VA 23060		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID.	<u> </u>	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	-	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	COMPLETION DATE
F 609	Continued From page	e 18	E E	60	00		
		pleted, the investigation's	-	00			
		ved by the Director of	A A straint of A A				
!	•	Coordinator and one other	A transmitter to a				
	-	nemberNote: See state	A A		un h		
	specific guidelines fo				\$ 2		
	oposiio gaiasiii io	abass reperting.					
	The facility policy, " F	Resident Abuse - Resident -					
		ented in part, "Residents					
		ed to about by anyone,					
:	including but not limit	ted to facility staff, other	4				1
	residents, consultant	s or volunteers, staff of other					
	•	individual, family members			\$ \$ \$		
		iends or other individualsA	4		:		ı
	DOCUMENTED inve	-			·		1
		or of Nursing, or their	1				:
:	•	nitiated within twenty -four					
	, ,	owledge of the alleged					
		gation included talking with and indirectly), any family					
:		s involved, and any visitor or					
		8. The Administrator,					** *
		or their designee, must notify					
		Service Agency and the local					
		alleged abuse per state					
		our knowledge of the alleged	100				
	incident. 9. The Stat	te Department of Health is to	40 manuary 1 m				*
:	be notified by the Ad	ministrator, Director of	A		***		
	Nursing or their design	gnee of the facility's	1				
	_	nt to resident altercations in					
:		ijured to the extent that					
	physical intervention						
·		ital is required per state	A		!		
	specific protocols."						
	ACM #41 +b dimenter	of auraina	AAA				
		of nursing, was made aware	1				
:	or the above concern	n on 9/5/19 at 2:53 p.m.	W 1.00.00		**************************************		1
:	No further information	n was provided prior to exit.	A COMPANY				Vanadoria
:	record mornida		and the character and				See .

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

Event ID: YPPK11

Facility ID: VA0083

If continuation sheet Page 19 of 33



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		495299	B. WING			000	1	
NAME OF P	ROVIDER OR SUPPLIER			S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 09/1	05/2019	
EI IZADET	H ADAM CRUMP HEALT	TH AND DEHAR		36	MOUNTAIN ROAD CORRECTED COPY			
ELIZABET	H ADAM CROWP HEAL	TH AND REMAD		G	LEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 609	Continued From page	e 19	F	609		:		
		y of Medical Terms for the 5th edition, Rothenberg and				:		
	Qrtly Assessment at I CFR(s): 483.20(c)	Least Every 3 Months	F	638	F638		10/5/19	
	§483.20(c) Quarterly A facility must assess quarterly review instrand approved by CM once every 3 months. This REQUIREMENT by: Based on staff interverview, and clinical redetermined the facilit MDS (minimum data scheduled time frame the survey sample, R. #8. The facility staff fassessment within the days from the previous #5, #6, #1, #7 and #8. The facility staff fa assessment within the days from the previous #5, #6, #1, #7 and #8. Resident #5 was admitted to: Parkinson progressive neurolog	a resident using the ument specified by the State S not less frequently than is not met as evidenced iew, facility document ecord review, it was y staff failed to complete the set) assessment within the efor five of eight residents in lesident #5, #6, #1, #7, and ailed to complete the MDS escheduled time frame 92 us assessment for Resident 8.			 Resident #1, #6, #7, and #8 quarterly assessments will be complete 9/27/19. Resident #1 quarterly assessment was completely assessment be completed within the sched time frame of 92 days from the previous assessment. An audit will be conducted to ensure quarterly assessment has been completed within the scheduled timeframe of 92 day the previous assessment. MDS Coordinators will be reducated by the Regional MDS Consultant/Designee on complete quarterly assessments within the scheduled timeframe of 92 day the previous assessment. Audits will be conducted by Administrator/Designee to ensure the previous assessment. 	oleted ts will uled o ave es from eting he vs from the ure		
		expressions sometimes	tremmun a coldado aldeir i Dilli Bull		quarterly assessment have bee completed within the schedule			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		495299	B. WING		C 09/05/2019
ELIZABETH ADAM CRUMP HEALTH AND REHAB 3600 MOUNTAIN ROAD GLEN ALLEN, VA 23060				STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD CORRECTED C GLEN ALLEN, VA 23060	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 638	impaired perceptions state of mild to severe without specific cause such as quickened he epilepsy (neurological recurrent episodes of the most recently ME quarterly assessment reference date) of 5/6 resident's BIMS (brief a 15 out of 15 indicate cognitively intact. A review of the MDS (electronic medical refollowing assessment with was transmitted and assessment with an A but was not complete. An interview was connurse) #1, the MDS of PM. When asked the completion of the MD completed within 14 owithin 90 days and not the set due date". We delay in completion, for the only person till Mathree weeks with emeasked process for compactivities complete set as the set of the set of the process for compactivities complete set as the set of the set of the process for compactivities complete set as the process for compactivities compactivities compactivities compactivities compactivities compactivities compactivi	antal disorder in which ached from reality and has a (2), anxiety disorder (a exprehension, often exprehension, of exprehension, of exprehension, exprehension, of exprehension, of exprehension, exprehension	F 63	timeframe of 92 days from the previous assessment weekly tin four weeks then monthly times three months. Results of the a will be reviewed at the monthly meeting for three months to sucompliance. Compliance Date: 10/5/19	udits y QAPI

PRINTED: 09/26/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL [*] A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495299	B. WING			1	C (05/2040	
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 09	/05/2019	
MANIE OF TE	COVIDEN ON GOT FEEN			1	3600 MOUNTAIN ROAD CORRECTED	ากกง		
ELIZABET	H ADAM CRUMP HEAL	TH AND REHAB			GLEN ALLEN, VA 23060	JUFI		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 638	Continued From pag	e 21	F	638	8			
		nember (ASM) #1, the vas made aware of the above 2:45 PM.						
	Kaplan 2. Barron Dictionary Kaplan 3. Barron Dictionary Kaplan	of Medical Terms 7th edition,						
		iled to complete the MDS ne scheduled time frame for						
	12/1/2015 with diagr limited to: Alzheime of mental ability and by personality chang (1), major depressive mind with feelings of and hopelessness) (of mild to severe app	mitted to the facility on noses that include but are not r's disease (progressive loss function, often accompanied ges and emotional instability) e disorder (dejected state of sadness, discouragement 2), anxiety disorder (a state prehension, often without ing in body changes such as and sweat) (3).						
	quarterly assessmer reference date) of 5/ resident's BIMS (brie was a 03 out of 15 (i cognition). The resid	ubmitted MDS assessment, a nt, with an ARD (assessment 24/2019, coded that the ef interview for mental status) indicating severely impaired dent's functional status was setup help only with transfer,	Action (Alberta N. Acadesa (e. e. e. Acadesa (e. e. Acadesa (e. e. e. e. Acadesa (e. e. e. e. e. Acadesa (e. e. e. e. e. e. e. e. e. Acadesa (e. e. e					

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

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Facility ID: VA0083

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ALTH AND REHAB		360	REET ADDRESS, CITY, STATE, 00 MOUNTAIN ROAD .EN ALLEN, VA 23060					
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F 638	and eating; two per dressing and toiler dressing and toiler. A review of the MI (electronic medical following assessment with an ARD (assessment annual assessment with a progress but not completed within within 90 days and the set due dater. delay in completion of the completed within within 90 days and the set due dater. delay in completion of the completed within within 90 days and the set due dater. delay in completion of the complete section activities completes completes section though. Administrative standirector of nursing concern on 9/5/19	priridor, locomotion on/off unit berson assist with bed mobility, it use. DS section of the EMR all record), documented the ments. A quarterly assessment bessment reference date) of mitted and accepted. The mit, with an ARD of 9/18/18 was accepted. A significant change an ARD 8/12/19, was in completes as of 9/5/19. Conducted with RN (registered S coordinator on 9/5/19 at 5:00 the time frame for the MDS, RN #1 stated, "It is to be 14 days, quarterly assessments of no longer than 14 days after When asked why there was a m, RN #1 stated "Staffing, I was I May, then I've been out sick for emergency surgery". When completion, RN #1 stated, completes sections C, D, E, Q; as section F, and dietary K. I have to finalize the MDS	F	638						
	Kaplan	ry of Medical Terms 7th edition,	A SA MARANA MANAGANA	n = 1611 tên bil 1.00m.WHXW88						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/26/2019 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 495299 B. WING 09/05/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD CORRECTED COPY **ELIZABETH ADAM CRUMP HEALTH AND REHAB** GLEN ALLEN, VA 23060 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 638 Continued From page 23 F 638 3. Barron Dictionary of Medical Terms 7th edition, 3. The facility staff failed to complete a quarterly assessment within 92 days from the previous assessment for Resident #1. Resident #1 was admitted to the facility on 8/17/17 with a recent readmission on 8/20/19, with diagnoses that included but were not limited to: dementia, depression, high blood pressure, anxiety disorder, and frequent falls. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date (ARD) of 5/3/19, coded the resident as scoring a "3 out of 15" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded in Section G - Functional Status as requiring extensive assistance of one or more staff members to complete her activities of daily living. A review of the MDS section of the electronic medical record documented the following assessments. A significant change assessment with an ARD of 4/18/19 was transmitted and accepted. A significant change assessment with an ARD of 5/3/19 was documented as transmitted and accepted. A quarterly assessment with an ARD of 7/31/19 was documented as "In progress." Thus, not completed and not transmitted.

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An interview was conducted with RN (registered nurse) #1, the MDS coordinator; on 9/5/19 at 10:45 a.m., RN #1 was asked to review the MDS section of the electronic medical record. When

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Facility ID: VA0083

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION	(X:	3) DATE SURVEY COMPLETED
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	transmitting a quarte stated, "I have 14 da When asked what h MDS assessment w stated, "Honestly, I j with MDS and I had to emergency surge what reference or pocomplete the MDS at they use the RAI (reinstrument) manual. Administrative staff director of nursing, a concern on 9/5/19 at No further information. A. The facility staff fam MDS assessment w Resident #7. Resident #7 was ad 10/5/18 with diagnoral limited to: demential pressure and history. The most recent MD assessment reference assessment reference resident as scoring interview for mental resident was capable decisions. The resident promote the staff for he	uirements for completing and erly assessment, RN #1 ays after the ARD date." appened with the quarterly ith an ARD of 7/31/19, RN #1 ust got an assistant to help to be out for three weeks due ry. I am behind." When asked olicy the facility uses to assessments, RN #1 stated, sident assessment member (ASM) #1, the was made aware of the above		538			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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PREFIX (EACH (DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
assessments ARD of 2/9/1 quarterly ass documented annual asses documented completed an An interview nurse) #1, th 10:45 a.m., F section of the asked about transmitting a stated, "I hav When asked MDS assess stated, "Hone with MDS an to emergenc Administrativ director of nu concern on 9 5. The facility MDS assess Resident #8 with diagnos to: anxiety di pressure, de mental disore mania and de The most rece	ord documents. A quarter of the request of the representation of the request of t	nented the following terly assessment with an ansmitted and accepted. A twith an ARD of 5/7/19 was mitted and accepted. An with an ARD of 8/6/19 was rogress." Thus, not ansmitted. ducted with RN (registered coordinator; on 9/5/19 at as asked to review the MDS nic medical record. When irements for completing and refly assessment, RN #1 rys after the ARD date." ppened with the annual h an ARD of 8/6/19, RN #1 st got an assistant to help to be out for three weeks due ry. I am behind." member (ASM) #1, the as made aware of the above 2:53 p.m. led to complete an annual h an ARD of 8/6/19 for mitted to the facility on 8/3/18 recluded but were not limited resomnia, high blood and bipolar disorder (a recterized by episodes of	F	638			

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 495299 B. WING 09/05/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD CORRECTED COPY ELIZABETH ADAM CRUMP HEALTH AND REHAB GLEN ALLEN, VA 23060 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 26 F 638 assessment reference date of 5/7/19, coded the resident as scoring a"13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. In Section G - Functional Status, the resident was coded as being independent in all of her activities of living except toileting, personal hygiene and bathing. A review of the MDS section of the electronic medical record documented the following assessments. A quarterly assessment with an ARD of 2/9/19 was transmitted and accepted. A quarterly assessment with an ARD of 5/7/19 was documented as transmitted and accepted. An annual assessment with an ARD of 8/7/19 was documented as "In progress." Thus, not completed and not transmitted. An interview was conducted with RN (registered nurse) #1, the MDS coordinator; on 9/5/19 at 10:45 a.m., RN #1 was asked to review the MDS section of the electronic medical record. When asked how often must assessments be completed and transmitted by, RN #1 stated, "I have 14 days after the ARD date." When asked what happened with the annual assessment of 8/6/19, RN #1 stated, "Honestly, I just got an assistant to help with MDS and I had to be out for three weeks due to emergency surgery. I am behind." Administrative staff member (ASM) #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:53 p.m.

Chapman, page 72.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and PRINTED: 09/26/2019

PRINTED: 09/26/2019 FORM APPROVED OMB NO. 0938-0391

F 640 Encoding/Transmitting Resident Assessments SS=D CFR(s): 483.20(f) (1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: PREFIX TAG PREFIX	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD CORRECTED COPY GLEN ALLEN, VA 23060 ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 640 Encoding/Transmitting Resident Assessments SS=D CFR(s): 483.20(f)(1)-(4) \$483.20(f) Automated data processing requirement- \$483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD CORRECTION GLEN ALLEN, VA 23060 ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1. Resident #1 discharge, return anticipated assessment has been completed and transmitted. 2. An audit will be conducted to ensure discharge, return anticipated			A95299	R WING					
SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREVIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DEFICIENCY DEFICIE	NAME OF PROVIDER	D AD SHODHED	433233			TOTET ADDRESS OFFICE THE CODE	09/	05/2019	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 640 Encoding/Transmitting Resident Assessments SS=D CFR(s): 483.20(f)(1)-(4) \$483.20(f) Automated data processing requirement- \$483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: PREFIX TAG CROCK-RECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 1. Resident #1 discharge, return anticipated assessment has been completed and transmitted. 2. An audit will be conducted to ensure discharge, return anticipated					36	600 MOUNTAIN ROAD CORRECTED CO	PΥ		
SS=D CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: 1. Resident #1 discharge, return anticipated assessment has been completed and transmitted. 2. An audit will be conducted to ensure discharge, return anticipated	PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT			(X5) COMPLETION DATE	
(ii) Annual assessment. (iii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (iv) A subset of items upon a resident's transfer, reentry, discharge, and death. (iv) Background (face-sheet) information, if there is no admission assessment. § 483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. § 483.20(f)(3) Transmittal requirements. Within 14 days after a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (iii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior quarterly assessment. (iv) Quarterly review. (vii) A subset of items upon a resident's transfer,	SS=D CFR(s §483.2 require §483.3 a facility each r (i) Adr (ii) Sig (iv) Qu (v) As reentry (vi) Ba is no a §483.2 after a a facility each r (vi) Ba is no a §483.2 after a a facility contain standa and th CMS s encode the CM (i) Adr (ii) Adr (ii) Adr (ii) Adr (iii) Sig (v) Sig assess (vi) Sig assess (vi) Qu	(s): 483.20(f)(1) 2.20(f) Automate irement- 2.20(f)(1) Encodi illity completes a ty must encode resident in the imission assessment	d data processing Ing data. Within 7 days after Iresident's assessment, a Ithe following information for facility: Interest to the facility information for facility: Interest to the facility information for facility: Interest to the facility information for the facility information for the Interest to the facility information for each resident Interest to the facility information for each resident Interest to the facility information for each facility information for each facility information for each resident's Interest to the facility information for each facility information for each facility information for each facility information for each facility information for facility i		640	 Resident #1 discharge, return anticipated assessment has been completed and transmitted. An audit will be conducted to ensure discharge, return anticipates assessments have been completed and transmitted within the scheduled timeframe. MDS Coordinators will be reeducated by Regional MDS Consultant/Designee on discharge return anticipated assessments a completed and transmitted with the scheduled timeframe. Audits will be conducted by the Administrator/Designee to ensure discharge, return anticipated assessments are being completed and transmitted within the scheduled timeframe weekly time four weeks then monthly times to months. Results of the audits with reviewed at the monthly QAPI meeting for three months to suscompliance. 	ge, peing in ne re d three ill be	10/5/19	

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Event ID: YPPK11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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F 640	Continued From page	e 28	F6	40		:	
	reentry, discharge, a (viii) Background (facinitial transmission of does not have an add §483.20(f)(4) Data for transmit data in the for a State which has by CMS, in the formal approved by CMS. This REQUIREMENT by: Based on staff interview, it was determed.	nd death. ce-sheet) information, for an f MDS data on resident that mission assessment. rmat. The facility must ormat specified by CMS or, an alternate RAI approved at specified by the State and I is not met as evidenced riew and clinical record nined the facility staff failed to be assessment within the	THE CONTROL OF THE CO				
	discharge, return ant	d to complete and transmit a icipated, assessment, with ence date (ARD) of 8/17/19	Miles and the second control of the second c				
	The findings include:		Hydratholts : de :	7		:	
	8/17/17 with a recent with diagnoses that in	nitted to the facility on readmission on 8/20/19, ncluded but were not limited sion, high blood pressure, I frequent falls.	PRODUKTU ALIMAN MINIMU FINI KANCHUNGA () NY 1715 A 7184 A				
	assessment, a signification with an assessment of 5/3/19, coded the rest 15" on the BIMS (briescore, indicating the impaired to make dainesident was coded in the significant of the second of the sec	S (minimum data set) icant change assessment, reference date (ARD) of sident as scoring a "3 out of ef interview for mental status) resident was severely ily cognitive decisions. The n Section G - Functional xtensive assistance of one or					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		**************************************	3) DATE SURVEY COMPLETED	
		495299	B. WING			C	
NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB				3	TREET ADDRESS, CITY, STATE, ZIP CODE 600 MOUNTAIN ROAD CORRECTED COPY 6LEN ALLEN, VA 23060	09/05/2019	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 640	more staff members to complete her activities of daily living. A review of the MDS section of the electronic medical record documented the following assessments. A significant change assessment, with an ARD of 5/3/19 that was completed and transmitted. A discharge - return anticipated assessment, with an ARD of 8/17/19, documented, "In Progress." When asked how long she has to complete a discharge assessment, RN #1 stated she had 14 days after the ARD to complete it and transmit it. When asked what happened with the discharge assessment of 8/17/19, RN #1 stated, "Honestly, I just got an assistant to help with MDS assessments. I had to be out for three weeks due to emergency surgery. I am behind." Administrative staff member (ASM) #1, the director of nursing, was made aware of the above concern on 9/5/19 at 2:53 p.m.		F 640				
	Quality of Care CFR(s): 483.25 § 483.25 Quality of care is a furth applies to all treatment facility residents. Basessement of a resident residents receive accordance with professor practice, the compreheare plan, and the residents.	ndamental principle that int and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of lensive person-centered	Colored Colored for the statement of the	684	 Resident #1 antibiotic is now completed. An audit of residents receiving antibiotics will be conducted to ensure administered per physiciar orders. Licensed nurse will be re-educa by DON/Designee on administering 	ted	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	,	495299	B. WING _		117	ĺ	C 05/2019
NAME OF PROVIDE	R OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
ELIZABETH ADAM CRUMP HEALTH AND REHAB					00 MOUNTAIN ROAD CORRECTED CO LEN ALLEN, VA 23060)PY	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
Base revier ensure #1) revier ensure ensu	X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 6	584	antibiotics per physician's order include checking stat book for availability. 4. Audits will be conducted by DON/Designee on ensuring resi are receiving antibiotics per physician's orders weekly times weeks then monthly times three months. Results of the audits wereviewed at the monthly QAPI meeting for three months to su compliance. Compliance Date: 10/5/19	dent four e vill be	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		495299 B. WING		~		0.	C 9/05/2019	
NAME OF PROVIDER OR SUPPLIER				-	STREET ADDRESS, CITY, STATE, ZIP CODE		7/03/2019	
					3600 MOUNTAIN ROAD CORRECTED	COPY		
ELIZABET	H ADAM CRUMP HEAL	TH AND REHAB		,	GLEN ALLEN, VA 23060			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	F 684 Continued From page 31		F	684	4			
	"7" indicated, "Other/	see nurse's note."	TWO IN		THE ANNIA COLUMN			
	The nurse's note dated, 8/9/19 at 9:42 a.m. documented the physicians order above and "pharmacy notified."		e comment					
	revised on 2/12/19, of Alteration in elimination urge incontinence, to "Interventions" docur fluids. Evaluate freque pisodes. Monitor an symptoms) of UTI (urgential and the symptoms) of UTI (urgential and the symptoms) of UTI (urgential and the symptoms) and the symptoms) of UTI (urgential and the symptoms) and the symptoms) of UTI (urgential and the symptoms) and the symptoms are symptoms) of UTI (urgential and the symptoms) and the symptoms are symptoms) and the symptoms are symptoms.	mented in part, "Encourage lency/timing of incontinence ld report S&S (signs and rinary tract infection): or or consistency of urine,						
	supply box were revi was listed as in the S	STAT (immediate) drug ewed. The following drug STAT box: Nitrofurantoin acrobid) 100 mg - quantity 4						
	nurse) #2 on 9/5/19 a process staff follows not available for adm "First you check the	nducted with RN (registered at 11:06 a.m., regarding the if a prescribed medication is sinistration. RN #2 stated, STAT box. If [the medication the pharmacy and you call their instructions."						
	practical nurse) #1 or regarding the proces medication is not ava LPN #1 stated, "Usur nurse practitioner. Yout why is isn't here.	nducted with LPN (licensed in 9/5/19 at 11:10 a.m., is staff follows if a prescribed allable for administration. ally you contact the doctor or ou call the pharmacy to find if it is on hand in the STAT rom the STAT box first, and						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495299	B. WING		MANAGEMENT AND	09/0) 05/2019
NAME OF PROVIDER OR SUPPLIER ELIZABETH ADAM CRUMP HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 3600 MOUNTAIN ROAD CORRECTED CO GLEN ALLEN, VA 23060			30,2013
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR		ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE	
F 684	contents of the STAT reviewed with LPN # listed Macrobid as av Administrative staff in nursing, was made a on 9/5/19 at 2:53 p.m. No further information (1) This information of following website:	teps if it's not there. The box on Unit A were 1. The STAT box contents railable in the STAT box. nember #1, the director of ware of the above findings	F	684			





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