STATEMENT OF DEPICIENCIES (X1) PROVIDER/SUPPLIENCLIA AND PLAN OF COPRECTION IDENTIFICATION NUMBER.		(X2) MULT A. BULLOR	PLE CONSTRUCTION IG	OMB NO. 0936-0 (x3) DATE SURVEY COMPLETED	
		495392	8, WING		04/99/00005
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/23/2020
IGGIWAK	R HEALTH AND REHA	B CENTER		44 CIAMONO BRIVE PETERSBURG, VA 23803	
(XA) ID PREFIX TAG	PEACH DEFICIEN	STATEMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 000	Initial Comments		εα	00	
	survey was conducts 01/23/2020. The fac compliance with 42 C Requirement for Long	g-Term Care Facilities. No etigated during the survey.	F00		
	survey was conducted 1/23/2020. No compti Corrections are required.			RECEIVE JAN 3 1 20	20
, e c , ti	at the time of the survi consisted of 14 curren hree closed record re			VOHIOL	,C
	ree of Accident Haza CFR(s): 483.25(d)(1)(rds/Supervision/Devices 2)	F 689	Director of Nursing implemented failmats per plan. Resident #202 experienced no negative ocome.	care D2/13/2020 ut-
9	483.25(d) Accidents. he facility must ensur 483.25(d)(1) The resi s free of accident haz	e that - dent environment remains ards se is possible; and		2. Any resident has the potential to be effected fall mats are not implemented per physician orders, Audit completed to identify residents fall mat orders, no other residents have beel identified to not have fall mats in place according to the control of the c	with
Su	upervision and assists ocidents. his REQUIREMENT	ident receives adequate unce devices to prevent is not met as evidenced		to care plan and physician orders. 3. Nursing staff will be aducated on this standard ensure compliance for all fall mats to be in place indicated per the residents care plan.	l to
B ar pr	ased on observations to staff interview, the ovide assistive device	n. clinical record review, facility staff falled to as to prevent accidents for sample. Resident #202.		4.Director of nursing or designee will conduct re- rounds of residents with fall mats care planned in ensure proper placement (weekly 5 times a weekly four weeks, then weekly for two months.)	o l

Kanneth W. Byers.

Any deficiency statement ending with an esterois (") denotes a deficiency which the inetitation may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for running homes, the findings stated above are disclosable 80 days following the date of survey whether or not a plan of correction is provided. For running homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deliciencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2587(02-99) Previous Versions Obsoless

Event ID: Y46811

Facility ID: VA0397

01/31/2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FO	ED: 01/24/20 RM APPROV
STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA EDENTIFICATION NUMBER 495398		(X2) MRJETIP	LE CONSTRUCTION	(X3) DAT	<u>(O. 0938-03</u> TE BURVEY MPLETED	
		B. WING				
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS CITY, STATE, ZIP CODE		1/23/2020
DINWIDD	IE HEALTH AND REHAB	CENTER	1	46 DIAMONO DRIVE PETERSBURG, VA 23803		
(X4):D PREFIX TAG	EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED OPPICIENCY)	DBE	COMPLETION CATE
F 689	F 689 Continued From page 1 Resident #202 was observed without fall mats to each side of the bed per physician orders and care plan interventions.		F 689	5.Director of nursing or designee will review au findings, and report to the QAPI committee more times three. For further analysis and recommendations.		
t	The findings include:					
* • • • • • • • • • • • • • • • • • • •	01/07/2020 with diagn encounter, heart diseas congestive heart failur kidney disease - stage pulmonary disease (CoThe most recent minim 01/14/2020 which was	s, sleep apnea, chronic 3, and chronic obstructive OPO). turn data set (MDS) dated the admission assessment				
	for daily decision makir 15. Under section G, F MDS, Resident #202 w	son physical assistance assistance with one nce for bed mobility,				
o w 1	baerved laying in the b vere observed at this tir	2 was observed laying in		RECEIVE	ם	
ol O fo ev	in 01/22/2020 at 7:15 a lectronic clinical record baserved on the physicial flowing order: "Fall ma very shift for Prophylaxi /08/2020, Start Date 0	was reviewed. an orders was the its utilized while in bed s, Order Date		JAN 3 1 2025		
A	review of Resident #20	2's care plans	Ī		1	

		AND HUMAN SERVICES			FOR	D: 01/24/20 MAPPROV D: 0938-03
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION SUPPLIER/CLIA SUPPLIER/		(X2) MULTIPLE A BUILDING	CONSTRUCTION		SURVEY PLETED	
		495398	B. WING	<u> </u>		*****
NAME OF PRO	VIDER OR SUPPLIER	·	S1	PREET ADDRESS. CITY, STATE, ZIP CODE	1 01	23/2020
DINWIDDIE	HEALTH AND REH	AB CENTER	1	DIAMOND DRIVE ETERBBURG, VA 23503		
(X4) IS PREFIX TAG)	EACH DEFICE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR USC IDENTIFYING INFORMATION!	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		ixaj Completion Dage
did	reconditioning and lagnoses) ARF (a poxia and COPD envices Interved Date Initiate /15/2020" review of the "Fall /07/2020" assess iderate fall risk. Taistory of 1-2 falls der the "Gait Analessment, Reside able to independent in independent of the place." 01/22/2020 at 7:4 erved leying In the red at this time regarding in the bed water in place. Resident #202 stated days and he was ident #202 was astance getting up ident #202 was astance getting up ident #202 stated and that he preferest. Resident #2	ilowing: "Is at risk for falls; general decline dx scute renal failure) with - admitted to Hoapice nitions:Fall mats while in d 01/07/2020, Revised I Risk Assessment, dated ed #Resident #202 as a The assessment documented within the last six months. It is section of the int #202 was assessed as ently come to a standing s of balance while standing, on assistance to move from the section. Resident #202 was a bed. No fall mats were	F 689	AN 3 2020 VIDENCE	 	
\$78.00 950		O a.m., the certified nursing who routinely provided			1	

A SUILDING COMPLETED A95398 S. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 46 DIAMOND DRIVE PETERSBURG, VA. 23903 [X4. ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (BACH DEFICIENCY MUST SE PRECEDED BY FULL PREFIX (BACH CORRECTION OR SHOULD BE COMPLETED.) TAG REGULATORY OR USC IDENTIFYING INFORMATIONS A SUILDING STREET ADDRESS, CITY, STATE, 2P CODE 46 DIAMOND DRIVE PETERSBURG, VA. 23903 PROVIDERS PLAN OF CORRECTION OR COMPLETED OF PROVIDERS PLAN OF CORRECTION OR COMPLETED.	TATEMENT	TOF DEFICIENCIES OF CORRECTION	MEDICAID SERVICES [X1] PROVIDER/BUPPLIER/CLIA ICENTIFICATION NUMBER		TPLE CONSTRUCTION	OMB !	RM APPROV NO. 0938-0: TE SURVEY
DIAMMODIE HEALTH ARD REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (M.1D SUMMARY STATEMENT OF DEFICIENCIES (M.1D SUMMARY STATEMENT OF DEFICIENCIES (M.1D SUMMARY STATEMENT OF DEFICIENCIES SOME CROSS-REFERENCE) OF THAT SECRET STATEMENT OF DEFICIENCIES DEFICIENCY TAB CROSS-REFERENCE OF THE APPROPRIATE FERSIVE CROSS-RE					vG	co	MPLETED
DANISH REALTH AND REHAB CENTER SARANT EXTREMENT OF DEFINENCES SARANT EXTREMENT OF DEFINENCES SARANT EXTREMENT OF DEFINENCES SECRETIVELY AND TEMPORARY MAST BE PRECEDED BY RULL PRETTY AND SARANT EXTREMENT OF DEFINENCES SECRETIVELY AND TEMPORARY MAST BE PRECEDED BY RULL PRETTY PRETTY TAG PROVIDED THAN OF COMMETTINE PRETTY TAG PROVIDED THAN OF COMMETTINE PRETTY TAG PROVIDED THAN OF COMMETTINE CROSS-REFERENCE TO TO THE APPROPRIATE DEFICIENCY) F 689 Sessistance to Resident #202 was interviewed regarding the use of fell mats. CNA #1 stated the (Resident #202) is on inceptice and Irm not waver of hospite or anyone also saying the needs fall mats. "CNA #1 continued and stated "the domest get up, he lays in the bed most of the firm because he is weak." On 01/22/2020 at 3:00 p.m., the director of nursing (DON) was interviewed regarding how it was communicated to staff if a readent required safety devices such as fall mats. The DON stated the intervention would show on the care plan and then transferphrint on the Kardex for the staff which the CNA reviews for the resident's care needs. On 01/22/2020 at 3:35 p.m., the above sandings were discussed with the facility administrator the director of nursing (DON) and the nurse consultant.	NAME OF F	PROVIDER OR SUPPLIES	495398	B. WING			1/23/2020
SAMMAY STATEMENT OF DEFICIENCES BEACH PETICIENCY MUST BE RECEDED BY PULL REGALITORY OR USC DENTIFYING INFORMATION F 689 Continued From page 3 assistance to Resident #202 was interviewed regarding safety interventions including the use of tall mats. CNA #1 stated The (Resident #202) is on hospice and I'm not aware of hospice or anyone also saying he needs fall mats. " CNA #1 continued and stated "the doesn't get up, he lays in the bed most of the time because he is weak." On 01/22/2020 at 3:00 p.m., the director of nursing (DON) was interviewed regarding how it was communicated to staff if a resident required safety devices such as fall mats. The DON stated the intervention would show on the care plan and then transfer/print on the Kardax for the staff which the CNA reviews for the resident's Care needs. On 01/22/2020 at 3:35 p.m., the above findings were discussed with the facility administrator the director of nursing (DON) and the nurse consultant.					46 DIAMOND DRIVE	PCODE	
assistance to Resident #202 was interviewed regarding safety interventions including the use of fail mats. CNA #1 stated "he (Resident #202) is on hospice and I'm not aware of hospice or anyone else saying he needs fail mats." CNA #1 continued and stated "he doesn't get up, he lays in the bed most of the time because he is weak." On 01/22/2020 at 3:00 p.m., the director of nursing (DON) was interviewed regarding how it was communicated to staff if a resident required safety devices such as fail mats. The DON stated the intervention would show on the care plan and then transferiprint on the Kardex for the staff which the CNA reviews for the resident's care needs. On 01/22/2020 at 3:35 p.m., the above fandings were discussed with the facility administrator the director of nursing (DON) and the nurse consultant.	PREFIX	(BACH DEFICIENCY	MUST BE DRECEDED ON BUIL	PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE M CROSS-REFERENCED TO	CTION SHOULD BE OTHE APPROPRIATE	COMPLETO JATE
VDHIOLC	a so o o o o o o o o o o o o o o o o o o	assistance to Resident regarding safety interval regarding safety interval fall mats. CNA #1 state on hospice and I'm not anyone else saying he continued and stated "hin the bed most of the till the bed most of the till continued and stated "hin the bed most of the till continued and stated the intervention was communicated to stated the intervention was and then transfer/pitalf which the CNA revision and then transfer/pitalf which the CNA revision needs.	#202 was interviewed antions including the use of ad "he (Resident #202) is aware of hospice or needs fall mats." CNA #1 le doesn't get up, he lays me because he is weak." D.m., the director of relevant regarding how it laff if a resident required all mats. The DON rould show on the care first on the Kardex for the lews for the resident's	F 68	AM.	3 · 2029	

PRINTED: 01/24/2020 FORM APPROVED

ND PLAK	nt of deficiencies Nof Correction	(X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER	(X2) MULTIPL A. BUHLDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
·····	100000000000000000000000000000000000000	VA0397	E. WING		01/23/2020
MEOF	PROVIDER OR BUPPLIER	STREET	ADDRESS, CITY, STA	ATE ZIP CONE	1 01123/2020
MAYIDD	HEALTH AND REHAE		NOND DRIVE	THE BUILT	
		PETER	98URG, VA 2380	3	
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIES EAX (EACH DEFICIENCY MUST 88 PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RF POUR
F000	Initial Comments		F 000		
F 001 1	1/23/2020. The facilit with the following Virg Licensure of Nursing I Licensure of Nursing I The census in this 60 time of the survey. The of 14 current Resident record reviews. Non Compliance The facility was out of a following state licensure the facility was not in collowing Regulations for facilities: 2VAC5-371-220 Nursin	icted on 1/21/2020 through by was not in compliance this Regulations for the Facilities. bed facility was 56 at the te survey sample consisted treviews and three closed compliance with the te requirements: as evidenced by: compliance with the or the Licensure of Nursing		12VAC5-371-220 Nursing Services 12VAC5-371-220(A) Cross References to F-8 Pease cross reference to Plen of Correction f -689.	369 for
				1AN 3 2020)

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE STATE FORM	Administrator	00/31/2020
SIMIE PUHM	G0S011	Noorpougition sheet 1 of 1