PRINTED: 03/05/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495282	B. WING		R-C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 ELM STREET LOUISA, VA 23093	12/11/2019	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
{F 000}	abbreviated survey co	edicare/Medicaid revisit to the onducted 11/04/19 through cted on 12/10/19 through	{F 00	0}		
	compliance with 42 C Term Care Requirem deficiencies are ident	FR Part 483 Federal Long				
F 657		vey. The survey sample ent resident reviews gh 110).	F 6	57	1/6/20	
SS=E	S483.21(b) Comprehe \$483.21(b)(2) A complete \$483.21(b)(2) A complete (i) Developed within 7 the comprehensive at (ii) Prepared by an inincludes but is not lim (A) The attending phy (B) A registered nurse resident.  (C) A nurse aide with resident.  (D) A member of food (E) To the extent practive resident and their resident reprotopracticable for the resident's care plan.  (F) Other appropriate	ensive Care Plans brehensive care plan must  7 days after completion of ssessment. terdisciplinary team, that hited to ysician. e with responsibility for the  responsibility for the  d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident bresentative is determined			170/20	
ARORATORY I	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATUR	 PE	TITI F	(X6) DATE	_

12/19/2019

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

Facility ID: VA0148

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		495282	B. WING			12/	11/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISA H	EALTH & REHABILITAT	ION CENTER		210 ELM STREET LOUISA, VA 23093			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	team after each asses comprehensive and comprehensive and comprehensive and comprehensive and comprehensive and clinical staff failed to review and clinical staff failed to review and comprehensive care board to the resident pressure ulcer preversure ulcer to residents in the surface and th	rised by the interdisciplinary rised by the interdisciplinary resement, including both the quarterly review  T is not met as evidenced  on, resident interview, staff I record review, the facility and revise the CCP replan) for the use of a foot shad wheelchair, and for an interventions, for one of curvey sample (Resident  admitted to the facility on a for this resident included, one anemia, chronic pain, hypothyroidism, history of an interventions, for one of curvey sample (Resident sestive heart failure), COPD outline on any disease), diabetic extremity and pressure ulcer  os (minimum data set) was sentent dated 11/26/19. This resident as having a cognitive gone the resident is intact for gone stage 3 pressure ulcer sisting to the right lower instageable (present upon	F	657	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleg deficiencies herein.  To remain in compliance with all state a federal regulations, the center has take or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center sallegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.  F-657  1. Resident #104 scare plan now includes all current interventions, include the foot box, and all pressure ulcer interventions recommended from the wound care clinic. MD and Responsible party have been notified.  2. All residents receiving positional and pressure ulcer interventions are at risk.  3. SDC or designee to educate:  a. All licensed nursing staff on updating the care plan to include all pressure	ed and en ding le d/or	
	score of 13, indicatin daily decision making documented with one (present upon admis- extremity and one un admission) to the left	g the resident is intact for g skills. The resident was e Stage 3 pressure ulcer sion) to the right lower			SDC or designee to educate:      All licensed nursing staff on updatin	g	

NAME OF PROVIDER OR SUPPLIER  LOUISA HEALTH & REHABILITATION CENTER  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 2  During initial tour of the facility on 12/10/19 at 11:00 AM, Resident #104 was observed in her room in her wheelchair. Resident #104 had bilateral leg rests to the wheelchair that were in the normal sitting position with knees bent. Resident #104 had multipodus boots to both feet.  STREET ADDRESS, CITY, STATE, ZIP CODE 210 ELM STREET LOUISA, VA 23093  F 657  COUISA, VA 23093  F 657  PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL (EACH CORRECT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	. ,	(X3) DATE SURVEY COMPLETED	
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LOUISA HEALTH & REHABILITATION CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 657  Continued From page 2  During initial tour of the facility on 12/10/19 at 11:00 AM, Resident #104 was observed in her room in her wheelchair. Resident #104 had bilateral leg rests to the wheelchair that were in the normal sitting position with knees bent. Resident #104 had multipodus boots to both feet.  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PROVIDE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PROVIDE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PROVIDE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY  PROVIDE ACTION SH			495282	B. WING _			12/11/2019	
LOUISA, VA 23093    X44   ID	NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE		
Coulsa, VA 23093   Country   Count	I OUISA H	IFAI TH & RFHARII ITA	TION CENTER		210 ELM STREET			
F 657  Continued From page 2  During initial tour of the facility on 12/10/19 at 11:00 AM, Resident #104 was observed in her room in her wheelchair. Resident #104 had bilateral leg rests to the wheelchair that were in the normal sitting position with knees bent. Resident #104 had multipodus boots to both feet.  PREFIX TAG  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 657  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICE TO THE APP	LOUIDAT	ILALITI & REHABILITA	HON SENTER		LOUISA, VA 23093			
During initial tour of the facility on 12/10/19 at 11:00 AM, Resident #104 was observed in her room in her wheelchair. Resident #104 had bilateral leg rests to the wheelchair that were in the normal sitting position with knees bent. Resident #104 had multipodus boots to both feet.  ensuring all interventions included on the care plan are in place.  4. DON or designee will audit 100% of care plans in the center to ensure inclusion of all pressure ulcer and/or positional interventions, then 50% daily for	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTI CROSS-REFERENCI	IVE ACTION SHOULD BE ED TO THE APPROPRIATE	(X5) COMPLETION DATE	
On 12/10/19 at 12:50 PM, Resident #104 was observed again, sitting in the room, in the wheelchair in the same position, and in the same area of the room. Resident #104 was interviewed and stated she had an ulcer on her right leg and that she had and unstageable ulcer on her left heel. Both of Resident #104's legs were wrapped with profore compression dressings that covered her feet, up to just below the knees. Resident #104 stated that she was getting therapy and that staff were changing the dressings twice a week. Resident #104 had bilateral leg rests to the wheelchair. Resident #104's right leg had moved off of the calf support pad, and the resident's foot was not touching the foot rest petal, nor the floor. The resident's left calf support pad had rotated and Resident #104's calf was laying on the top edge of the calf pad support (not flat) causing pressure to the back of the resident's calf. Resident #104 denied pain.  Resident #104's current CCP (comprehensive care plan) was reviewed and documented, "Contractures: The resident has contractures of the right lower legright lower leg to keep clean and prevent skin breakdownresident has a Stage 3 pressure ulcer to her RLE (right lower extremity, and [unstageable] pressure ulcer to the left heeldevices heel float, multipodus boots to bilateral feet, foot cradleposition resident as neededposition resident for comfortPotential	F 657	During initial tour of 11:00 AM, Resident room in her wheelch bilateral leg rests to the normal sitting por Resident #104 had a considerable of the room. Resident #104 had a considerable of the room. Resident #104 had and stated she had that she had and an heel. Both of Resident #104 stated that she staff were changing Resident #104 had a considerable off of the calf support was not touching the The resident's left cand Resident #104's edge of the calf pad pressure to the back Resident #104 denied Resident #104's cur care plan) was revied "Contractures: The of the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan) was revied the right lower leg clean and prevent sident #104's cur care plan was revied the right lower leg clean and prevent sident #104's cur care plan was rev	the facility on 12/10/19 at #104 was observed in her rair. Resident #104 had the wheelchair that were in sition with knees bent. Inultipodus boots to both feet.  O PM, Resident #104 was ing in the room, in the me position, and in the same resident #104 was interviewed an ulcer on her right leg and unstageable ulcer on her left rent #104's legs were wrapped resion dressings that covered relow the knees. Resident rewas getting therapy and that the dressings twice a week. Sollateral leg rests to the resident was laying on the floor. The floor rest petal, nor the floor. The floor rest petal, nor the floor. The floor resident's calf. The resident's calf. The resident's calf. The resident has contractures rewed and documented, reresident has contractures resident has	F 6	ensuring all intervent care plan are in place 4. DON or designee care plans in the cent inclusion of all pressu positional intervention 2 weeks, then 25% fit weeks, then review fit QA meeting.	will audit 100% of ter to ensure ure ulcer and/or ns, then 50% daily for ive times weekly for 2 indings in following		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG	_	(X3) DATE SURVEY COMPLETED			
		495282	B. WING _			R-C <b>12/11/2019</b>		
	ROVIDER OR SUPPLIER	ON CENTER		STREET ADDRESS, CITY, 210 ELM STREET LOUISA, VA 23093	STATE, ZIP CODE	12717/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)		ETION	
F 657	preventionPressure wheelchair" The printervention listed on Resident #104's phys and documented, " in place every shift! treatment order: 5-7 training, w/c mobility. At approximately 2:10 observations were renurse, LPN (Licensed Resident #104 was o #104's left leg calf su observed in the imprestated, "I see what yo began to reposition the legs to the proper poundress Resident #10 where the calf supporesident's calf in the wundressed the left caresident's left leg for #104's posterior calf approximately 4 inchainch deep. LPN #1 stresident's leg and/or improperly positioned on the resident's calf. Resident #104 had calf. Resident #104 had calf. Resident Resident #104 had calf.	ment related to obts, and foot cradle for a reduction surface to ressure reduction surface the CCP was not specific.  sician orders were reviewed Monitor off loading boots are PT (Physical Therapy) times/week for 6 weeksgait"  O PM, the above ported to Resident #104's d Practical Nurse) #1. bserved again. Resident poper position. LPN #1 ou are saying." LPN #1 then the pad and the resident's sistion. LPN #1 was asked to 04's left leg down to the area of pad was laying on the wrong position. LPN #1 If area and then raised the observation. Resident had an indentation of the slong and approximately 1 ated that she agreed that the other calf pad must have been to leave an indented area LPN #1 then stated that	F	557				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG	(X3	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 210 ELM STREET LOUISA, VA 23093	ı	12/11/2019	
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F 657	she had been up in 6:00 AM and had not Resident #104 was check on her since I "No." Resident #10 therapy that morning something out from Resident #104 state was, but it wasn't a some type of suppoor The therapy departr (occupational therapy of therapy services 12/10/19 and 12/11/interviews, a foot be after admission and morning on 12/11/19. On 12/10/19 at 2:45 about documentatio implemented in any PTA stated there was system about this do box support device she was taking it bat this time to put it bat this time to put it bat with OT to advance took the box off. Thimplemented on day resident's admission removed today (12/19/19/19/19/19/19/19/19/19/19/19/19/19/	Resident #104 stated that the wheelchair since around of been put back to bed. asked if anyone had been to unch and the resident stated, 4 stated that she had gone to g and that therapy had taken under her legs this morning. If that she didn't know what it pillow, but did state that it was rt for her legs.  The PTA and the director (OT #2) were interviewed on 19. According the the x was implemented 3 days was in place until early 9.  PM, the PTA was interviewed on of foot box being of the therapy notes and the service. The PTA had the foot in her hand and stated that ck down to Resident #104 at ck in place.  PM, the OT was interviewed. The resident had been working ambulation and that therapy the OT stated that the box was a number three, after the nand stated that the box got 10/19).	F 6	57			
		rs, therapy progress notes or n for this device. On 12/11/19					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495282	B. WING			1	R-C		
	ROVIDER OR SUPPLIER  EALTH & REHABILITAT			210 EL	T ADDRESS, CITY, STATE, ZIP CODE  M STREET  SA, VA 23093	12	/11/2019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PRECEDED BY FULL PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 657	that device should ha Resident #104, since that it was implement director stated that it documented and shoresident's CCP.  On 12/10/19 at approadministrator, DON (corporate nurse were with the survey team not specific to the prodid not include the fothe foot box was actuand would not have I for pressure relief. Tresident's wound car information from the information was not I clinical record.  On 12/11/19 at 7:30 records were reviewed resident was original each week following orders documented, compression dressin for long periods of tir of the heart or above and/or when sitting. compression pump to place pillow under kricalf"	rapy director was asked if ave been documented for a therapy staff were saying ted on day 3. The therapy should have been on the boximately 4:00 PM, the director of nursing) and the amade aware in a meeting that the resident's CCP was a assure relieving device and ot box. The DON stated that ually for proper alignment been in the resident's CCP the DON was asked for the action of the orders, notes and awound care clinic, as this ocated in the resident's  AM, Resident #104's wound and documented that the ly seen on 11/21/19 and was The wound physician  "profore lite multilayer g-bilateral. Avoid standing ne. Elevate legs to the level of or 30 minutes 3 times daily other - Use your wice a day, prop leg up, nee to relieve pressure on the	F	657					
	nurse met with the si	urvey team and were asked bund care orders and							

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF DE	ROVIDER OR SUPPLIER	433202	D. Wiito		STREET ADDRESS, CITY, STATE, ZIP CODE	12/	/11/2019
	EALTH & REHABILITATI	ON CENTER		2	210 ELM STREET  LOUISA, VA 23093		
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F 657	this information came she had it faxed and the was in her office. The the orders and interventile resident's CCP. The are original orders from and stated that the number of the resident was not a stated that the number of the record and corporate nurse were information was not a medical record and winformation could be plan if the information. The corporate nurse on the wound physicial care clinic should have resident's care plan.  No further information presented prior to the to evidence the CCP include interventions of pressure ulcers for Treatment/Svcs to Pre CFR(s): 483.25(b)(1) Pressure saled on the compressident, the facility medical components of the compression	ation was not in the ord and was asked where of from. The DON stated that that some of the information of DON was made aware that entions were not included in the DON stated that those of the information of the DON stated that those of the information of the DON stated that those of the information of the plan. The DON and of the made aware that this of practice, to prevent does not sure how that the put on the resident's care of the was in the DON's office. Stated that the information of the been included in the of the was reviewed and revised to for the care and prevention of the care, consistent with the of practice, to prevent the of the prevention	F €	657			1/6/20
	pressure ulcers and culcers unless the indi- demonstrates that the						

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{F 686}	with professional star promote healing, prenew ulcers from deverance ulcers from deveran	and services, consistent indards of practice, to vent infection and prevent eloping.  T is not met as evidenced on, resident interview, staff if record review, the facility ent care and services for the re ulcers for one of 10 ey sample, Resident #104. If to ensure pressure relief in included on the resident's or anemia, chronic pain, hypothyroidism, history of inbosis), CHF (congestive (chronic obstructive DM (diabetes mellitus), lower extremity and	{F 686	F-686  1. Resident #104 s foot box has bee returned to resident s wheelchair to maintain proper chair positioning, and recommended pressure relief interventions are now being complete per recommendation. MD and Responsible party have been notified  2. All residents utilizing a wheelchair device are at risk.  3. SDC or designee will educate:  a. All nursing staff on identifying pote pressure that may require intervention pressure relief interventions, and communicating with therapy on chang with devices/interventions.  b. All Therapy staff on communicating with nursing team when interventions being placed, trialed, adjusted, or removed.  4. DON or designee will audit 100% or resident s wheelchairs for any potent pressure points, then validate on rour 3x daily for 2 weeks, the 2x daily for 2 weeks, then review findings in followin QA meeting.	d as a ntial n, ges are of tial ds		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LOUISA H	EALTH & REHABILITATI	ON CENTER		210 ELM STREET LOUISA, VA 23093				
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{F 686}	Continued From page 8		{F 6	86}				
		ir. Resident #104 had ne wheelchair that were in ition with knees bent.			5. Date of Compliance: 1.6.2020.			
	observed again, sittin wheelchair in the sam area of the room. Res and stated she had a that she had and and heel. Both of Resider with profore compressher feet, up to just be #104 stated that she staff were changing the Resident #104 had bis wheelchair. Resident off of the calf support was not touching the The resident #104's	ne position, and in the same sident #104 was interviewed in ulcer on her right leg and unstageable ulcer on her left int #104's legs were wrapped sion dressings that covered low the knees. Resident was getting therapy and that he dressings twice a week. Lateral leg rests to the at #104's right leg had moved pad, and the resident's foot foot rest petal, nor the floor. If support pad had rotated calf was laying on the top support (not flat) causing of the resident's calf.						
	care plan) was review "Contractures: The of the right lower leg. clean and prevent ski a Stage 3 pressure ul extremity, and [unstagleft heeldevices hee bilateral feet, foot cra neededposition resi for further skin impair CVAmultipodus boo preventionPressure	resident has contracturesright lower leg to keep n breakdownresident has cer to her RLE (right lower geable] pressure ulcer to the el float, multipodus boots to dleposition resident as dent for comfortPotential ment related to ots, and foot cradle for						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495282	B. WING			R-C <b>12/11/2019</b>		
	ROVIDER OR SUPPLIER			STREET ADDRESS, 210 ELM STREET LOUISA, VA 230	CITY, STATE, ZIP CODE	<u>  121</u>	11/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
{F 686}	Resident #104's physicand documented, " in place every shiftI treatment order: 5-7 to training, w/c mobility.  At approximately 2:10 observations were renurse, LPN (Licensed Resident #104 was to Resident #104's left I again observed in the stated, "I see what you began to reposition to the gas to the proper posundress Resident #10 where the calf supportesident's calf in the word with the control of the proper posundressed the left caresident's left leg for #104's posterior calf approximately 4 inchainch deep. LPN #1 stresident's leg and/or improperly positioned on the resident's calf.  Resident #104 was a up in the wheelchair. she had been up in the 6:00 AM and had not Resident #104 was a check on her since lu "No." Resident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning something out from users and the sident #104 therapy that morning sident #104 therapy that morning sident #104 therapy that morning sident #104 therapy that	the CCP was not specific.  sician's orders were reviewed Monitor off loading boots are PT (Physical Therapy) imes/week for 6 weeksgait"  O PM, the above ported to Resident #104's departed to Resident #104's left leg down to the area for pad was laying on the wrong position. LPN #1 for a rea and then raised the observation. Resident had an indentation of the long and approximately 1 atted that she agreed that the the calf pad must have been it to leave an indented area	{F 6	86}				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		495282	B. WING _			R-C <b>12/11/2019</b>		
	ROVIDER OR SUPPLIER	ION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 210 ELM STREET LOUISA, VA 23093	•	12/11/2013		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
{F 686}	type of support for h On 12/10/19 at 2:20 therapist assistant) v stated that she had v that morning between PTA stated that the r on to prevent pressure, Resident #104 had a PTA stated that the r therapy was using for Resident #104 in alique been doing trials with she thought the reside admission and that r yesterday, then it was that Resident #104 of was asked if she had resident's legs. The something nursing d PTA stated that som therapy) sees the re how she is doing and PTA stated that it ca didn't know if anyone lunch. The PTA was locating information support to determine device and to determ implemented and wh  On 12/10/19 at 2:45 interviewed. The PT original order to have discontinue this [foor asked about docume implemented in any	er legs.  PM the PTA (physical was interviewed. The PTA worked with Resident #104 on 7:00 and 8:00 AM. The resident had her "puff boots" are. The PTA was asked if anything else in place. The resident had a "little box" that or support and to keep grament and that therapy had hout it. The PTA stated that dent had the device since Resident #104 had it all day as removed. The PTA stated didn't have it today. The PTA do put pillows under the PTA stated that may be oes, but not therapy. The eone from OT (occupational sident in afternoon to ask do if she is comfortable. The in be anytime after lunch, but had seen her today after asked for assistance in regarding the foot box of if there was an order for this nine when it was removed.  PM, the PTA was TA stated, "There is no	{F 6	86}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY PLETED
		495282	B. WING			R-C	
NAME OF P	ROVIDER OR SUPPLIER	430202	3	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	12/	11/2019
LOUISA H	EALTH & REHABILITATI	ON CENTER		210 E	ELM STREET ISA, VA 23093		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE
{F 686}	box support device in she was taking it back time to put it back in procession of the potential of the poten	t box. The PTA had the foot her hand and stated that k down to the resident at this place.  PM, the OT was interviewed. esident #104 had been divance ambulation and that box off. The OT stated that inted on day number three dimission, and stated that the eay. The OT stated that she etween 10:00 and 11:00 AM. e box was becoming an ent #104 and that is why it off was made aware of the dent #104's left leg calf pad he back of the resident's calf, he saw Resident #104 today stated that she "poked" her asked the resident how she stated that Resident #104 she didn't see Resident hir in an abnormal position k by. The OT was asked mented. The OT stated that herapy does; they don't isn't a facility requirement to PM, Resident #104 was di asked if anyone from her, specifically anytime after TA putting the box back in by 2:45 PM) and the resident	{F 6	86}			
	were reviewed from a	idmission to present and did					

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		PLE CONSTRUCTION  3		(X3) DATE SURVEY COMPLETED		
		495282	B. WING			R-C <b>12/11/2019</b>		
NAME OF PROVIDER OR SUPPLIER  LOUISA HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 210 ELM STREET LOUISA, VA 23093	l	12/11/2019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
{F 686}	foot box support for feet.  On 12/10/19 at appriadministrator, DON corporate nurse were information in a meet.  On 12/11/19 at appriation was observed wheelchair with the place. Resident #10 was better for her, at thank you."  On 12/11/19 at 9:30 nurse met with the set the per their intervied positioning foot box removed on 12/10/17 resident was monitor was last seen by the The DON and corpor of discrepancies regas far as observation resident and therapy corporate nurse were no documentation to was checked on at a regarding the foot both of the corporate for the position of the corporate of the	roximately 4:00 PM, the (director of nursing) and the re made aware of the above eting with the survey team.  coximately 8:15 AM, Resident in her room, sitting in her foot box support device in 04 was asked if that device and she stated, "Yes Ma'am,  AM, the DON and corporate survey team and stated that was with therapy, the for Resident #104 was 9 at 8:00 AM and that the ared through out the day and at 0.0T at 1:56 PM.  For a transport the resident with the product of the product	{F 68	6}				
	The DON stated that	n of the above observations. t the foot box was actually for d would not have been in						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495282	B. WING		R-C <b>12/11/2019</b>		
NAME OF PROVIDER OR SUPPLIER  LOUISA HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 210 ELM STREET LOUISA, VA 23093	12/11/2019		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION		
{F 686}	DON was asked for orders, notes and in care clinic for the may wounds, as this inforesident's chart.  On 12/11/19 at 7:30 records were review resident was original seen each week follorders documented, compression dressir for long periods of time of the heart or above and/or when sitting. compression pumps place pillow under kincalf"  On 12/11/19 at 10:2 [also known as OT # stated that any device should be do progress notes.  On 12/11/19 at 10:3 nurse met with the swhy Resident #104's progress note information came frow had it faxed to ensurinformation from each she had some information. The DON was asked in the resident's clinical regions.	P for pressure relief. The the resident's wound care formation from the wound anagement of the resident's rmation was not located in the  AM, Resident #104's wound red and documented that the lly seen on 11/21/19 and was owing. The wound physician "profore lite multilayer ng - bilateral. Avoid standing me. Elevate legs to the level er for 30 minutes 3 times daily	{F 686				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495282 B. WING			R-C <b>12/11/2019</b>				
	ROVIDER OR SUPPLIER	ION CENTER		210	REET ADDRESS, CITY, STATE, ZIP CODE DELM STREET DUISA, VA 23093			
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 686}	wound clinic and state facility will take off or and care plan. The I were supposed to do her office. The DON were backed up and into the system by mand corporate nurse Resident #104 had be since 11/21/19 and the very first visit. The that the information of from the wound care on Resident #104's conformation did not syresident's current or 12/11/19 at 10:44 AM again interviewed. That each resident is therapy department they will communicate assist in the process. That therapy staff will often and they don't but document every notes and that it is more therapy staff were sare on day 3. The therapy should have been document therapy staff were sare on day 3. The therapy down can happen at	ers are from the [name] ed that the nurses at the ders and put in the record DON was asked how they that if the records were in stated that the facility staff that it had not been scanned edical records. The DON were made aware that een going to the wound clinic nose orders were listed from he corporate nurse stated on the physician's orders clinic should have been put hare plan, but stated that that becifically need to be on the her sheet.  If, the therapy director was he therapy director stated individualized and that the rials things all the time and he verbally with nursing to The therapy director stated check on resident's every so document on a daily basis, or of a summary. The hasked if that device should hed for Resident #104, since hydrically stated that it cumented and should have he s CCP (comprehensive care her that the progress he compass anything done	{F €	86}				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495282	B. WING		R-C <b>12/11/2019</b>
NAME OF PROVIDER OR SUPPLIER  LOUISA HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 210 ELM STREET LOUISA, VA 23093	12/11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
{F 686}	presented prior to the to evidence that the care interventions fo ulcers for Resident #	n and/or documentation was e exit conference on 12/11/19 facility staff implemented r the prevention of pressure £104.	{F 68		
F 842 SS=D	CFR(s): 483.20(f)(5)  §483.20(f)(5) Reside (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use or except to the extent to do so.  §483.70(i) Medical re §483.70(i)(1) In accordance with a cagrees not to use or except to the extent to do so.  §483.70(i) Medical re §483.70(i)(1) In accordance with a re- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The facall information contaregardless of the formation	ent-identifiable information. release information that is to the public. elease information that is to an agent only in ontract under which the agent disclose the information the facility itself is permitted ecords. ordance with accepted ds and practices, the facility ral records on each resident enented; le; and rganized cility must keep confidential ined in the resident's records, on or storage method of the in release is- or their resident expermitted by applicable law;	F 84	<del>1</del> 2	1/6/20

R-C	
495282 B. WING 12/11/	2010
NAME OF PROVIDER OR SUPPLIER  LOUISA HEALTH & REHABILITATION CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  210 ELM STREET  LOUISA, VA 23093	2019
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or lo coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.  §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.  §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law.  §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (iii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by; Based on observation, resident interview, staff interview, and clinical record review, the facility staff falled to maintain and complete and	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C		
495282			B. WING			12/	11/2019
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISA H	EALTH & REHABILITATI	ON CENTER			10 ELM STREET		
				L	OUISA, VA 23093		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 842	Continued From page	e 17	F	342			
		c records, which included			electronic record.		
	orders and intervention resident's medical rec	ons, were not part of the cord.			All residents receiving medical services outside the center are at risk.		
	Findings include:				Regional Consultant will educate     administrator or designee on ensuring	that	
	Resident #104 was admitted to the facility on 11/15/19. Diagnoses for this resident included, but were not limited to: anemia, chronic pain, high blood pressure, hypothyroidism, history of DVT (deep vein thrombosis), DM (diabetes mellitus), diabetic ulcer to right lower extremity				clinical documents are uploaded into the electronic record to maintain record accuracy.		
					Administrator or designee will audit     100% of all patients returning from		
	and pressure ulcer to	left heel.			receiving medical services outside the center for provided documentation beir	-	
	an admission assessi	S (minimum data set) was ment dated 11/26/19. This			uploaded in the electronic record 5 time weekly for 4 weeks, then review finding		
	score of 13, indicating	sident as having a cognitive the resident is intact for			in the following QA.		
	assessed as requiring	skills. The resident was gextensive assistance of 2			5. Date of Compliance: 1.6.2020.		
		ocumented with one Stage 3					
	unstageable (present	nt upon admission) and one upon admission).					
	11:00 AM, Resident # room in her wheelcha bilateral leg rests to the the normal sitting pos	ne facility on 12/10/19 at 104 was observed in her ir. Resident #104 had ne wheelchair that were in ition with knees bent. ultipodus boots to both feet.					
	observed again, sittin wheelchair in the sam area of the room. Res and stated she had a	PM, Resident #104 was g in the room, in the ne position, and in the same sident #104 was interviewed in ulcer on her right leg and unstageable ulcer on her left					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		C	(X3) DATE SURVEY COMPLETED  R-C 12/11/2019	
		495282					
NAME OF PROVIDER OR SUPPLIER  LOUISA HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 210 ELM STREET LOUISA, VA 23093	<u>'</u>	1211/2010	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	with profore compher feet, up to just #104 stated that staff were changir Resident #104 ha wheelchair. Resident #104 ha wheelchair. Resident #105 for the calf suppersonant touching The resident's left and Resident #105 edge of the calf paperssure to the base Resident #104's contractures: of the right lower I clean and prevent a Stage 3 pressure extremity, and [un left heeldevices bilateral feet, foot neededposition for further skin important CVAmultipodus preventionPress wheelchair" The was not specific, resident's phy and documented, in place every shift treatment order: 5 training, w/c mobil compression dres	ident #104's legs were wrapped ression dressings that covered is below the knees. Resident he was getting therapy and that ag the dressings twice a week. It do bilateral leg rests to the dent #104's right leg had moved bort pad, and the resident's foot the foot rest petal, nor the floor. It calf support pad had rotated days calf was laying on the top ad support (not flat) causing tack of the resident's calf.  The resident has contractures regulated and documented, and the resident has elected to her RLE (right lower stageable) pressure ulcer to the heel float, multipodus boots to cradleposition resident as resident for comfortPotential pairment related to boots, and foot cradle for sure reduction surface to be pressure reduction surface to be pressured to the pressure reduction surface to be pressured to the pressure reduction surface to be pressured to the pressure with the pressure with the pressure with the pressure with the pressure	F	342			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED  R-C	
			A. BOILD				
		495282	B. WING	B. WING			11/2019
	ROVIDER OR SUPPLIER  EALTH & REHABILITATI	ON CENTER	•	21	TREET ADDRESS, CITY, STATE, ZIP CODE 10 ELM STREET OUISA, VA 23093		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	nurse, LPN (Licensed Resident #104 was of #104's left leg calf surplement observed in the improstated, "I see what you began to reposition the legs to the proper poundress Resident #10 where the calf supporesident's calf in the resident's left leg for #104's posterior calf approximately 4 incheinch deep. LPN #1 st	D PM, the above ported to Resident #104's d Practical Nurse) #1. bserved again. Resident pport pad was again oper position. LPN #1 then he pad and the resident's sition. LPN #1 was asked to 04's left leg down to the area rt pad was laying on the wrong position. LPN #1 If area and then raised the observation. Resident had an indentation of es long and approximately 1 ated that she agreed that the	F	842			
	resident's leg and/or the calf pad must have been improperly positioned to leave an indented area on the resident's calf. LPN #1 then stated that Resident #104 had cellulits of the legs.  Resident #104 was asked how long she had been up in the wheelchair. Resident #104 stated that she had been up in the wheelchair since around 6:00 AM and had not been put back to bed. Resident #104 was asked if anyone had been to check on her since lunch and the resident stated, "No." Resident #104 stated that she had gone to therapy that morning and that therapy had taken something out from under her legs this morning. Resident #104 stated that she didn't know what it was, but it wasn't a pillow, but did state that it was some type of support for her legs.  On 12/10/19 at approximately 4:00 PM, the administrator, DON (director of nursing) and the corporate nurse were made aware in a meeting						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	, ,	DATE SURVEY COMPLETED				
		495282	B. WING			R-C				
NAME OF PROVIDER OR SUPPLIER  LOUISA HEALTH & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 210 ELM STREET LOUISA, VA 23093	l	12/11/2019				
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	The DON was asked care orders, notes a wound care clinic for resident's wounds, a found in the resident On 12/11/19 at 7:30 records were review resident was original seen each week follor orders documented, compression dressir for long periods of time of the heart or above and/or when sitting. compression pump to place pillow under kind calf"  On 12/11/19 at 10:30 nurse met with the swhy Resident #104's progress note information came from had it faxed to ensure information from each she had some information the resident's clinic DON was made aware found in the resident's clinic DON was	in of the above observations. It for Resident #104's wound and information from the rethe management of the is this information was not it's clinical record.  AM, Resident #104's wound ed and documented that the ally seen on 11/21/19 and was owing. The wound physician "profore lite multilayer and period by bilateral. Avoid standing me. Elevate legs to the level of for 30 minutes 3 times daily. Other - Use your twice a day, prop leg up, there to relieve pressure on the cord and asked where this own. The DON stated that she are that she had all of the cord and sked where this own. The DON stated that the ation originals in her office. It why this information was not cal record anywhere. The are that the orders were not it's clinical record. The DON	F	· ·						
	wound clinic and sta facility will take off or and care plan. The were supposed to do	lers are from the [name] ted that the nurses at the rders and put in the record DON was asked how they to that if the records were in I stated that the facility staff								

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	<b>495282</b> B. W				R-C			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRE	ESS, CITY, STATE, ZIP CODE	12/	11/2019	
	EALTH & REHABILITATI	ON CENTER		210 ELM STRE LOUISA, VA	ET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD E DSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 842	were backed up and into the system by me and corporate nurse. Resident #104 had be since 11/21/19 and the very first visit. The that the information of from the wound care on Resident #104's conformation did not spresident's current ord. No further information presented prior to the to evidence Resident complete and accura and orders for the preprevention.	that it had not been scanned edical records. The DON were made aware that een going to the wound clinic lose orders were listed from the corporate nurse stated in the physician's orders clinic should have been put are plan, but stated that that pecifically need to be on the er sheet.  In and/or documentation was exit conference on 12/11/19 #104's clinical records were the to include interventions essure ulcer care and	F	342				