PRINTED: 03/26/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495210	B. WING	-		02	C /24/2021
		ABILITATION CENTER		901	REET ADDRESS, CITY, STATE, ZIP CODE EAST PRINCESS ANNE ROAD RFOLK, VA 23504	1 02	12412021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
	COVID-19 Focused 2/23/21 and continu facility was in comp Part 483.73, Requir Facilities.	Emergency Preparedness I Survey was conducted onsite used offsite on 2/24/21. The liance with E0024 of 42 CFR rements for Long-Term Care					
F 000	114 at the time of si pandemic a total of positive for COVID- recoveries. Since the of 25 staff had tested a total of 25 resident 5 resident deaths re- survey sample cons		FO	00			
	survey was conduct offsite on 2/24/21. C investigated: VA000 deficiencies. The fa 42 CFR Part 483.80 for the implementati Medicare & Medicai	50784 was Substantiated with acility was in compliance with infection control regulations, on of The Centers for d Services and Centers for ommended practices to					
	114 at the time of supandemic a total of positive for COVID-recoveries. Since the of 25 staff had teste	80 certified bed facility was arvey. Since the start of the 58 residents had tested 19 with a total of 51 resident e start of the pandemic a total d positive for COVID-19 with					
AROKATORY	DIRECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGN.	ATURE		TITLE		(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 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.

Electronically Signed

03/01/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495210	B. WING	;		0.2	C 2 /24/2021
NORFOL		ABILITATION CENTER		901	REET ADDRESS, CITY, STATE, ZIP CODE EAST PRINCESS ANNE ROAD RFOLK, VA 23504	1 02	12412021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 000 F 609 SS=D	a total of 25 resident 5 resident deaths re survey sample cons review; Resident #1 reviews; Resident # Reporting of Alleged CFR(s): 483.12(c)(1	nt recoveries. There had been elated to COVID-19. The sisted of one closed record and four current record through #5. d Violations		609			3/1/21
	§483.12(c)(1) Ensurinvolving abuse, negmistreatment, include source and misapprare reported immed hours after the allegs that cause the allegs serious bodily injury the events that cause and do not rethe administrator of officials (including to adult protective servitor jurisdiction in lon-	re that all alleged violations glect, exploitation or ding injuries of unknown ropriation of resident property, liately, but not later than 2 gation is made, if the events ation involve abuse or result in r, or not later than 24 hours if se the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in ate law through established					
	designated represer accordance with Sta Survey Agency, with incident, and if the a appropriate corrective	rt the results of all administrator or his or her ntative and to other officials in ate law, including to the State in 5 working days of the alleged violation is verified we action must be taken. IT is not met as evidenced					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/26/2021 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 495210 B. WING 02/24/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 EAST PRINCESS ANNE ROAD NORFOLK HEALTH AND REHABILITATION CENTER NORFOLK, VA 23504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 609 Continued From page 2 F 609 Based on staff interview, facility document review Past noncompliance: no plan of and clinical record review it was determined that correction required. facility staff failed to report an allegation of sexual abuse reported to administration on 2/3/21; AND an injury of unknown origin obtained on 2/2/21 in a timely manner to the appropriate state agencies for one of 5 sampled residents, Resident #1. The findings included: 1. Resident #1 was admitted to the facility on 1/12/21 with diagnoses that included but were not limited to unspecified convulsions, vascular dementia without behavioral disturbance, history of TIA (stroke), retention of urine, type two

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		495210	B. WING _		0:	C 2/24/2021
		ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC 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 609	laceration on the up other visible injuries Laceration was cleasterile strips applied reinserted and hem observe. primary ca (Name of Son, Nexincident. Risk mana assessment completed. Neuro civital signs are withing plan has been upda continues rounding. signs or pain or discolowest position and continue to monitor. Review of Resident's summary dated 2/2/2/1/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2	oper left side of eyebrow. No spresent at this time. aned with Darkins (sic) and d. 18 Fr (French) Foley was aturia (blood in urine) are provider (Name) and family to of Kin) made aware about agement completed, post eted, and incident report hecks initiated and residents a normal limits. Resident care ated and patient is on Resident does not show any comfort at this time. Bed in call bell within reach. will resident." Is #1's Urology appointment (21 documented in part, the ts in office today with head rehab center, Wound is ne butterfly closure. Pt	F 60			
	presents for evaluat Foley catheter beca though pt was taken be at baseline ment left forehead. On ex alertLaceration no active bleedingNu reports she (Reside possibility of sexual is not sure if pt's der concerns, related to	ion after fall this morning. me dislodged during fall, to Urology clinicPt noted to al status. Laceration noted to am. pt awake and ted to left forehead without rsing staff notes pt's son nt #1) is concerned for assault at nursing facility. Son mentia is playing into these				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495210	B. WING				C
		HABILITATION CENTER		901	REET ADDRESS, CITY, STATE, ZIP COD EAST PRINCESS ANNE ROAD RFOLK, VA 23504		2/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	including police re (Sexual Assault N spoke with his sis police officer and home without furth (Emergency Department of the sexual of the facility and the facility administration of the facility and the facility and the facility and the facility assaulted discharged from the facility of note, the catheter reinserted sustained a fall the facility and the facility assaulted discharged from the facility and facility assaulted discharged from the facility and facility an	urse Exam). Patient's son has ter, patient's daughter, who is a decided they will take patient ner action in the ED	F6	09			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Company of the Compan	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495210	B. WING		0.0	C
	PROVIDER OR SUPPLIER K HEALTH AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 901 EAST PRINCESS ANNE ROA NORFOLK, VA 23504	IP CODE	2/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 609	root cause of the all been notified and the will be submitted not revealed that it was agencies on 2/4/21 Review of a witness nurse who worked 2 the following: "I star report and did my re (sic). I saw (Name of with head of bed elenoted. At about 4:48 station and notified that (Name of Resident (Na	the Foley catheter could be the legation. The police have the results of the investigation of later than 2/11/21. Infirmation for the initial FRI sent to the appropriate state at 5:30 p.m. It is statement from the male 2/2/21 11-7 shift documented the draw shift at 11 pm, took regular rounding on all patient of Resident #1) laying in bed revated, no distress or pain a.m., CNA came to nurses the writer of this statement for the writer of this statement for Foley was pulled outI with the resident's room, resident had a laceration to could not verbalize what had a present in room I performed sment. Resident had a 3.0 x left eyebrow and resident's the and laying on the floor. No were observed on resident. In was cleaned with Darkins of strips applied to laceration. In room, I informed resident of loved Foley. A new 18 Fr Foley in reinsertion, hematuria was the (Name of physician), ADON of Nursing) and Family (Name about incident"	F 6	09		
	CNA present on 2/2 following: "I saw her	21; documented in part, the				

AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495210	B. WING_		02	C 2/24/2021
		ABILITATION CENTER		901 EAST PRINCESS ANNE ROA NORFOLK, VA 23504	P CODE	TENEUZ I
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 609	midnightshe was 2:15 a.mshe was room at 3:45 a.m the room at about 5 rounds, her night skin between the two and a clean gown. I bottom and back six brief on her right six the floor. I didn't wa went around to put When I turned her I I fastened her brief, and went directly to gathered supplies forme that once he waroom together and while catheter was in while catheter was in the Director of Social about her above not that Resident #1's domother alleged that OSM #3 stated that the facility on 2/3/21 statement. OSM #3 didn't believe her ministory of making propast. When asked with the facility. When asked with the facility. When as allegation to after he daughter, OSM #3 smeeting everyday. We meeting everyday.	fineI saw her again at about clean and dryI looked in she was still fine. I came in :30 AM doing my second aft and brief were on the floor bedsI grabbed clean sheets came back in an cleaned her de and put clean gown and deI saw the Foley was out on to leave her half nude so I the other side of the gown on. saw the cut on her forehead. put her gown on the left arm notify the nurseNurse or Foley catheter. He informed is ready, we both went into stayed in the room together	F 60			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495210	B. WING		05	2/24/2021
NORFO	T	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504	CODE	124/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPLETION DATE
F 609	When asked who regarding this allegation that she alerted the couldn't say if it was that that she knew because she didn'and not tell anyone coordinator was, of did not have one. It knew a psychologiasked if an allegation is made she didn't report the document when as the didn't report the document when as made by a resident allegation of abused did not believe the stated, "I can't go a conducted with AS Nursing) and ASM Director of Nursing were made aware Resident #1's daug social worker, ASM had come into the social worker had it stated that there we could not remember them aware. When sexual abuse shout that an allegation of within 2 hours and	specifically she alerted gation of "rape," OSM #3 stated e DON and ADON but she as immediately. OSM #3 stated it was that day (2/3/21) to go home with that information e. When asked who the abuse DSM #3 stated that the facility OSM #3 stated that she ast came to the building. When ion of abuse should be ely, OSM #3 stated, "If an . Absolutely." When asked why have allegation immediately and and who she reported to; OSM ughter clearly stated she didn't wis her mother better than ked if an allegation of rape to should be considered an even if the resident's family allegation occurred, OSM #3	F 60	09		

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495210	B. WING			02	C / 24/2021
		ABILITATION CENTER		STREET ADDRESS, CITY, S' 901 EAST PRINCESS ANN NORFOLK, VA 23504		1 02	12412021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPE FICIENCY)	BE	(X5) COMPLETION DATE
	and ADON were marked should have be 2/4/21 the next day, have. ASM #2 then facility Administrato 2/3/21. On 2/4/21 at 12:48 conducted with ASM ASM #1 stated that 2/3/21 that the daugexpressing concern her mom claimed to that from his unders didn't believe this hat the called the dato follow up with her FRI was submitted a daughter on 2/4/21. allegations of abuse stated that allegation within 2 hours. Whe abuse should be invesident's family do occurred, ASM #1 sallegation the facility is no fire behind the On 2/24/21 at 12:48 aware of the above 2. Review of the clin Resident #1 obtaine 11-7 shift. The follow "Was notified by CN Assistant) about reslaceration to the fore	ade aware on 2/3/21 if a facility ien sent then, rather than ASM #2 stated that it should stated that ASM #1, the r was also made aware on p.m., an interview was M #1, the facility Administrator. he was made aware on the period of them being that is swith one of them being that is be raped. ASM #1 stated at after his conversation with the When asked when a should be reported, ASM #1 and a factor of abuse should be reported in asked if all allegations of restigated even if the not believe the allegation tated that with any kind of a needs to make sure "There smoke." p.m., ASM #1 was made concerns. ical record revealed that d a head laceration on 2/2/21, wing note was documented:	F6	609			

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		495210	B. WING _		0:	C 2/24/2021
	_	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504		124/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 609	laying on the floor. what happened and head to toe assess laceration on the up other visible injuries. Laceration was cleasterile strips applied reinserted and hem provider (Name) and of Kin) made aware management compcompleted, and indicthecks initiated and within normal limits updated and patien. Resident does not a discomfort at this tircall bell within reach resident." Review of Resident that neurochecks we conducted until 8:30 arrived to take Resiappointment. Resid within normal limits. The next note by the Nursing) documente headed to morning pt (patient) lying on medical transporters egg-sized hematoms slightly discolored bedges, small lacerate hematoma about 3 steri-strip in middle, noted to laceration.	Resident could not verbalize thow injury occur. Upon a full ment, resident had 3.0 x 0.5 oper left side of eyebrow. No sepresent at this time. And with Darkins (sic) and the design of	F 60	09		

AND PLAN OF CORRECTION (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The state of the same of the s	X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY
		495210	B. WING		05	C 2/24/2021
	PROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 901 EAST PRINCESS ANNE RO. NORFOLK, VA 23504	ZIP CODE	124/2021
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 609	you head didn't you the hematoma, atte touching hematom pt, to best of my as smiled and nodded. Review of Residen summary dated 2/2 following: "preser wound due to fall a bleeding and has o (patient) denies he Review of Emerged documented in parold) female with his presents for evaluate Foley catheter becathough pt was take be at baseline menteft forehead. On eatertLaceration not active bleedingLawound care instructive bleedingLawound care inst	a?" pt reached up and touched empted to stop pt from a and laceration, explained to bility, not to touch area. Pt d in understanding." It's #1's Urology appointment 2/21 documented in part, the fints in office today with head at rehab center, Wound is one butterfly closure. Pt and pain." Incy room notes dated 2/2/21 tt, the following: "75 yo (year story ofvascular dementia, ation after fall this morning. I ame dislodged during fall, in to Urology clinicPt noted to tal status. Laceration noted to exam. pt awake and oted to left forehead without aceration repairprovided tions and return timeframe for a statement from CNA #1, the 2/21; documented in part, the	F 6	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495210	B. WING		0.	C
		HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP (901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504	CODE	2/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 609	went around to put When I turned he I fastened her brid and went directly gathered supplies me that once he wroom together and while catheter was On 2/23/21 at 9:4 conducted with RI nurse who was or obtained the lacer how he determine 2/2/21 if she was required extensive with bed mobility when the CNA told laceration to her hout; he went into the Foley on the groundings that out of bed and go stated that he resident back into bed, and nursing aide on duable to pull herself stated that he treafall. When asked i what had happened speak English and trying to tell him so understand her. Wher family to see if	at the other side of the gown on. I saw the cut on her forehead. If, put her gown on the left arm to notify the nurseNurse If or Foley catheter. He informed was ready, we both went into distayed in the room together	F 609			

	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		D. 0938-0391 TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	S 880	3		COMPLETED	
		495210	B. WING		0:	C 2 /24/2021	
	PROVIDER OR SUPPLIER LK HEALTH AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 901 EAST PRINCESS ANNE ROAL NORFOLK, VA 23504	CODE	ILTIZUZ I	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 609	stated that he just to RN #1 stated that la ADON and the ADO cannot assume ressee the fall and if the what happened. RN verbal in-service on injury of unknown of was educated if the injury of unknown of investigation, RN #1 could not recall if the investigation. On 2/24/21 at 10:12 conducted with ASN Member) #3, the ADN Member) #3 when assistance from one transfers; ASM #3 swas determined. It document what you ASM #3 stated that documenting. When she found out this in then treated Reside Unknown Origin," A that she had a lot go stated that she was 6:30 a.m." When as Resident #1 to see a stated that she did in Con 2/24/21 at 10:37 conducted with CNA	old the son that she had fallen. ater that day he notified the DN informed him that he idents have fallen if he did not he resident can not tell him N #1 stated that he was given a rigin. When asked if after he en treated the incident like an rigin and started an 1 stated that he did not. RN #1 he ADON had started an 1 stated that he did not. RN #1 he ADON had started an 1 stated that he did not. RN #1 he ADON (Assistant Director of ked how it was determined do a fall on 2/2/21 if she was he and required extensive he to staff with bed mobility and stated, "I don't know how that he bid the nurse that you can't didn't see or didn't know." she educated RN #1 on a sked at that point, when an asked at that point, when an asked at that she did not, bing on that morning. ASM #3 "racing to set up a clinic at sked if she checked on what had happened, ASM #3	F 609				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- Sec. 1987	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495210	B. WING			C 02/24/2021	
	PROVIDER OR SUPPLIER K HEALTH AND REH	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504	CODE	2/24/2021	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 609	night, CNA #1 state rounded on Reside CNA #1 stated that point and did not ne stated that at approto check in on Resibed on her left side noticed feces all ovand thrown on the f shirt were also on the there was no blood that she immediate brief and began to clothes on her. CNA turned the resident big laceration to her CNA #1 stated that and the nurse did a room to gather Fole stated that she was while the nurse was asked if Resident # into bed if she had f stated there was a thanging off her bed resident using her ubed. On 2/24/21 at 2:44 nurse was asked if Incident) was submunknown origin. ASI the following: "They (regarding the allegathey believed the lace and to be a part of t abuse."	and that the last time she int #1 was around 3:45 a.m. the resident was dry at that seed to be changed. CNA #1 eximately 5:30 a.m., she went dent #1 and saw her lying in and the stated that she also er the bed, her brief pulled officior and her Foley and night the floor. CNA #1 stated that on the floor. CNA #1 stated that on the floor. CNA #1 stated that on the rup and put new and a clean her up and put new and the right right, she noticed a reforehead near her left eye. She immediately got the nurse in assessment and left the eye catheter supplies. CNA #1 instructed to remain present instructed to get herself back fallen out of the bed, CNA #1 time when Resident #1 was and she had witnessed the apper body to get back into the p.m., ASM #4, the corporate a FRI (Facility Reported itted for the laceration of M #4 responded via email with only submitted the one FRI ation of sexual abuse) since ceration to be caused by a fall the allegation of sexual and the allegation and the allegation and	F 6	09			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495210	B. WING _		0.7	C 02/24/2021	
	PROVIDER OR SUPPLIEI K HEALTH AND RE	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504	CODE	124/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (E	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 609	also submitted to On 2/24/21 at 12:4 Administrator and Nursing) were ma concerns. Facility policy titled "Abuse/Neglect/M documents in part 1. Immediately up- violations involving or mistreatment, in source and misap the Administrator v State Agency, but allegation is made allegation involves bodily injury or not events that caused abuse and do not a. Notify the Virgin of Licensure and of report b. Notify the Adult local Ombudsman enforcement author and/or medical exa for any incident of neglect, or misapp or others licensed (Department of He Administrator mus a complete written the submitted FRI Health Office of Lic within (5) working of	the appropriate state agencies. 48 a.m., ASM #1, the ASM #2, the DON (Director of de aware of the above d, isappropriation/Crime"	F 60	9			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second of the second	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495210	B. WING	-		C 02/24/2021	
	PROVIDER OR SUPPLIER LK HEALTH AND REF	RHABILITATION CENTER		STREET ADDRESS, CITY, 901 EAST PRINCESS A NORFOLK, VA 2350	, STATE, ZIP CODE ANNE ROAD	1 02/2 // 2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 609	Nurse emailed this Regarding the abo was documented: laceration to forehed on floor. Resident's that resident made 2/2/21. Daughter mallegation before the came to the facility the Administrator sto the officer. 1. FRI done regard 2/3/21. 2. Review of chart: notified NP (nurse Click Care) conver and replacing Fole: 3. RN documented late entry, assumpt 4. Resident admitted were entered for the S. RN replaced the Action: 1. Resident dischard 2. Falls which occumer reviewed to eunknown origin was identifiedcomplet 3. Nurses will be ed a. Identifying an injub. Accurate documer. MD/NP (Medical Party) notification of when pulled out. d. Obtaining orders	s writer a Plan of Correction ove issue. The following in part, "Resident found in bed with a lead, Foley Catheter tubing lying is daughter made staff aware an allegation of rape on made police aware of the he facility was able to. Police of on 2/6/21 and requested that send results of his investigation ding allegation of rape on the results of his investigation of rape on the results of injury of unknown orders are foley. The results of the past 30 days the results of the past 30 days the results of the results of injury of unknown origin. The results of incident. In Doctor) and RP (Responsible of injury, replacement of Foley appletion date: 2/19/21.	F 60	09			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495210	B. WING			
	NAME OF PROVIDER OR SUPPLIER NORFOLK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP (901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504	CODE	02/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 609	b. Injury of unknown c. Timely report of a 2/16/21. 5. Incident notes wi monitor accurate id accurate document notification of the M basis. A random we Foley cath will be coorder is present for Further review of th (Identify) Possible A that facility staff incl worker, DON, ADO! Administrator were 2/19/21.	n origin abusecompletion date: Il be reviewed by a Nurse to entification of an injury, ation of an incident, timely D/NP on a random weekly ekly monitor of residents with empleted to ensure that an the catheter. e staff education titled, "ID abuse; Reporting" revealed uding the facility social	F 60	09		
F 610 SS=D	CFR(s): 483.12(c)(2) §483.12(c) In responeglect, exploitation must: §483.12(c)(2) Have violations are thoroused with the second secon	LIANCE (Correct Alleged Violation 2)-(4) Inse to allegations of abuse, or mistreatment, the facility evidence that all alleged lighly investigated. Int further potential abuse, or mistreatment while the	F 61	0		3/1/21

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	What have sentence to provide	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495210	B. WING _		02	C 2/24/2021	
NORFOL		HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504	CODE	/L4/202	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 610	§483.12(c)(4) Repositive stigations to the designated represe accordance with State Survey Agency, with incident, and if the appropriate correction This REQUIREMENT by: Based on staff interand clinical record of facility staff failed to injury of unknown of for one of 5 samples sample, Resident # The findings included Resident #1 was add 1/12/21 with diagnoral limited to unspecified dementia without be of TIA (stroke), reterand to the second of TIA (stroke), reterand to the second of TIA (stroke), reterand to the second with an ARD (assess 1/18/21. Resident #1 severely impaired in out of 15 on the BIM Status) exam. Resident #1 severely impaired in out of 15 on the BIM Status) exam. Resident with bed of the second of the second dependence on one dependence on one	ort the results of all e administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is verified tive action must be taken. NT is not met as evidenced erview, facility document review review, facility document review review, it was determined that origin that occurred on 2/2/21 ed Residents in the survey etc. dmitted to the facility on oses that included but were not ed convulsions, vascular ehavioral disturbance, history ention of urine, type two and muscle weakness. I recent MDS (minimum data as an admission assessment assment reference date of etch was coded as being an cognitive function scoring 06 MS (Brief Interview of Mental dent #1 was coded as assistance with two staff mobility, and transfers, and the from one staff with dressing,	F 610	Past noncompliance: no past noncompliance or required.	plan of		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/26/2021 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 495210 B. WING 02/24/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 EAST PRINCESS ANNE ROAD NORFOLK HEALTH AND REHABILITATION CENTER NORFOLK, VA 23504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 610 | Continued From page 18 F 610 Resident #1 obtained a head laceration on 2/2/21, 11-7 shift. The following note was documented: "Was notified by CNA (Certified Nursing Assistant) about resident laying in bed with laceration to the forehead, it was also noted that Foley (catheter) was pulled out of patient and laying on the floor. Resident could not verbalize what happened and how injury occur. Upon a full head to toe assessment, resident had 3.0 x 0.5 laceration on the upper left side of eyebrow. No other visible injuries present at this time. Laceration was cleaned with Darkins (sic) and sterile strips applied. 18 Fr (French) Foley was reinserted and hematuria (blood in urine) observe. primary care provider (Name) and family (Name of Son, Next of Kin) made aware about incident. Risk management completed, post assessment completed, and incident report completed. Neuro checks initiated and residents vital signs are within normal limits. Resident care plan has been updated and patient is on continues rounding. Resident does not show any signs or pain or discomfort at this time. Bed in lowest position and call bell within reach, will (sic) continue to monitor resident " Review of Resident #1's clinical record revealed

within normal limits

that neurochecks were initiated at 5:45 a.m. and conducted until 8:30 a.m., when medical transport

The next note by the ADON (Assistant Director of Nursing) documented the following: "When headed to morning meeting, got on elevator with pt (patient) lying on stretcher accompanied by 2 medical transporters. Pt (Patient) was noted to have an egg-sized hematoma to left side of

arrived to take Resident #1 to her Urology appointment. Resident #1's neurochecks were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A STATE OF THE PARTY OF THE PAR	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495210	B. WING			C 02/24/2021
NORFO	NORFOLK HEALTH AND REHABILITATION CENTER (YA) ID SUMMARY STATEMENT OF DEFICIENCIES			STREET ADDRESS, CITY, STATE, ZIP 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504	CODE	J2/24/2021
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 610	forehead, slightly daround edges, smale hematoma about 3 middle, small amt of laceration. When or "oooh, you did get a you?" pt reached up attempted to stop pand laceration, expability, not to touch understanding." Review of Resident summary dated 2/2 following: " present wound due to fall at bleeding and has or (patient) denies head to the patient of the pati	Il laceration noted in middle of cm long with 1 steri-strip in of dried blood noted to commented about hematoma, a nice bump on you head didn't o and touched the hematoma, a from touching hematoma lained to pt, to best of my area. Pt smiled and nodded in 's #1's Urology appointment /21 documented in part, the ts in office today with head rehab center, Wound is ne butterfly closure. Pt and pain." cy room notes dated 2/2/21, the following: "75 yo (year tory ofvascular dementia, tion after fall this morning. The dislodged during fall, in to Urology clinicPt noted to all status. Laceration noted to last status. Laceration noted to last status. Laceration noted to last status. The last provided in and return timeframe for statement from CNA #1, the /21; documented in part, the	F 6	10		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED		
		495210	B. WING	B. WING			C
	PROVIDER OR SUPPLIER	IABILITATION CENTER		901	EET ADDRESS, CITY, STATE, ZIP CODE EAST PRINCESS ANNE ROAD RFOLK, VA 23504	02	2/24/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	0.000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 610	rounds, her night shin between the two and a clean gown. I bottom and back sidbrief on her right sidthe floor. I didn't wa went around to put When I turned her I I fastened her brief, and went directly to gathered supplies for me that once he waroom together and while catheter was i On 2/23/21 at 9:49 a conducted with RN nurse who was on dobtained the lacerathow he determined 2/2/21 if she was for required extensive a with bed mobility an when the CNA told haceration to her hea out; he went into the Foley on the ground #1 stated that he as surroundings that th out of bed and got h stated that her residfalls and that her behe saw her last. RN staff if the resident v back into bed, and h nursing aide on duty able to pull herself u stated that he treate	hift and brief were on the floor bedsI grabbed clean sheets I came back in an cleaned her de and put clean gown and deI saw the Foley was out on ant to leave her half nude so I the other side of the gown on. I saw the cut on her forehead, put her gown on the left arm o notify the nurseNurse for Foley catheter. He informed as ready, we both went into stayed in the room together		510			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495210		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495210	B. WING			C	
NAME OF PROVIDER OR SUPPLIER NORFOLK HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, 2 901 EAST PRINCESS ANNE RO NORFOLK, VA 23504	ZIP CODE	2/24/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 610	what had happend speak English and trying to tell him so understand her. Wher family to see i happened, RN #1 stated that he just RN #1 stated that ADON and the	ed, RN #1 stated that she didn't dethat it seemed like she was comething but that he could not when asked RN #1 if he called if they could translate what had stated that he did not. RN #1 told the son that she had fallen. later that day he notified the con informed him that he sidents have fallen if he did not the resident can not tell him that he sidentifying the incident as an origin. When asked if after he nen treated the incident like an origin and started an #1 stated that he did not. RN #1 the ADON had started an	F6	10			
	conducted with AS Member) #3, the A Nursing). When as that Resident #1 h found lying in her lassistance from or transfers; ASM #3 was determined. I document what yo ASM #3 stated that documenting. Whe she found out this then treated Resid Unknown Origin," that she had a lot g stated that she wa 6:30 a.m." When a	AZ a.m., an interview was SM (Administrative Staff ADON (Assistant Director of Sked how it was determined and a fall on 2/2/21 if she was beed and required extensive to staff with bed mobility and stated, "I don't know how that told the nurse that you can't u didn't see or didn't know." It she educated RN #1 on the ent #1 on the ent #1 in jury as an "Injury of ASM #3 stated that she did not, going on that morning. ASM #3 is "racing to set up a clinic at the extending of the checked on the what had happened. ASM #3					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/26/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495210 B. WING 02/24/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 EAST PRINCESS ANNE ROAD NORFOLK HEALTH AND REHABILITATION CENTER NORFOLK, VA 23504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 22 F 610 stated that she did not. When asked how staff communicated with Resident #1, ASM #3 stated that the Director of Rehab could speak Spanish and would come in to see the resident every day. When asked if the Director of Rehab worked 11-7 shift, ASM #3 stated that she did not. When asked if anyone alerted the Director of Rehab to come talk to Resident #1 later in the morning prior to Resident #1's urology appointment, ASM #3 stated that she didn't think so. ASM #3 stated that she would have expected RN #1 to call the family to translate what the resident was trying to convey to the nurse. On 2/24/21 at 10:37 a.m., an interview was conducted with CNA (Certified Nursing Assistant) #1, the CNA who worked on 2/2/21 11-7 shift. When asked what she could recall happened that night, CNA #1 stated that the last time she rounded on Resident #1 was around 3:45 a.m. CNA #1 stated that the resident was dry at that point and did not need to be changed. CNA #1

stated that at approximately 5:30 a.m., she went to check in on Resident #1 and saw her lying in bed on her left side. CNA #1 stated that she also noticed feces all over the bed, her brief pulled off and thrown on the floor and her Foley and night shirt were also on the floor. CNA #1 stated that there was no blood on the floor. CNA #1 stated that she immediately grabbed new sheets and a brief and began to clean her up and put new clothes on her. CNA #1 stated that when she turned the resident to the right right, she noticed a big laceration to her forehead near her left eye. CNA #1 stated that she immediately got the nurse and the nurse did an assessment and left the room to gather Foley catheter supplies. CNA #1 stated that she was instructed to remain present while the nurse was re-inserting the Foley. When

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495210			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495210	B. WING			С
	NAME OF PROVIDER OR SUPPLIER NORFOLK HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504	CODE	2/24/2021
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETION DATE
	asked if Resident into bed if she had stated there was a hanging off her beresident using her bed. On 2/24/21 at 12:4 Administrator and Nursing) were made concerns. On 2/24/21 at 1:05 Nurse emailed this Regarding the abowas documented: laceration to forehed on floor. Resident's that resident made 2/2/21. Daughter mallegation before the came to the facility the Administrator sto the officer. 1. FRI done regard 2/3/21. 2. Review of chart: notified NP (nurse Click Care) conversand replacing Foley 3. RN documented late entry, assumpt 4. Resident admitted were entered for the 5. RN replaced the Action: 1. Resident discharting the same to the Action: 1. Resident discharting the Action: 1. Resident dischar	#1 was able to get herself back fallen out of the bed, CNA #1 time when Resident #1 was d and she had witnessed the upper body to get back into the witnessed the upper body to get back into the B a.m., ASM #1, the ASM #2, the DON (Director of de aware of the above p.m., ASM #4, the Corporate writer a Plan of Correction we issue. The following in part, 'Resident found in bed with a ead, Foley Catheter tubing lying a daughter made staff aware an allegation of rape on hade police aware of the perfacility was able to. Police on 2/6/21 and requested that end results of his investigation ing allegation of rape on RN (Registered Nurse) practitioner) via PCC (Point station after initiating treatment of Cath. inaccurate information (times, ions of fall). Ed with Foley but no orders ee Foley. Foley without and order	F 6	10		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
-		495210	B. WING		C 02/24/2021	
		ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE	ULD BE	(X5) COMPLETION DATE
F 610	were reviewed to e unknown origin was identifiedcompleting. Nurses will be ed a. Identifying an injub. Accurate docume c. MD/NP (Medical Party) notification of when pulled out. d. Obtaining orders replacementcomp Facility staff will be ea. Abuse b. Injury of unknown c. Timely report of a 2/16/21. 5. Incident notes will monitor accurate ideaccurate documenta notification of the MI basis. A random were Foley cath will be coorder is present for the full that facility staff inclusions for the full that facility staff inclusions were expected by the following present for the full that facility staff inclusions were expected by the full that facility staff inclusions for th	Insure than an injury of a correctly on date: 2/15/21. Sucated on: Iry of unknown origin. Iry origin of treatments, Foley letion date: 2/19/21. Iry origin of the injury, Iry origin of an incident, timely D/NP on a random weekly or	F 61			
	PAST NON COMPL Bowel/Bladder Incon CFR(s): 483.25(e)(1	tinence, Catheter, UTI	F 690			3/1/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495210	B. WING			
NAME OF PROVIDER OR SUPPLIER NORFOLK HEALTH AND REH		1	STREET ADDRESS, CITY, STATE, ZIP CODE 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504	02/24/2021	
PREFIX (EACH DEFICIENCY	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION	
resident who is contadmission receives maintain continence condition is or becondition in the continence, based comprehensive assensure that- (i) A resident who erindwelling catheter is resident's clinical condition catheterization was (ii) A resident who erindwelling catheter of is assessed for remassible unless that cand (iii) A resident who is receives appropriate prevent urinary tract continence to the expective appropriate prevent uninary tract continence to the expective appropriate receives appropriate restore as much nor possible. This REQUIREMEN by: Based on staff inter	ence. facility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical mes such that continence is ntain. resident with urinary d on the resident's essment, the facility must the facility without an s not catheterized unless the endition demonstrates that necessary; nters the facility with an or subsequently receives one oval of the catheter as soon he resident's clinical condition atheterization is necessary; es incontinent of bladder the treatment and services to the infections and to restore tent possible. resident with fecal	F 690	Past noncompliance: no plan of correction required		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495210	B. WING			C 02/24/2021	
		ABILITATION CENTER		STREET ADDRESS, CITY, STA 901 EAST PRINCESS ANNE NORFOLK, VA 23504	ATE, ZIP CODE	Value Track	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCE	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
	facility staff failed to a Foley catheter for residents; Resident The findings include Resident #1 was ad 1/12/21 with diagno limited to unspecifie dementia without be of TIA (stroke), reterdiabetes mellitus, and Resident #1's most set) assessment was with an ARD (asses 1/18/21. Resident #1 severely impaired in out of 15 on the BIM Status) exam. Resident #1 severely impaired in out of 15 on the BIM Status) exam. Resident #1 severely impaired in out of 15 on the BIM Status) exam. Resident #1 severely impaired in out of 15 on the BIM Status) exam. Resident #1 severely impaired in out of 15 on the BIM Status) exam. Resident #1 was considered as a sistence at ing, and personal dependence on one Resident #1 was considered as having a Review of Resident that she was admitted catheter in place. The regarding her Foley physician. The follow " She had acute under a Foley catheter. She remains with a Foley Further review of Resident Further Further Resident Further Further Resident Further Resident Further Further Resident Further Further Further Resident Further	o obtain an order for the use of one of five sampled (#5.) dmitted to the facility on sees that included but were not ed convulsions, vascular chavioral disturbance, history ntion of urine, type two and muscle weakness. The recent MDS (minimum data as an admission assessment assent reference date of 1 was coded as being a cognitive function scoring 06 MS (Brief Interview of Mental dent #1 was coded as assistance with two staff mobility, and transfers, and the from one staff with dressing, all hygiene, and total the staff member with toileting. The ded in Section H (Bowel and a urinary catheter. #1's clinical record revealed the ded to the facility with a Foley the first documented note was on 1/13/21 by the wing in part, was documented: inary retention. She required the failed a voiding trial and by catheter."	F 6	90			
		for the use of a Foley					

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495210	B. WING		0.0	C		
NAME OF PROVIDER OR SUPPLIER NORFOLK HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 901 EAST PRINCESS ANNE ROAD NORFOLK, VA 23504				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 690	Review of Resident #1's hospital discharge instructions dated 1/12/21 failed to evidence orders for the Foley Catheter. Resident #1's care plan dated 1/12/21 failed to evidence any care instructions for the use of her		F 69	90				
	Foley catheter. Review of the clinic Resident #1 pulled 2/2/21 on 11-7 shift documented: "Was Nursing Assistant) with laceration to the that Foley was pulled the floor. Resident happened and how Foley was reinserted urine) observe. print family (Name of Scabout incident."	cal record revealed that out her Foley catheter on t. The following note was a notified by CNA (Certified about resident laying in bed ne forehead, it was also noted ed out of patient and laying on could not verbalize what injury occur18 Fr (French) ed and hematuria (blood in mary care provider (Name) and on, Next of Kin) made aware						
	On 2/23/21 at 9:49 conducted with RN nurse who was on was observed on the occurred after he sout, RN #1 stated the and because the refoley in place, he refoley in place, he refoley in aide preful had an order for #1 stated that he we check for an order at	a.m., an interview was (Registered Nurse) #1, the duty when Resident #1's Foley ne floor. When asked what had aw Resident #1's Foley pulled hat he grabbed Foley supplies esident previously had a 18 FR e-inserted an 18 Fr Foley with esent. When asked if Resident an 18 FR Foley catheter, RN as not sure, that he didn't even at that time. When asked who ensuring orders are in place						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/26/2021 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING _ COMPLETED C 495210 B. WING 02/24/2021 NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

()(1)	CHAMADY OTATELED	NC NC	NORFOLK, VA 23504		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	at the time of an admission for the use of a Foley catheter, RN #1 stated that the nurse doing the admission nurse would be responsible. When asked of he knew if Resident #1 had orders in place for the use of her Foley, RN #1 stated, "No. I don't." When asked what catheter orders would specify, RN #1 stated that catheter orders included directions of how often to change the Foley, Foley care every shift, and an order for the use of the Foley including size and diagnosis. When asked why Resident #1 had a Foley in place, RN #1 stated that Resident #1 had urinary retention. On 2/24/21 at 10:12 a.m., an interview was conducted with ASM (Administrative Staff Member) #3, the ADON (Assistant Director of Nursing). When asked if orders were required for the use of a Foley Catheter, ASM #3 stated that orders usually specified the size and diagnosis for the use of the Foley as well as orders specifying when to change the Foley. ASM #3 stated that the facility usually changed the Foley every 30 days from the day it was inserted. When asked why Resident #1 had a Foley, ASM #3 stated that she had urinary retention with previous failed voiding trials in the hospital. When asked if Resident #1 had an order for the use of the Foley, ASM #3 stated that she had urinary retention with previous failed voiding trials in the hospital. When asked if Resident #1 had an order for the use of the Foley, ASM #3 stated that she would have expected the nurse doing Resident #1's admission to put Foley orders in place, or clarify if directions were not on the hospital discharge paperwork. On 2/24/21 at 12:48 a.m., ASM (Administrative Staff Member) #1, the Administrator and ASM #2, the DON (Director of Nursing) were made aware of the above concerns.	F 690			

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/26/2021 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495210 B. WING 02/24/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 EAST PRINCESS ANNE ROAD NORFOLK HEALTH AND REHABILITATION CENTER NORFOLK, VA 23504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) Continued From page 29 F 690 On 2/24/21 at 12:51 a.m., an interview was conducted with ASM #2, the DON (Director of Nursing). ASM #2 confirmed that Resident #1 did not have orders for the use of her Foley Catheter. Facility policy titled, "Urinary/Catheter Care." documented in part, the following: "Licensed nurses may perform indwelling, in an out urinary catheterization, removal of urinary catheters and application of External Catheters with physician's orders..." On 2/24/21 at 1:05 p.m., ASM #4, the Corporate Nurse emailed this writer a Plan of Correction Regarding the above issue. The following in part, was documented: "Resident found in bed with a laceration to forehead, Foley Catheter tubing lying on floor. Resident's daughter made staff aware that resident made an allegation of rape on 2/2/21. Daughter made police aware of the allegation before the facility was able to. Police came to the facility on 2/6/21 and requested that the Administrator send results of his investigation to the officer. 1. FRI done regarding allegation of rape on 2. Review of chart: RN (Registered Nurse) notified NP (nurse practitioner) via PCC (Point Click Care) conversation after initiating treatment and replacing Foley Cath. 3. RN documented inaccurate information (times,

Action:

late entry, assumptions of fall).

1. Resident discharged on 2/2/21.

were entered for the Foley.

4. Resident admitted with Foley but no orders

5. RN replaced the Foley without and order....

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/26/2021 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: A. BUILDING COMPLETED 495210 B. WING 02/24/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 901 EAST PRINCESS ANNE ROAD NORFOLK HEALTH AND REHABILITATION CENTER NORFOLK, VA 23504 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 690 | Continued From page 30 F 690 2. Falls which occurred over the past 30 days were reviewed to ensure than an injury of unknown origin was correctly identified...completion date: 2/15/21. Nurses will be educated on: a. Identifying an injury of unknown origin. b. Accurate documentation of incident. c. MD/NP (Medical Doctor) and RP (Responsible Party) notification of injury, replacement of Foley when pulled out. d. Obtaining orders for treatments, Foley replacement...completion date: 2/19/21. Facility staff will be educated on: a. Abuse b. Injury of unknown origin c. Timely report of abuse....completion date: 5. Incident notes will be reviewed by a Nurse to monitor accurate identification of an injury, accurate documentation of an incident, timely notification of the MD/NP on a random weekly basis. A random weekly monitor of residents with Foley cath will be completed to ensure that an order is present for the catheter. Further review of the staff education revealed that nursing staff were educated on the replacement

COMPLAINT DEFICIENCY

PAST NON COMPLIANCE

2/19/21.

of a Foley catheter with a physician's order on

No further information was presented prior to exit.