STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/11/2020 through 02/13/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2-11-2020 through 2-13-2020. One complaint was investigated during this survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 94 certified bed facility was 86 at the time of the survey. The survey sample consisted of 25 current Resident reviews, and 4 closed record reviews.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when	F 582		3/17/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/04/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 582	Continued From page 1	F 582		

changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.
(v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.
This REQUIREMENT is not met as evidenced by:

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F 582	Continued From page 2 Based on Staff interview and facility documentation review, the facility staff failed to complete a skilled nursing facility (SNF) Advanced Beneficiary Notice of Medicare non-coverage (ABN/NOMNC) for one Resident, (Resident #182), in a sample of 3 residents. The findings included: For Resident #182, no SNF/ABN NOMNC was provided prior to discharge from skilled services. On 2-13-2020, a review of the facility's ABN/NOMNC forms issued during the last six months was conducted. Three discharged residents were chosen for review. Resident #182 was admitted to skilled nursing care in the facility on 1-3-2020, and discharged on 1-15-2020. The last Medicare covered day for the Resident was 1-15-2020. The Resident's benefit days had not been exhausted, however, the Resident had reached a plateau, and it was felt that he no longer required skilled nursing care and that level of care was discontinued without the Resident receiving notice of the change in time to appeal the decision. The Resident was called via telephone after discharge to notify him of his loss of coverage as no form was signed by the Resident while living in the facility. The Resident was his own responsible party, and had signed all admission paperwork. The form was signed as given via telephone on 1-13-2020, however, the Resident was still in the	F 582	1. Resident #182 was discharged from the facility on 1/14/2020. 2. All residents who have the potential to receive an Advanced Beneficiary Notice of Medicare Non-Coverage (ABN/NOMNC) have the potential to be affected by this practice. An audit will be conducted by the Social Services Department/Designee for all residents who have had the potential to receive an ABN/NOMNC in the past 30 days for proper completion. 3. The Administrator/Designee will re-educate the Social Services Department on completion of ABN/NOMNC per the regulation. 4. The Administrator/Designee will audit all ABN/NOMNC for completion per regulation weekly for twelve weeks. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

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F 582	Continued From page 3 facility at that time. The Director of Nursing and Administrator were interviewed and stated that they did not know what happened in that situation, and further, that the previous Social Services Director had completed the form. They stated that there was currently no social worker at the facility as the previous social worker resigned and exited her position on 1-24-2020. On 2-13-18, at 4:00 p.m., at the end of day meeting, the Facility Administrator was made aware of the staff failure for NOMNC provision. She provided no further information.	F 582		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		3/17/20

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F 584	Continued From page 4 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and clinical record review the facility staff failed to provide a clean, comfortable and homelike environment for 1 Resident (#54) in a survey sample of 29 Residents. The findings included: For Resident #33 the facility staff failed to provide sheets that were clean and without holes. Resident # 33 a 79 year old woman admitted to the facility on 8/5/19 with diagnoses of but not limited to hemiplegia and hemiparesis following a stroke affecting right side, vascular dementia, major depressive disorder, hypertension and history of stroke. Resident # 33's most recent MDS (Minimum	F 584	1. The sheet was removed from Resident #33's bed and a clean sheet without holes was provided on 02/11/2020. 2. All residents who reside at the facility have the potential to be affected by this practice. A quality audit will be conducted by the Housekeeping Director/Designee on all linens to ensure no stains or holes are present. 3. The Director of Nursing/Designee will re-educate nursing staff and housekeeping staff on safe, clean, comfortable, homelike environment, including but not limited to proper disposal of stained or torn linens. 4. The Director of Nursing/Designee will	

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DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 584	Continued From page 5 Data Set) with an ARD (Assessment Reference Date) of 12/4/20 coded as a Quarterly codes Resident #33 as having a BIMS (Brief Interview of Mental Status) score of 4 indicating severe cognitive impairment. The Resident is also coded as being "Always incontinent" for bowel and bladder. On 2/11/20 at approximately 6:30 PM observed Resident #33 sitting on bed in room. The bed covers were pulled down and the bottom sheet was exposed. Observed a yellow stain extending out approximately 6 inches in a circular patten around her buttocks area The room had a distinct odor of urine present. On 2/11/20 at approximately 6:35 PM an interview with CNA B who stated, yes I see the urine stain on the bed, and yes it is dry and yes I see the holes in the sheet. CNA B stated " I am agency and its short in here all the time we do the best we can." At approximately 6:55 PM the Administrator was in the hall and she also observed the yellow stain on the sheets and the holes in them. She stated that the "Resident and her bed should have been changed and sheets with holes are not to be put on Resident beds." On 2/12/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided	F 584	complete quality rounds weekly for twelve weeks to ensure resident bed linen is without stains and/or holes. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	
F 586 SS=D	Resident Council with External Entities CFR(s): 483.10(k) §483.10(k) Contact with External Entities. A facility must not prohibit or in any way	F 586		3/17/20

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F 586	Continued From page 6 discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, staff interview, and Resident Representative interview, the facility staff interfered and prevented the free communication, as a direct request from a family member, to speak with state surveyors for one family member for a survey sample of 29 residents. The findings included; On 2-13-2020 surveyors observed 3 staff members stationed at the end of the Administrative office hallway. The hallway contained only offices for the directors, the Administrator, and a conference room where surveyors were located, which was across from the administrator's office. Those staff members were Admin (E), Admin (G), and Admin (H). Each of the three corporate staff members were observed standing by the hallway entrance individually or together at all times from 9:30 a.m., until 11:40 a.m.	F 586	1. The family member spoke with surveyors on 02/13/2020. Admin (G) and Admin (E) were provided with education by the Regional Vice President of Operations on guidelines on not interfering and/or preventing the free communication of family members speaking with the survey team. 2. All residents and/or responsible parties have the potential to be affected by this practice. 3. The Regional Vice President of Operations/Designee will re-educate Administration staff on guidelines on not interfering and/or preventing the free communication of family members speaking with the survey team. 4. During visits from State Surveyors or other similar entities, the Administrator/Designee will monitor for	

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	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

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F 586	Continued From page 7 At 11:45 a.m., two surveyors exited the hallway, and saw all three at the nursing station talking. The surveyors were approached by a family member who asked "are you from the state?", the surveyors responded yes, and family member stated I am so glad, I have been here since 9:00 a.m., and I wanted to talk to you but they just kept giving me the run around (pointing to the nursing station) and I didn't know where to find you." The family member was escorted to the conference room for interview. After the interview was concluded, the family member was escorted back down the hallway by 2 surveyors to find Admin (E), (G), and (H) again standing at the entrance to the hallway. The family member was asked in their presence which individual refused to bring her to the surveyors, and she pointed to Admin (E), and Admin (G). Admin (G) stated "I simply told her to come and talk to the Director of Nursing (DON) first, and then she could come and speak to surveyors." The family member then stated that she did that, and the DON said she would get back to her, but that had been at 9:30 a.m., and no one had come. The POA further stated that she asked Admin (E) to see the surveyors because she couldn't wait any longer, as she had to get to work." Admin (E) told her that "surveyors were with other family members, and she would have to come back later." Admin (E), (G), and (H) were asked at that time what role they were responsible for in the facility on a daily basis. They all answered that they were not in the facility daily, and were here to simply assist the administrator with her survey. They were asked if they knew the resident or family populations in the facility, and worked with	F 586	the ongoing accessibility and open door guidance from all team members. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

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F 586	Continued From page 8 them on a regular basis. All answered "no". On 2-13-2020 at 4:00 p.m., at the end of day debrief, the Administrator and DON were notified of findings. No further information was presented by them.	F 586		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		3/17/20

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F 656	Continued From page 9	F 656		

desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed, for 3 residents of 29 residents (Resident #36, Resident #332, Resident #25) to implement or develop the comprehensive care plan.

The Findings included:

1. For Resident #36, the facility staff failed to implement the Bowel and Bladder care plan.

Resident #36 was an 87 year old. Resident #36's diagnoses included Generalized Muscle Weakness, and incontinence of bowel and bladder.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 12/4/19 was reviewed. Resident #8 had a Brief Interview of Mental Status score of 8, indicating moderately impaired cognition. Resident #8 was coded as requiring the physical assistance of one person for transfers for toileting and hygiene. Resident #8 was also coded as always being

1. Incontinence care was immediately addressed at the time of staff awareness for Resident #36. For Resident #332, pillows and fall mat to the left side of the bed were implemented per the care plan at the time of staff awareness. For Resident #25, the care plan was revised to include use of a Bi-Pap machine for apnea during sleep.

2. All residents who reside at Dockside Health and Rehabilitation Center and utilize fall prevention devices, Bi-Pap machines, and/or have bowel and bladder incontinence have the potential to be affected by this practice. A quality audit will be conducted by the Director of Nursing/Designee of all current incontinent residents' care plans for implementation of interventions per the Bowel and Bladder Care Plan. A quality audit will be conducted by the Director of Nursing/Designee of all residents for implementation of fall interventions per the care plan. A quality audit will be conducted by the Director of

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F 656	Continued From page 10 incontinent of bowel and bladder. On 2/12/20, a review was conducted of Resident #36's clinical record, revealing a care plan. An excerpt read, "10/8/19. Resident is incontinent of bowel and bladder. Resident will receive assistance with toileting / maintained comfortable clean and dry / free from skin breakdown. Implement toileting program as indicated. Provide incontinence care as needed." On 1/11/20, Resident #36 developed a rash on her buttocks and inner thigh. The physician's order read, "1/11/20. Calmoseptine 0.44-20. 6% Oint [ointment] -Apply bilateral buttocks every shift. 1/11/20. Skin-Prep Box - Apply to right inner thigh every shift." On 2/12/20 at 3:00 P.M., an interview was conducted with Resident #36's family member in the conference room. She showed the survey team a picture she had taken of her mother dated 10/22/19. She complained that her mother was often left sitting in feces and had a strong odor of urine. The picture showed Resident #36 sitting at the nurse's station in her wheelchair. She had a very large liquid stain on her pants, which covered most of her lap, in addition to a puddle of liquid on the floor. Resident #36's daughter also said that Resident #36 had an incident in the beauty parlor about 10:00 A.M., an hour before the interview. The Activities Aide (Employee D) was also in the beauty parlor at the time. It was the beautician's usual practice to ask staff to transfer Resident #36 from her wheelchair into the beauty parlor chair. Upon the transfer, Resident #36's brief was so full that urine and feces leaked out of her brief	F 656	Nursing/Designee for current residents who utilize a Bi-Pap machine for apnea to ensure it is included in the care plan. 3. The Director of Nursing/Designee will re-educate all licensed nursing staff on care plans, including but not limited to implementation of interventions per the care plan and development and revision of care plans. 4. The Director of Nursing/Designee will conduct an audit of five residents, five times weekly for twelve weeks to ensure implementation of fall intervention strategies per the care plan. The Director of Nursing/Designee will review new admissions for Bi-Pap usage to ensure it is included in the plan of care five times weekly for twelve weeks. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

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F 656	Continued From page 11	F 656		

onto her wheelchair. Resident #36 was unable to have her hair done at that time because she had to be taken to her room for incontinence care.

On 2/12/20 at 3:45 P.M., an observation was made on the activity porch of Resident #36 sitting in her wheelchair. She appeared to be clean.

On 2/13/20 at 9:00 A.M., an interview was conducted with the Activities Aide (Employee D). She was asked to describe the incident that occurred in the beauty parlor on the previous day. She stated, "That happened yesterday at approximately 10:00 A.M. in the beauty shop. When they lifted her to put her in the beauty chair urine and feces fell out. It got all over her chair and the floor. Two staff persons did the transfer.

On 12/12/20 at approximately 11:00 A.M., an interview was conducted with the Director of Nursing (Employee B) in the conference room. She was unable to explain what led to the incontinence care issues. She stated that she had only been in her position for few months. She submitted 2 concern forms. An excerpt read, "6/29/19. Per [family member] resident was left in feces and placed in her room because resident cursed; which is 'abuse'. 11/25/19 About 2 weeks ago res. [resident] on act [activity] porch with puddle of urine under her. RP [responsible party] req. [requested] res [resident] checked every 2 hours and documentation of such. Req. [requested] ensure leg rests in place...Doesn't feel resident receives adequate personal hygiene & is concerned she will become septic."

No further information was received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 656	Continued From page 12	F 656		

2. For Resident #332, the facility staff failed to implement the care plan and provide pillows to establish bed parameters as indicated in the care plan.

Resident #332, a 63-year old male/female, was admitted to the facility on 02/06/2020. Diagnoses included but not limited to schizophrenia, dementia, and type 2 diabetes mellitus. Due to the new admission status, a Minimum Data Set assessment was not completed.

On 02/12/2020 at 8:48 AM, Resident #332 was observed lying in her bed with the head of the bed elevated approximately 45 degrees and leaning to the left side of the bed, laterally bent at the waist. This surveyor looked for a certified nursing assistant to alert staff Resident #332 was leaning in her bed. This surveyor and Certified Nursing Assistants E and F (CNA E, CNA F) entered Resident #332's room and CNA E began repositioning Resident #332 in her bed.

On 02/12/2020 at 9:06 AM, Resident #332 was observed sitting up in her bed with the head of the bed elevated. A staff member was assisting her to eat her breakfast meal. There were no pillows observed that lined the sides of the bed.

On 02/12/2020 at 11:05 AM, this surveyor was standing in the hall outside Resident #332's room and observed Resident #332 lying in her bed with the head of the bed elevated 45 degrees. Resident #332 upper torso was bent at the waist and leaning over the left side of the bed. Resident #332's head and left shoulder were extended past the edge of the bed. There were no pillows

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 656	Continued From page 13	F 656		

tucked under the sheet on the left side of the bed. At that time, the administrator entered Resident #332's room, looked around Resident #332's bed and living area and then left the room. At approximately 11:07, a housekeeper then entered Resident #332's room and walked back to the doorway, looked down the hall, and stated to a staff member by nurse's station, "Get one of the nurses" and "she needs to be pulled over on the bed." At 11:11 AM, the administrator and Registered Nurse A (RN A) entered Resident #332's room and donned gloves to render care. RN A spoke to Resident #332 and stated that they were going to "get you another pillow and get you more comfortable." Another staff member entered the room and handed them pillows as the administrator and RN A repositioned Resident #332 in bed.

On 02/12/2020 at 11:21 AM, a meeting with the administrator was conducted. When asked why she entered Resident #332's room the first time, she stated she wanted to see why "everyone" was standing outside the room and to see if there were any concerns. When asked why she entered Resident #332's room the second time, the administrator stated that she wanted to "see if staff followed up" because she "had a positioning concern." The administrator acknowledged Resident #332 was leaning over the left side of the bed and there were no pillows or fall mat on left side of bed present.

On 02/12/2020 at 2:50 PM, Resident #332 was observed in her bed lying on her back with the head of the bed elevated approximately 30 degrees. There were pillows tucked under the bottom (fitted) sheet along both sides of the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 656	Continued From page 14	F 656		

The care plan was reviewed. A focus initiated on 02/10/2020 (two days after the actual fall) was entitled, "Actual fall and at risk for future falls related to: decreased mobility, weakness, history of falls." An intervention initiated on 02/10/2020 associated with this focus documented, "Utilize pillows to assist in definition of bed parameters."

The facility staff provided a copy of their policy entitled, "Comprehensive Care Planning."All direct care staff must always know, understand, and follow their Resident's Care Plan. If unable to implement any part of the plan, notify your charge nurse or MDS Coordinator, so that this can be documented or the Care Plan changed if necessary."

On 02/12/2020 at approximately 6:10 PM, the administrator and DON were notified of findings. The administrator acknowledged that Resident #332 did not have pillows to provide bed parameters. The DON stated that her expectation is that if it is on the care plan, the measure should be in place.

3. For Resident #25 the facility staff failed develop and implement a care plan that addresses the use of her Bi-pap machine for apnea during sleep.

Resident #25, a 58 year old woman admitted to the facility on 11/24/19 with diagnoses of but not limited to acute and chronic respiratory failure with hypoxia, pneumonia, heart failure, anxiety disorder, Atrial fibrillation, and chronic obstructive pulmonary disorder.

Resident #25's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Dater)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 656	Continued From page 15 of 12/01/19 coded as an OBRA Assessment. Resident #25's MDS coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 indicating the Resident has no cognitive impairment. Resident #25 is independent in all ADL (Activities of Daily Living) however she is on oxygen and uses the Bi-pap machine at night for Sleep Apnea (Sleep Apnea is sleep disorder where the breathing stops and starts). On 2/11/20 at 7:15 PM a review of the Resident's care plan revealed no care plan for a BiPAP. On 2/12/20 at approximately 1:00 PM the DON was asked about the Bi-Pap machine and she stated that she was unaware of the Bi-Pap not being care planned. She stated that any medical equipment usage and treatments should be documented on the care plan. The administrator was made aware of the concerns during the end of day meeting and no further information was provided.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 657	Continued From page 16 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on Observation, clinical record review, staff interview, and facility document review, the facility staff failed to review and revise a nutritional care plan for one Resident (Resident #60) in a survey sample of 29 Residents. The findings included; Resident #60's care plan did not reflect severe weight loss, Registered Dietician (RD) recommendations, and that the resident dependant upon staff to eat. Resident #60 was admitted to the facility initially on 4-28-17. Diagnoses included; Depression, blindness left eye, history of falling, Parkinson's disease, and high cholesterol. The most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 12-27-19.	F 657	1. The care plan for Resident #60 was updated to include significant weight loss and interventions for weight loss. 2. All residents who reside at the facility have the potential to be affected by this practice. The Director of Nursing/Designee will conduct an audit of nutritional care plans for inclusion of recommendations from the Registered Dietician and accuracy in reflection of resident status. 3. The Director of Nursing/Designee will educate licensed nursing staff on comprehensive care plan and revision, including but not limited to inclusion of nutritional care plans and recommendations from the Registered Dietician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 657	Continued From page 17 Resident #60 was coded with a Brief Interview of Mental Status score of 13 indicating mild cognitive impairment. The Resident required limited assistance with activities of daily living (ADL's), to include set up and supervision for eating. The only exceptions were toileting, hygiene, and bathing, which required extensive assistance from one staff member. The previous quarterly MDS assessment dated 9-23-19, was also reviewed. Both documented "no weight loss". Resident #60's weights (in pounds) were documented as follows: 2/21/19-150.3 3/26/19-146.3 4/5/19- 145.0 5/8/19- 143.0 6/12/19- 142.2 7/28/19- 142.0 8/12/19- 135.0 9/11/19- 134.2 10/9/19- 130.0 11/4/19- 132.4 12/4/19- 120.8 1/13/2020- 117.8 2/11/2020- 102.0 Resident #60's "Dietary Assessment Notes" completed by the Registered Dietician (RD) were all reviewed from March 2019 through February 2020. The notes describe the Resident's orders, and plans. A synopsis of that information follows in chronological order below; 8-12-19 - 10% weight loss over 180 days, recommend weekly weights & fortified meals with breakfast & dinner.	F 657	4. The Director of Nursing/Designee will complete an audit of all resident with recommendations from the Registered Dietician weekly for update and revision to the care plan. Findings will be submitted to QAPI for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 657	Continued From page 18	F 657		

12-9-19 - weight loss, encourage to eat in dining hall, re-weight, weekly weights due to significant loss, start med pass 2.0 (supplement drink) 120 milliliters (ml) twice per day, will continue to monitor.

Resident #60 was observed eating in the dining area across from the nursing station on two occasions. The first observation took place on 2-12-2020 at 9:00 a.m., and the second at 12:00 p.m. The third observation was on 2-12-2020 at 5:30 p.m., in the Resident's room. The first 2 observations the Resident was sitting in a "Geri" reclining chair being fed by staff, and he consumed 100% of both meals. The third observation he was being fed and consumed 100% of his meal.

Resident #60's care plan was reviewed and revealed the only portion of the 99 page care plan document specifically dealing with nutrition was as follows;

"Focus" listed; "nutrition risk related to Parkinson's, potential for dehydration related to constipation medications, weight loss exhibited, resident with behaviors and increased confusion at times, falls, and risk of varied oral intake." initiated by the former RD on 5-7-17, and not revised until 1-14-2020.

"Interventions/Tasks" listed; Encourage resident to dine in dining room as appropriate, monitor dietary intake and monitor for constipation, monitor for signs and symptoms of dehydration, monitor weight per protocol, provide diet per order, provide supplements/fortified food items as indicated/per order, respect resident dietary choices, review preferences per routine and as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 657	Continued From page 19 needed, The Resident's diet, changes and additions to that diet, supplements, weekly weights, and help needed with feeding were not included in the care plan to guide staff in the care of this Resident. It was not updated with the Resident's significant weight loss, nor interventions for that weight loss. At the end of day meeting on 2-13-2020, Resident #60's lack of care plan updates, and failure of staff to follow policy for weight loss, was reviewed with the Administrator and Director of Nursing. No further information was provided.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide services that meet professional standards of quality care for 1 residents (Resident #332) in a sample size of 29 residents. The findings included: 1. For Resident #332, the facility staff failed to create an Activities of Daily Living (including meal consumption) flowsheet since her admission on 02/06/2020.	F 658	1. An Activities of Daily Living Flow Sheet was initiated on 02/12/2020 for Resident #332. 2. All residents who are admitted to the Dockside Health and Rehabilitation Center have the risk of being affected by this practice. The facility has converted to electronic charting of Activities of Daily Living. 3. The Director of Nursing/Designee will educate certified nursing assistants on documentation, including but not limited to	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 658	Continued From page 20 Resident #332, a 63-year old female, was admitted to the facility on 02/06/2020. Diagnoses included but not limited to schizophrenia, dementia, and type 2 diabetes mellitus. Due to the new admission status, a Minimum Data Set assessment was not completed. On 02/11/2020 at approximately 7:10 PM, in the course of a nutrition investigation for Resident #332, an interview with Licensed Practical Nurse D (LPN D) was conducted. When asked about the documentation for intake and output, LPN D stated that the Certified Nursing Assistants (CNA's) document on the ADL [Activities of Daily Living] flowsheet kept in the section book for each unit. When asked to see the ADL flowsheet for Resident #332, LPN D and this surveyor looked through the section book and the ADL flowsheet for Resident #332 could not be located. LPN D stated it may not be there because Resident #332 was recently admitted. When asked when Resident #332 was admitted, LPN D looked through Resident #332's hard chart and verified Resident #332 was admitted on 02/06/2020 (5 days ago). When asked about the expectation for creating an ADL flowsheet, LPN D stated that it should be "put in there [the section book] on admission." On 02/12/2020 at approximately 6:00 PM, the administrator and DON were notified of findings. When asked why it's important to initiate an ADL flowsheet, the DON stated it's important to "document their care and meal intake." The DON verified their professional standard reference was Lippincott. According to Lippincott Nursing Procedures, Seventh Edition, 2016, under the section entitled,	F 658	the importance of complete and thorough charting of Activities of Daily Living and meal intake. 4. The Director of Nursing/Designee will monitor Activities of Daily Living charting five times weekly for twelve weeks to ensure completion of documentation. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 658	Continued From page 21 "Documentation", it was written, "Documentation is the process of preparing a complete record of the patient's care and is a vital tool for communication among health care team members. Accurate, detailed documentation shows the extent and quality of care that nurses provide, the outcomes of that care, and treatment and education that the patient still needs. Thorough, accurate documentation decreases the potential for miscommunication and errors. Documentation is a valuable method for demonstrating that the nurse has applied nursing knowledge, skills, and judgment according to professional nursing standards." On 02/13/2020 at the end of survey, the administrator and DON had no further information or documentation to offer.	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility document review, staff interview, Resident interview, and family interview, the facility staff failed to provide meaningful activities from	F 679	1. Resident #81 has been reassessed by the Administrator for her activity preferences and interests.	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 679	Continued From page 22 12-13-19 until the time of survey for one Resident (Resident #81) in a survey sample of 29 residents. The findings included; Resident #81 was admitted to the facility on 11-23-19. Diagnoses included; Angina, atrial fibrillation, osteoarthritis of the knee, chronic kidney disease, chronic congestive heart failure, recurrent depression, recurrent falls, and insomnia. Resident #81's most recent Minimum Data Set Assessment was a full admission assessment with an assessment reference date of 11-30-19. She was coded with no cognitive impairment. She required only assistance with meal preparation and tray set up and was otherwise independent with all activities of daily living (ADLs). The Resident had difficulty with walking, and so in her room used a walker, and outside of her room, used a wheel chair for ambulation. Resident #81 was first observed on 2-11-2020 during initial tour of the facility at approximately 6:45 p.m. in her room in a low bed. She did not respond to verbal stimulation, and appeared to be asleep. The Resident was interviewed on 2-13-2020 at 3:00 p.m., when asked what activities she enjoyed, the Resident stated "They don't really have many activities here that I want to attend, so there's not much to do." The Resident's care plan was reviewed and revealed under the heading of "focus", "At risk for self care deficit, pain, visual impairment." As	F 679	2. All residents have the potential to be affected by this practice. An audit of all residents admitted since 12/13/2019 will be conducted to ensure completion of an assessment of activity preferences. 3. The Regional Vice President of Operations/Designee will re-educate the Administrator on meaningful activities and the requirements for an Activity Director. A qualified person has been designated to oversee the program until a qualified Activity Director is hired. 4. The Director of Nursing/Designee will audit all newly admitted residents for completion of an activities assessment weekly for twelve weeks. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 679	Continued From page 23 interventions/tasks, the document listed "Encourage to attend activities, and assist as necessary." Under the heading of "focus", "The Resident has nutritional risk....."." As interventions/tasks, the document listed "Invite the Resident to activities that promote additional intake daily." No other Activity likes, dislikes, or care planning for meaningful activities was found in the Resident's clinical record. The Administrator was interviewed in the conference room on 2-13-2020 at 3:30 p.m., and stated they had no qualified Activity Professional in the facility. The previous Activity professional's last day was 12-13-19. The Administrator informed surveyors that the previous activity professional's assistant was conducting activities. On 2-13-2020 at 4:00 p.m., the Administrator and Director of nursing were made aware of the findings. No further information was presented by the facility.	F 679		
F 680 SS=E	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one	F 680		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 680	Continued From page 24 of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, facility document review, staff interview, Resident interview, and family interview, the facility staff failed to provide a qualified Activity Professional for 62 days as of the end of survey. The findings included; The Administrator was interviewed in the conference room on 2-13-2020 at 3:30 p.m., and stated they had no qualified Activity Professional in the facility. The previous Activity professional's last day was 12-13-19. The Administrator informed surveyors that the previous activity professional's assistant was conducting activities. On 2-13-2020 at 4:00 p.m., the Administrator and Director of nursing were made aware of the findings. No further information was presented by the facility.	F 680	1. The facility is currently seeking a qualified Activity Professional. A qualified person has been designated to oversee the program until a qualified Activities Director is hired. 2. All residents have the potential to be affected by this practice. 3. The Regional Vice President of Operations/Designee will re-educate the Administrator on meaningful activities and the requirements for an Activity Director. Advertising for a qualified Activity Director has been increased via local newspapers and online venues, such as Indeed. 4. The Administrator/Designee will report on participation of activities weekly for twelve weeks. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 25 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review and facility documentation review, the facility failed to provide services and care for 1 Resident (Resident # 72) in a survey sample of 29 Residents. The findings include: Resident #72's right eye was red, swollen, and draining. The staff did not assess the eye, nor notify the physician of a possible eye infection until surveyors brought it to their attention after 2 days of observations. Resident #72 was admitted to the facility on 1-13-2020. Diagnoses included: Diabetes, malnutrition, functional quadriplegia, peripheral vascular disease, recurrent pain, recurrent depression, and skin wounds. On 2-11-2020 at 6:30 p.m., during initial tour of the building an interview was attempted with Resident #72. The Resident was also noted to have a swollen and red right eye, draining clear fluid. When asked if the eye was painful the Resident shook his head "yes". The Resident's most recent (Minimum Data Set) MDS was reviewed. The MDS was a full admission assessment dated 1-21-2020. The assessment coded Resident #72 as having a (Brief Interview of Mental Status) BIMS score of 5 indicating severe cognitive impairment.	F 684	1. Resident #72 was assessed on 02/12/2020 and the provider was notified of the findings. 2. All residents have the potential to be affected by this practice. The Director of Nursing/Designee will conduct a quality review round on current residents to assess for eye infections and ensure the provider is aware. 3. The Director of Nursing/Designee will re-educate licensed nurses on provision of services, including but not limited to assessment for infection, documentation, and notification of providers. 4. The Director of Nursing/Designee will perform quality review rounds twice weekly for twelve weeks to assess for potential infections and ensure the provider is aware. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 684	Continued From page 26 The Residents care plan was reviewed and documented under a heading of "focus", "Resident is at risk for infection related to chronic disease, and wound" dated 1-27-2020. As interventions/tasks, the document listed "Report signs and symptoms of infection to MD (doctor)." On 2-12-2020 at 2:00 p.m., the Resident was again visited, and he right eye was found to be more swollen and red. The Resident was asked if anything had been done for his eye. He shook his head and said "no". On 2-13-2020 in an interview with the Director of Nursing (DON). When asked what had been done for the Resident's right eye, she stated they called the doctor last night after surveyors alerted them and got eye drops. On 2-13-2020 at the end of day debriefing at 4:00 p.m., the Administrator and DON were made aware of a possible right eye infection of 2 observed days duration without intervention until surveyors brought it to their attention. No further information was provided by the facility.	F 684		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making	F 687		3/17/20

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	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 687	Continued From page 27 appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and clinical record review the facility staff failed to provide podiatry services for 1 Resident (#54) in a survey sample of 29 Residents. The findings included: For Resident #33 the facility staff failed to provide podiatry services. Resident # 33 a 79 year old woman admitted to the facility on 8/5/19 with diagnoses of but not limited to hemiplegia and hemiparesis following a stroke affecting right side, vascular dementia, major depressive disorder, hypertension and history of stroke. Resident # 33's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/4/20 coded as a Quarterly codes Resident #33 as having a BIMS (Brief Interview of Mental Status) score of 4 indicating severe cognitive impairment. The Resident is also coded as being "Always incontinent" for bowel and bladder. On 2/11/20 at approximately 6:30 PM, this surveyor observed Resident #33 sitting on bed in room. Resident #33 was dressed in her clothes and had no shoes on her feet. Her toe nails were approximately 1/2 " in length. When asked if she would like to get her toenails cut she stated she would.	F 687	1. Resident #33 underwent nail care on 02/13/2020. It has been verified that this resident will be seen on the next visit by Podiatry. 2. All residents have the potential to be affected by this practice. The Director of Nursing/Designee will audit all current residents for the need for podiatry services. 3. The Director of Nursing/Designee will re-educate licensed nursing staff of podiatry services, including but not limited to the importance of identifying podiatry needs and the proper notification channels to ensure needs are met. 4. The Director of Nursing/Designee will audit fifteen residents twice weekly for twelve weeks to ensure podiatry needs are addressed. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 687	Continued From page 28 On 2/13/20 at approximately 330 PM an interview was conducted with the DON who stated the Residents were provided nail care on their bath days. She stated that usually the Podiatrist did the toenails. When asked how often podiatry services were provided she stated every three months. On 2/13/20 a review of the Podiatry List revealed that Resident #33 had not had podiatry services for more than 6 months. On 2/13/19 at approximately 11:45 PM the DON asked the Resident if she would like to get her toenails trimmed and she answered that she would. A review of the clinical record showed no incidences of being uncooperative with care or refusing care. On 2/13/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 687		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure an accident hazard	F 689	1. For Resident #332, pillows and fall mat to the left side of the bed were implemented per the care plan at the time	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 689	Continued From page 29 free environment for one resident (Resident #332) in a survey sample of 29 residents. The findings included; For Resident #332, the facility staff failed to provide pillows to assist with positioning in bed to prevent a potential accident of falling out of bed. Resident #332, a 63-year old male/female, was admitted to the facility on 02/06/2020. Diagnoses included but not limited to schizophrenia, dementia, and type 2 diabetes mellitus. Due to the new admission status, a Minimum Data Set assessment was not completed. On 02/12/2020 at 8:48 AM, Resident #332 was observed lying in her bed with the head of the bed elevated approximately 45 degrees and leaning to the left side of the bed, laterally bent at the waist. This surveyor looked for a certified nursing assistant to alert staff Resident #332 was leaning in her bed. This surveyor and Certified Nursing Assistants E and F (CNA E, CNA F) entered Resident #332's room and CNA E began repositioning Resident #332 in her bed. On 02/12/2020 at 9:06 AM, Resident #332 was observed sitting up in her bed with the head of the bed elevated. A staff member was assisting her to eat her breakfast meal. There were no pillows observed that lined the sides of the bed. On 02/12/2020 at 11:05 AM, this surveyor was standing in the hall outside Resident #332's room and observed Resident #332 lying in her bed with the head of the bed elevated 45 degrees. Resident #332 upper torso was bent at the waist and leaning over the left side of the bed. Resident	F 689	of staff awareness on 02/12/2020. 2. The Director of Nursing/Designee will audit all current residents to ensure fall interventions strategies are being implemented per the care plan. 3. The Director of Nursing/Designee will educate licensed nursing staff on implementation of interventions per the care plan. 4. The Director of Nursing/Designee will audit five residents daily, five times weekly for twelve weeks for implementation of fall interventions per the care plan. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

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DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 689	Continued From page 30	F 689		

#332's head and left shoulder were extended past the edge of the bed. There were no pillows tucked under the sheet on the left side of the bed. At that time, the administrator entered Resident #332's room, looked around Resident #332's bed and living area and then left the room. At approximately 11:07, a housekeeper then entered Resident #332's room and walked back to the doorway, looked down the hall, and stated to a staff member by nurse's station, "Get one of the nurses" and "she needs to be pulled over on the bed." At 11:11 AM, the administrator and Registered Nurse A (RN A) entered Resident #332's room and donned gloves to render care. RN A spoke to Resident #332 and stated that they were going to "get you another pillow and get you more comfortable." Another staff member entered the room and handed them pillows as the administrator and RN A repositioned Resident #332 in bed.

On 02/12/2020 at 11:21 AM, a meeting with the administrator was conducted. When asked why she entered Resident #332's room the first time, she stated she wanted to see why "everyone" was standing outside the room and to see if there were any concerns. When asked why she entered Resident #332's room the second time, the administrator stated that she wanted to "see if staff followed up" because she "had a positioning concern." The administrator acknowledged Resident #332 was leaning over the left side of the bed and there were no pillows present.

On 02/12/2020 at 2:50 PM, Resident #332 was observed in her bed lying on her back with the head of the bed elevated approximately 30 degrees. There were pillows tucked under the bottom (fitted) sheet along both sides of the bed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 689	Continued From page 31 The care plan was reviewed. A focus initiated on 02/10/2020 (two days after the actual fall) was entitled, "Actual fall and at risk for future falls related to: decreased mobility, weakness, history of falls." An intervention initiated on 02/10/2020 associated with this focus documented, "Utilize pillows to assist in definition of bed parameters." The facility staff provided a policy last revised on 12/09/2019 entitled, "Fall Prevention and Management Policy." Under the header, "Policy", it was documented, "Residents will be assessed for fall risk[s] on admission, quarterly, after any fall, and as needed. If risks are identified, preventative measures will be put in place and care planned. All falls will be reviewed and investigated." Under the header, "Procedure", Paragraph 2, it was documented, "Individualized interventions will be implemented based on this assessment and care planned accordingly." On 02/12/2020 at approximately 6:10 PM, the administrator and DON were notified of findings. The administrator acknowledged that Resident #332 did not have pillows to provide bed parameters.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-	F 692		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 692	Continued From page 32 §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility documentation and clinical record review the facility staff failed to provide sufficient support to maintain ideal body weight and prevent weight loss for 3 Residents (#54 #60 and #9) in a survey sample of 29 Residents. The findings included; 1. For Resident # 54 the facility staff failed to weigh the resident weekly. Resident #54 a 96 year old woman who was admitted to the facility on 1/12/18 with diagnoses of but not limited to COPD, dementia, dysphagia, COPD, disorientation, anxiety, and major depressive disorder. Resident #54. Resident #54's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) 12/24/19 coded the Resident as having a BIMS (Brief Interview of Mental Status) of 1 indicating severe cognitive impairment. On 2/12/20 during clinical record review it was	F 692	1. The medical provider and Registered Dietician were made aware of weight loss for Residents #54, #60, #9. 2. All residents who reside at Dockside Health and Rehabilitation Center have the potential to be affected by this practice. The Director of Nursing/Designee will conduct an audit for all residents with recommendations from the Registered Dietician in the past ninety days to ensure the recommendations have been instituted and weekly weights obtained if indicated. 3. The Director of Nursing/Designee will re-educate licensed nursing staff on the process for Registered Dietician recommendations, including but not limited to the importance of obtaining approval for Registered Dietician's recommendations and weekly weights if indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 692	Continued From page 33 discovered that Resident #54 had lost 12.9% of her total body weight in 6 months. The review showed the Resident continued on monthly weights even with though there was significant weight loss. On Page 1 section C #4 of the weights policy, it read: "Weekly 'weights - Any resident with a new significant weight change (5%or more in one month, 7.5 or more in 3 months, or 10% or more in 6 months), will be weighed weekly until stable or unless the providers orders otherwise or the committee deems appropriate as in #5." On 2/13/20 at approximately 10:00 AM an interview was conducted with the DON who was asked about the weight policy. When asked if the Resident should be on weekly weights according to the policy. She replied yes. When asked who should order weekly weights she stated the RD usually would make that recommendation based on the monthly weights. On 2/13/20 the Administrator was made aware of the concerns and no further information was provided. 2. Resident #60 experienced severe weight loss. Three times the Registered Dietician (RD) made recommendations, however, there is no documentation showing they were instituted. In addition weekly weights were not obtained. Resident #60 was admitted to the facility initially	F 692	4. The Director of Nursing/Designee will audit all new recommendations from the Registered Dietician weekly for follow through and institution of recommendations as ordered by the provider. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

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	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 692	Continued From page 34	F 692		

on 4-28-17. Diagnoses included; Depression, blindness left eye, history of falling, Parkinson's disease, and high cholesterol.

The most recent Minimum Data Set assessment was a significant change assessment with an assessment reference date of 12-27-19. Resident #60 was coded with a Brief Interview of Mental Status score of 13 indicating mild cognitive impairment. The Resident required limited assistance with activities of daily living (ADL's), to include set up and supervision for eating. The only exceptions were toileting, hygiene, and bathing, which required extensive assistance from one staff member.

Resident #60's weights (in pounds) were documented as follows:

2/21/19-150.3
3/26/19-146.3
4/5/19- 145.0
5/8/19- 143.0
6/12/19- 142.2
7/28/19- 142.0
8/12/19- 135.0
9/11/19- 134.2
10/9/19- 130.0
11/4/19- 132.4
12/4/19- 120.8
1/13/2020- 117.8
2/11/2020- 102.0

Resident #60's "Dietary Assessment Notes" completed by the Registered Dietician (RD) were all reviewed from March 2019 through February 2020. The notes describe the Resident's orders, and plans. A synopsis of that information follows in chronological order below;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 692	Continued From page 35	F 692		

5-11-19 -No changes, good nutritional status. (previous RD)
6-30-19 - Regular diet, weight stable over 90 days.
8-12-19 - 10% weight loss over 180 days, recommend weekly weights & fortified meals with breakfast & dinner.
9-23-19 - weight stable, will continue to monitor. (new RD)
10-14-19 - 10% weight loss over 180 days, no recommendations, continue to monitor.
11-22-19 - weight loss trend noted, no changes, continue to monitor.
12-9-19 - weight loss, encourage to eat in dining hall, re-weight, weekly weights due to significant loss, start med pass 2.0 (supplement drink) 120 milliliters (ml) twice per day, will continue to monitor.
12-24-19 - weight loss trend, no changes, continue to monitor.

The weekly weights ordered 12-9-19 by the RD were not completed nor changed in the physician's orders.

The Resident was fed in the dining area by the nursing station, and had been for "Months" as stated by the Director of nursing due to "Residents in general don't like the dining room, and prefer to eat here." This was confirmed by observation of the Resident eating meals in the living room/dining area across from the nursing station, while being fed by a staff member. The Resident accepted everything he was offered and held his mouth open for more after each swallow. The Resident appeared to have a good appetite.

The "Medical Nutrition Therapy assessment " was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 692	Continued From page 36	F 692		

completed and appeared only twice in the clinical record from March 2019 through February 2020. A synopsis of those assessments are as follows;

(1) 1-14-2020 - Resident under weight with significant weight loss. Recommend increasing med pass supplement drink from 2 times per day to three times per day. Continue to monitor.

(2) 12-27-19 - Weight loss, no changes, continue to monitor.

The RD never documented the orders for weekly weights on the physician's order sheet, fortified foods two meals per day, med pass supplement twice per day, nor the change to med pass supplement three times per day on the physician's order sheet, to communicate them to staff or the physician. They were only documented in her notes.

Physician's orders, the Medication Administration Record, and the Treatment Administration Record (MAR/TAR) were requested for 6 months (September 2019 through February 2020), and were reviewed. Weekly weights (which were not completed), regular diet with fortified foods twice per day, and the Med pass supplement, did not get placed on the physician orders nor was it placed on the MAR/TAR for administration and communication to the nursing staff.

Resident #60's diet order was reviewed and was found on the tray card, and in physician's orders as a "Regular diet". The CNA (Certified Nursing Assistant) "Kardex" care plan, list's the Resident as "regular diet" only. It does not document that the Resident must be fed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 692	Continued From page 37	F 692		

The CNA "ADL Tracking Form" was also reviewed and revealed the following dietary intake documentation for 4 months in chronological order;

February 2020 - 39 possible meals for the month, only 10 meals were documented as given
January 2020 - 93 possible meals for the month, only 36 meals were documented as given.
December 2019 - 93 possible meals for the month, only 42 meals were documented as given.
November 2019 - 90 possible meals for the month, only 41 meals were documented as given.

Resident #60 was observed eating in the dining area across from the nursing station on two occasions. The first observation took place on 2-12-2020 at 9:00 a.m., and the second at 12:00 p.m.. The third observation was on 2-12-2020 at 5:30 p.m., in the Resident's room. The first 2 observations the Resident was sitting in a "Geri" reclining chair being fed by staff, and he consumed 100% of both meals. The third observation he was being fed and consumed 100% of his meal.

Resident #60's care plan was reviewed. The only portion of the 99 page care plan document specifically dealing with nutrition was as follows;

"Focus" listed; "nutrition risk related to Parkinson's, potential for dehydration related to constipation medications, weight loss exhibited, resident with behaviors and increased confusion at times, falls, and risk of varied oral intake." initiated by the former RD on 5-7-17, and not revised until 1-14-2020.

"Interventions/Tasks" listed; Encourage resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 692	Continued From page 38	F 692		

to dine in dining room as appropriate, monitor dietary intake and monitor for constipation, monitor for signs and symptoms of dehydration, monitor weight per protocol, provide diet per order, provide supplements/fortified food items as indicated/per order, respect resident dietary choices, review preferences per routine and as needed,

The care plan was not updated with the Resident's significant weight loss, nor were interventions for that weight loss reflected in the care plan (i.e. The Resident's diet, changes and additions to that diet, supplements, weekly weights, and help needed with feeding).

The Registered Dietitian (RD) was called via telephone requesting an interview on 2-13-2020 at 9:30 a.m., and a message was left on voice mail. She was called again at 3:00 p.m. and there was no answer, and no return call.

At the end of day meeting on 2-13-2020, Resident #60's weight loss and lack of dietary interventions that were recommended was reviewed with the Administrator and Director of Nursing. No further information was provided.

3. For Resident #9, the facility staff failed to do weekly weights.

Resident #9 was a 90 year old. Resident #9's diagnoses included Gastro-Esophageal Reflux Disease, and Heart Failure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 692	Continued From page 39 The Quarterly Minimum Data Set dated 7/2/19 was reviewed. Resident #9 was coded as having a Brief Interview of Mental Status Score of 13, indicating no cognitive impairment. Resident #9 was also coded as requiring setup assistance for eating. On 2/12/20 a review was conducted of Resident #9's clinical record. On 8/22/19 her weight was 111.4, then on 11/23/19 her weight had dropped to 88.0, resulting in a severe weight loss. Record review showed the facility did not obtain weekly weighs after her severe weight loss. The Weight Policy was reviewed, An excerpt read, "Any resident with a new significant weight change, 5% or more in one month, 7.5% or more in 3 months, or 10% or more in 6 months, will be weighed weekly...". No further information was received.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility	F 695	1. Resident #78's oxygen bag and tubing	3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 695	Continued From page 40 documentation and clinical record review the facility staff failed to provide oxygen within the accepted standards of practice for 1 Resident (#78) in a survey sample of 29 Residents. The findings included: For Resident #78 the facility staff failed to change oxygen tubing weekly as outlined in care plan and per facility policy. Resident #78 a 66 year old woman admitted to the facility on 7/28/16 with diagnoses of but not limited to schizophrenia, liver cell carcinoma, dysphagia, asthma, viral hepatitis and anxiety disorder. Resident #78's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/17/20 coded as a quarterly assessment codes Resident #78 as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. Resident #78 is independent with all ADLs (activities of daily living) and is continent of bowel and bladder. On 2/11/20 at approximately 7:00 PM the Resident was observed in bed, oxygen concentrator at bedside in off position with a bag and tubing dated 11/17/19. The Resident was asked if she uses oxygen she replied " Not all the time but I need it when I get short of breath so they leave it in my room in case I need it." When asked have you used it recently Resident replied "yes" On 2/11/20 at approximately 7:10 PM an interview was conducted with LPN B who stated that the date on the tubing was from the last time she	F 695	was changed on 02/12/2020. 2. All residents that are prescribed oxygen have the potential to be affected by this practice. A quality audit will be conducted by the Director of Nursing/Designee on all residents with orders for oxygen to ensure the tubing components have been changed as ordered and dated appropriately. 3. The Director of Nursing/Designee will re-educate licensed nurses on oxygen usage, including but not limited to the importance of changing tubing and bag as ordered and the importance of dating per policy. 4. The Director of Nursing/Designee will audit all residents with orders for oxygen weekly for twelve weeks to ensure tubing and bags have been changed per order. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 695	Continued From page 41 used it. "She hasn't used it in a good while." When asked if the old tubing should be left in the room she stated probably not. Review of Physicians orders read "Change oxygen tubing every Sunday when oxygen is being used. PRN Review of facility policy read: "Change tubing, mask, and cannula weekly and document according to facility policy." On 2/13/20 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not	F 726		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 726	Continued From page 42 limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure nurse aide competency in skills necessary to care for residents' needs for one resident (Resident #332) in a sample size of 29 residents. The findings included: For Resident #332, the nurse aides failed to operate the mechanical lift to obtain a weight according to manufacturer's instructions on 02/12/2020. They did not correctly zero the lift scale. Resident #332, a 63-year old female, was admitted to the facility on 02/06/2020. Diagnoses included but not limited to schizophrenia, dementia, and type 2 diabetes mellitus. Due to the new admission status, a Minimum Data Set assessment was not completed. On 02/12/2020 at 11:00 AM, an interview with CNA C was conducted. CNA C verified she was responsible for obtaining monthly weights on residents. When asked to observe CNA C obtain a weight on Resident #332, CNA C stated yes	F 726	1. CNA (C) and CNA (E) were re-educated on operation of the mechanical lift to obtain a weight. 2. All residents weighed with a mechanical lift have the potential to be affected by this practice. The Director of Nursing/Designee will audit/observe licensed nurse aides on proper procedure when obtaining weights via a mechanical lift. 3. The Director of Nursing/Designee will re-educate licensed nursing staff on the procedure for obtaining weights with a mechanical lift scale. 4. The Director of Nursing/Designee will audit five licensed personnel weekly for twelve weeks for proper method of obtaining weights with a mechanical lift. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 726	Continued From page 43	F 726		

and she would have to go get the mechanical lift to obtain the weight.

On 02/12/2020 at 11:25 AM, CNA C saw this surveyor in the hall and stated that she was ready to get a weight on Resident #332. CNA C, CNA E, and this surveyor entered Resident #332's room with a mechanical lift to obtain a weight. The mechanical lift sling was already positioned in place under Resident #332. CNA C positioned the hanger bar over Resident #332. CNA C and CNA E attached the sling straps to the hanger bar. CNA C lowered the hanger bar to eliminate tension. CNA E pressed the ZERO key and the word "ZERO" appeared on the display screen. CNA C then activated the lift, obtained Resident #332's weight, lowered the lift, and positioned Resident #332 back on the bed. When asked if that is how she always zeroed the mechanical lift, CNA C stated, "Yes."

On 02/12/2020 at approximately 1:55 PM, a copy of the mechanical lift manufacturer's instructions was requested and the facility staff provided a copy of a booklet entitled, "[Manufacturer and Product name] Manual/Electric Mobile Patient Lift User Manual." On page 55 in Section 11.3 entitled, "Weighing the Patient" excerpts of the steps documented:
1. Attach sling straps to the hanger bar.
2. Press the ON/OFF key. The ZERO key is pressed in order to avoid capturing the weight of the sling and the hardware. If the ZERO key is not pressed the weight of the sling and the weight of the hardware will be included in the weight displayed. NOT ZERO-ING OUT WILL GIVE A FALSE READING OF THE USER'S TRUE WEIGHT."
3. Press the ZERO key.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 726	Continued From page 44 4. Place patient in the sling. 5. Activate the lift mechanism to raise the patient until they are completely supported by the lift. 6. Note the weight display. 7. When the weight display becomes stable, press the LOCK button to lock the weight display." On 02/12/2020 at 5:00 PM, Employee G verified that the DON and ADON educate the nursing staff. On 02/13/2020 at approximately 6:00 PM, the DON stated that education on the mechanical lift is completed on hire but it is not done annually. A copy of all the education completed by CNA C was requested and the facility staff provided a 5-page document entitled, "[CNA C's name] Training." The dates of education ranged from 08/17/2018 through 02/10/2020. There was no topic on CNA C's transcripts related to operating a mechanical lift. The facility staff also provided a 10-page packet of CNA C's orientation training documents. It included pre-and post tests entitled, "Resident Handling Quiz" dated 12/18/2015 and contained one true/false question pertaining to mechanical lift transfers. In summary, the nurse aide did not follow the manufacturer's instructions to obtain an accurate weight for Resident #332. On 02/13/2020 at the end of the survey, the administrator and DON were notified of findings had no further information or documentation to offer.	F 726		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On	F 756		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 756	Continued From page 45 CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that	F 756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 756	Continued From page 46 requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, facility documentation, clinical record review the facility staff failed to ensure the Pharmacy drug regimen review were addressed for 1 Resident (Resident #19) in a survey sample of 29 Residents. This happened on multiple occasions. The findings included: For Resident # 19 the facility staff failed to address the Pharmacy recommendations. This happened on multiple occasions. Resident #19 a 91 year old woman admitted to the facility on 9/1/15 with diagnoses of but not limited to Atrial fibrillation, heart failure, hypertension, diabetes, Alzheimer's Dementia, anxiety disorder, depression and psychotic disorder. Resident #19's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/19/19 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 00 indicating severe cognitive impairment. Resident is non ambulatory and requires total care with all aspects of ADL. During the review of Pharmacy recommendations it was discovered that the facility physician was not addressing the recommendations in a timely manner. The following pharmacy recommendations were reviewed. "1/19/19 -Consultation Report"	F 756	1. A Pharmacy Drug Regimen Review was completed on 02/13/2020 and addressed by the provider on 02/20/20 for Resident #19. 2. All residents with pharmacy services have the potential to be affected by this practice. The Director of Nursing/Designee will complete an audit of all current residents to ensure that the pharmacy drug regimen reviews have been completed and addressed per the regulation. 3. The Director of Nursing/Designee will re-educate licensed nurses on pharmacy requirements and the importance of monthly drug regimen reviews, including provider review. 4. The Director of Nursing/Designee will review drug regimen reviews monthly for three months to ensure that they have been addressed by the provider. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 756	Continued From page 47	F 756		

"Comment-[Resident name redacted] has dementia and receives Quetiapine 50 mg [Milligrams] twice daily since 12/2017. No noted GDR attempted"
Recommendation:
Please consider gradual dose reduction."

"4/11/2019 -Consultation Report"
"Comment-[Resident name redacted] receives the following and has been discharged from psych services. 4
Quetiapine 50 mg twice daily since 12/2017. No noted GDR attempted..."

"Recommendation:"
"Please consider gradual dose reduction. of one medication. Perhaps consider decreasing Quetiapine to 37.5 mg qam [every morning] and 50 mg at qpm [every night] and monitor for return of symptoms."

"6/12/19 - Consultation Report"
"Comment: [Resident name redacted] receives a leukotriene receptor antagonist, montelukast, and has diagnosed psychiatric condition, dementia depression, and anxiety. She also has a PRN order for Ventolin HFA.

"Recommendation:"
"Please evaluate montelukast as contributing to a worsening or development of this individuals behavior or severity of psychiatric condition, and consider discontinuing its use at this time."

"6/12/19 - Consultation Report"
"Comment : Please clarify the following items on the medication administration record (MAR) prescriber order sheet (POS)
Duplicate Oxycodone/acetaminophen orders."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 756	Continued From page 48 All of the above mentioned pharmacy recommendations were not addressed by a facility physician, or nurse practitioner. On 2/13/20 at approximately 6:30 PM an interview was conducted with the DON who stated she was unaware that the physician was not acting on the pharmacy reviews. On 2/13/20 during end of the day conference the Administrator was made aware of the concerns and no further information was provided.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

(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
F 758	Continued From page 49 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview, facility documentation, clinical record review the facility staff failed to ensure Residents are free from unnecessary medications for 1 Resident (#19) in a survey sample of 29 Residents. The findings included; For Resident #19 the facility staff failed to ensure that the Resident had did not have PRN Lorazepam orders for longer than 14 days. Resident #19 a 91 year old woman admitted to	F 758	1. The anti-anxiety medication for Resident #19 was discontinued on 02/27/2020. 2. All residents with psychoactive medications that are ordered with a frequency of as needed have the potential to be affected by this practice. The Director of Nursing/Designee will audit all as needed psychoactive medications on current residents to ensure an appropriate stop date is present.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 758	Continued From page 50 the facility on 9/1/15 with diagnoses of but not limited to Atrial fibrillation, heart failure, hypertension, diabetes, Alzheimer's Dementia, anxiety disorder, depression and psychotic disorder. Resident #19's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 11/19/19 coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 00 indicating severe cognitive impairment. Resident is non ambulatory and requires total care with all aspects of ADL. On 2/13/120 at approximately 6:00 PM a review of the clinical record revealed that Resident # 19 had orders that began on 11/12/19 that read: "Lorazepam w/calibrated dropper 2 mg[Milligrams]/ ml [Milliliter] oral concentrate (generic for Ativan) take 0.25 ml by mouth every 4 hours as needed for anxiety. 11/12/19" A review of the current orders reveal that the order from 11/12/19 is current and still being used. On 2/13/20 a review of the clinical record revealed "Pharmacy Consultation Report" dated 1/14/20 read: "Comment: [Resident name redacted] has a PRN order for anxiolytic, which has been in place for greater than 14 days without a stop date; Lorazepam in addition to scheduled Alprazolam." Recommendation: If the mediation cannot be discontinued at this time please document the intended duration of	F 758	3. The Director of Nursing/Designee will re-educate licensed nurses on as needed psychoactive medications, including but not limited to obtaining a stop date from the provider. 4. The Director of Nursing/Designee will audit all new orders for as needed psychoactive medications weekly for twelve weeks to ensure a stop date is included in the order. Findings will be submitted to the QAPI committee for review and revision as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 758	Continued From page 51 therapy (end date). Perhaps consider 6 months in this resident followed by hospice care." The Pharmacy Recommendation was not addressed by the physician. Current order still has not stop date. On 2/13/20 at approximately 6:30 PM an interview was conducted with the DON who stated she was aware that the Resident was on Lorazepam PRN but was not aware the doctor did not have a stop date. On 2/13/20 during end of the day conference the Administrator was made aware of the concerns and no further information was provided.	F 758		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of	F 790		3/17/20

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	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 790	Continued From page 52 dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview, clinical record review and facility documentation review, the facility failed to provide dental evaluations and care for 1 Resident (Resident # 72) in a survey sample of 29 Residents. The findings include: Resident #72's dentures did not fit, and would not stay in his mouth, preventing him to talk and eat properly. Resident #72 was admitted to the facility on 1-13-2020. Diagnoses included: Diabetes, malnutrition, functional quadriplegia, peripheral vascular disease, recurrent pain, recurrent depression, and skin wounds.	F 790	1. The facility will ensure provision of dental services for Resident #72. 2. All residents have the potential to be affected by this practice. The Director of Nursing/Designee will conduct an audit on all current residents for dental issues and ensure that they are addressed if present. 3. Licensed nurses will be re-educated by the Director of Nursing/Designee on notification of dental issues, including but not limited to missing and/or ill-fitting dentures. 4. The Director of Nursing/Designee will review fifteen residents weekly for twelve weeks to ensure any dental issues are	

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	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 790	Continued From page 53 On 2-11-2020 at 6:30 p.m., during initial tour of the building an interview was attempted with Resident #72. The Resident attempted to talk with the surveyor, however, the upper plate of his dentures kept falling down, and the bottom plate was so loose it jutted out of his mouth every time he tried to speak, and he was unable to communicate. When asked if he had been to the dentist he shook his head to indicate "No". When asked if he wanted his dentures fixed, he shook his head to indicate "yes". The Resident's most recent (Minimum Data Set) MDS was reviewed. The MDS was a full admission assessment dated 1-21-2020. The assessment coded Resident #72 as having a (Brief Interview of Mental Status) BIMS score of 5 indicating severe cognitive impairment. The assessment indicated that the resident had no loosely fitting dentures. On 2-12-2020 any consults resident #72 had received from a Dentist, was requested. Staff stated there were none. The facility policy was reviewed and was titled "Dental Services Policy." 3 Excerpts from that policy follow below; 1. The policy documented at #1, "Dental services are available to meet resident's needs." The document describes (at section 9 and 10), that the DON or designee or clinical staff is responsible for notifying social services for the resident's need for those services. 3. At section 13, the document describes if the referral cannot be made in 3 days, the facility will	F 790	addressed. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 790	Continued From page 54 document what was done to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that lead to the delay. However, no documentation was in the clinical record for this. On 2-13-2020 in an interview with the Director of Nursing (DON) she stated "I have looked myself and there are no dental consults that I can find in the chart or in the computer system." On 2-13-2020 at the end of day debriefing at 4:00 p.m., the Administrator and DON were made aware of needed dental services for Resident #72, which were not obtained, and the facility policy had not been followed for those services. No further information was provided by the facility.	F 790		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested,	F 791		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

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DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 791	Continued From page 55 assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, facility documentation review, and in the course of a complaint investigation, the facility staff failed, for 2 residents (Resident #9 and Resident # 54) out of 29 sampled residents to provide emergency and routine dental services. The Findings included: 1. For Resident #9, the facility staff failed to provide emergency dental services after her	F 791	1. The facility will ensure provision of dental services for Resident #9. Resident #54 received new dentures on 02/25/2020. 2. All residents have the potential to be affected by this practice. The Director of Nursing/Designee will conduct an audit on all residents for dental issues and ensure that they are addressed if present. 3. Licensed nurses will be re-educated by	

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	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

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DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 791	Continued From page 56 bottom dentures were broken and unusable. Resident #9 was a 90 year old. Resident #9's diagnoses included Gastro-Esophageal Reflux Disease, and Heart Failure. The Quarterly Minimum Data Set dated 7/2/19 was reviewed. Resident #9 was coded as having a Brief Interview of Mental Status Score of 13, indicating no cognitive impairment. Resident #9 was also coded as requiring setup assistance for eating. On 2/12/20 at 10:30 A.M., an interview was conducted with Resident #9 in her room. She complained that her meat was often not cut up. She said that she could feed herself is the meal was setup. She stated, "Yesterday we had fried chicken. I couldn't eat it. It hurt my gums. It was too hard to chew because I can't wear my lower dentures. They have been broken for months." On 12/12/20 at approximately 11:00 A.M., an interview was conducted with the Director of Nursing (Employee B) in the conference room. She stated that she didn't know why the facility had not obtained emergency dental services for a period of months. The DON stated that she was aware that the dentures were broken. The Dental Services policy was reviewed, An excerpt read, "4/27/17. The facility will assist residents in obtaining routine and 24 hour emergency dental care / services to meet the needs of each resident. Facility will also be responsible for loss or damage in certain circumstances and will make prompt referrals for residents with lost or damaged dentures."	F 791	the Director of Nursing/Designee on notification of dental issues, including but not limited to missing and/or ill-fitting dentures. 4. The Director of Nursing/Designee will review fifteen residents weekly for twelve weeks to ensure any dental issues are addressed. Findings will be submitted to the QAPI committee for review and recommendations as indicated.	

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	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

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F 791	Continued From page 57	F 791		

The Customer Service At Meal Times policy was reviewed, An excerpt read, "Residents will be properly prepared for the meal by nursing...hearing aids in place, dentures in.."

No further information was received.

2. For Resident #54 the facility staff failed to provide dental services to replace dentures that were accidentally thrown out by staff.

Resident #54 a 96 year old woman who was admitted to the facility on 1/12/18 with diagnoses of but not limited to COPD, dementia, dysphagia, COPD, disorientation, anxiety, and major depressive disorder. Resident #54. Resident #54's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) 12/24/19 coded the Resident as having a BIMS (Brief Interview of Mental Status) of 1 indicating severe cognitive impairment.

On 2/12/20 at approximately 2:00 PM a family member was interviewed and stated that the resident had lost her dentures in September 2019 and then had them finally replaced in November and now the bottom denture was missing again as of 2/2/20. The family member said that the DON and Administration had been notified of the missing denture and thus far has not had an appointment made to get another one.

A review of the progress notes revealed the following:

"2/2/20 10:06 PM- " " Family also states bottom false teeth are missing and that she was going to

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	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 791	Continued From page 58 call administration. This nurse stated that she would make them aware." On 2/13/20 at 2:30 PM an interview was conducted with the DON who acknowledged that the Resident currently had the bottom denture missing. On 2/13/20 during the end of day meeting the Administrator was made aware of concerns and no further information was provided.	F 791		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842		3/17/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 842	Continued From page 59	F 842		

(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(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 to 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;
(ii) 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 842	Continued From page 60 services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed to maintain an accurate clinical record for three residents (Resident #332, #50, and #21) in a sample size of 29 residents. The findings included: 1) For Resident #332, there was no physician's order for the current "Do not Resuscitate" status. Resident #332, a 63-year old female, was admitted to the facility on 02/06/2020. Diagnoses included but not limited to schizophrenia, dementia, and type 2 diabetes mellitus. Due to the new admission status, a Minimum Data Set assessment was not completed. On 02/13/2020 in review of the progress notes, an excerpt of a nurse's note written by a LPN dated 02/06/2020 at 2:30 PM documented, "Code status: DNR [do not resuscitate]." On 02/13/2020 at 1:40 PM, this surveyor was unable to locate the physician's order for the DNR status in the hard chart. The DON was also present and looked through all the physician's orders and verified it was not in there. When asked how it was determined that Resident #332 have a DNR status as indicated in the electronic health record, the DON stated she would look into it. On 02/13/2020 at 1:50 PM, the DON stated that the admitting nurse usually gets the code status from the hospital discharge summary, reviews it	F 842	1. Resident #332's code status was clarified on 02/13/2020. The code status for Resident #50 was clarified on 02/12/2020. For Resident #21, the facility converted to electronic charting of Activities of Daily Living on 02/18/2020. CNA staff members who failed to document will be provided with education of timely completion of documentation of Activities of Daily Living. 2. All residents have the potential to be affected by this practice. The Director of Nursing/Designee will complete an audit of all current resident charts to ensure there are precise orders for code statuses. 3. The Director of Nursing/Designee will re-educate certified nursing assistants on documentation, including but not limited to the importance of complete and thorough charting of activities of daily living. The Director of Nursing/Designee will re-educate licensed nursing staff on obtaining code status orders and clarification of those orders when indicated. 4. The Director of Nursing/Designee will review fifteen residents weekly for twelve weeks to ensure code status orders are present. Charting on activities of daily living will be monitored five times weekly for twelve weeks to ensure completion of documentation. Findings will be submitted	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495422	A. BUILDING _____ B. WING _____	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOCKSIDE HEALTH & REHAB CENTER	74 MIZPAH ROAD LOCUST HILL, VA 23092

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F 842	Continued From page 61 with the admitting physician, and writes it as a verbal order on their facility physician order sheet. The DON verified it was not included in the admission orders. When asked how it is determined if Resident #332 wants to remain on DNR status since hospital discharge, the DON stated that they do not have a copy of the signed DNR form but the DNR status is re-visited on the physician's first visit after admission. When asked if Resident #332 had an accurate clinical record, the DON stated, "No." On 02/13/2020 at the end of survey, the administrator and DON had no further information or documentation to offer. 2. For Resident # 50 the facility staff failed to ensure she accurate orders for advance directives. Resident # 50 a 67 year old woman admitted to the facility on 10/21/19 with diagnoses of but not limited to hypertension, anxiety disorder, depressive disorder, history of stroke, arthritis, and lumbar radiculopathy (pain is often caused by nerve compressing causing pain to radiate from back to the lower extremity). Resident #50's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/9/19 a quarterly assessment coded the Resident as having a BIMS (Brief Interview of Mental Status) score of 15 indicating no cognitive impairment. On 2/11/20 during clinical record review it was noted that Resident #50 has current physician orders dated for February 2020 signed by physician on 1/26/20 that read:	F 842	to the QAPI committee for review recommendations as indicated.	

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F 842	Continued From page 62 "Full Code" However the Resident care plan read, "Resident has advanced directives: Resident is DNR. Date initiated: 10/25/19 Revised 10/30/19" On 2/11/19, an interview was conducted with LPN B who was asked where to find code status. She indicated the front of the chart would have the DNR form. When asked if she would initiate CPR if a Resident had a DNR form, she stated that she would not. LPN B then shown the POS (Physician Order Sheet) that stated FULL CODE and signed by physician. When asked what she would do if the Resident had 2 orders FULL CODE and DNR, and she answered I would have to call for clarification. On 2/12/20 an interview was conducted with the DON who stated that she was unaware of the conflicting orders. On 2/12/10 at 10:15 AM the DON produced a telephone order that read- " Clarification : Pt code status is DNR." On 2/13/20 during the end of day meeting the Administrator was made aware of the concern and no further information was provided. 3. For Resident #21, the facility staff failed document ADL's (activities of daily living). A CNA ADL (Certified Nursing Assistant Activities of Daily Living) Tracking Form for January 2020 and February 2020 was reviewed for Resident #21. The Tracking Form provided columns for	F 842		

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F 842	Continued From page 63 daily documentation of all ADL care provided, to include bed mobility, transfer, ambulation, dressing, eating (including appetite assessment and amount of meal/fluid intake), toilet use, personal hygiene, and bathing. These Tracking Forms revealed the following: January 2020: shift 7am-7pm 21 days out of 31, no documentation at all January 2020: shift 7pm-7am 2 nights out of 31, no documentation at all February 2020: shift 7am-7pm 11 days out of 12, no documentation at all February 2020: shift 7pm-7am 12 nights out of 12, documentation completed On 2/12/2020, an interview with a CNA (Certified Nursing Assistant), who wished to remain anonymous, was obtained. She verified that the CNA ADL Tracking Form is used by CNAs to document the care provided to the residents. She stated, "most of the time we are too busy to fill it out, I know we are supposed to but nobody makes us do it, nobody looks at it anyway". An interview was obtained with the Director of Nursing (DON, Employee B) who stated, "I don't know why the CNAs are not documenting on the Tracking Sheets, I expect it to be completed daily on each shift, this is how we monitor the ADLs for the residents and the care that the CNAs are providing". No additional information was received.	F 842		
F 868 SS=E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i)	F 868		3/17/20

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F 868	Continued From page 64 §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility documentation review, the facility staff failed to conduct 2 of 4 quarterly meetings that included the Medical Director. The Findings included: On 2/13/20 at approximately 12:30 P.M., an interview was conducted with the Administrator (Employee A) in her office. The Quality Assurance Program was reviewed. The Administrator was unable to provide documentation (Attendance Sheets) that the Medical Director attended two out of 4 required quarterly meetings. The Medical Director's signature was documented for the following meetings: 2/4/19, 3/14/19, 12/30/19. The Administrator stated that there had been "a	F 868	1. The Medical Director will attend QAPI committee meetings as per the regulation. 2. There is always potential for medical director absence for QAPI committee meetings. 3. QAPI committee meetings will be rescheduled in the event that the medical director is unable to attend. The Regional Vice President of Operations will re-educate the Administrator on the requirements of the medical director's presence at QAPI committee meetings per regulations. 4. The Administrator/Designee will audit the signature page for QAPI meetings quarterly for one year to ensure the attendance of a medical director. Findings	

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F 868	Continued From page 65 turnover of Medical Directors." (i.e. There have been 3 different Medical Directors during the past year.) No further information was received.	F 868	will be submitted to the QAPI committee for review and recommendations as indicated.	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility documentation review, the facility failed to maintain equipment for one resident (Resident #25) in a sample size of 29 residents. The findings included: For Resident #25 the facility staff failed to provide the missing part to the Bi-Pap Machine they provided for 1 week. Therefore the Resident was unable to use her Bi-pap. Resident #25, a 58 year old woman admitted to the facility on 11/24/19 with diagnoses of but not limited to acute and chronic respiratory failure with hypoxia, pneumonia, heart failure, anxiety disorder, Atrial fibrillation, and chronic obstructive pulmonary disorder. Resident #25's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Dater) of 12/01/19 coded as an OBRA Assessment. Resident #25's MDS coded the Resident as having a BIMS (Brief Interview of Mental Status)	F 908	1. The missing part to the Bi-Pap for resident #25 was obtained and provided on 02/13/2020. 2. All residents who utilize Bi-Pap machines have the potential to be affected by this practice. An audit will be conducted by the Director of Nursing/Designee for all residents currently using a Bi-Pap machine to ensure all necessary equipment is present. 3. The Director of Nursing/Designee will re-educate licensed nurses on provision of necessary equipment, including but not limited to essential parts of Bi-Pap devices. 4. The Director of Nursing/Designee will audit any new residents with Bi-Pap usage to ensure all necessary equipment is present five times weekly for twelve weeks. Findings will be submitted to QAPI committee for review and	3/17/20

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F 908	Continued From page 66 score of 15 indicating the Resident has no cognitive impairment. Resident #25 is independent in all ADL (Activities of Daily Living) however she is on oxygen and uses the Bi-pap machine at night for Sleep Apnea (Sleep Apnea is sleep disorder where the breathing stops and starts). On 2/11/20 at approximately 7:00 PM an interview was conducted with Resident # 25 who stated that she came in the facility with a Bi-Pap machine that the doctor ordered and the facility changed machines but they did not have one of the parts for the machine therefore it was rendered unable to function. Resident #25 stated she has spoken to several people about it but they still don't have the part. She states she has been without the Bi-pap machine for a week. Resident stated " I just don't want to wake up dead." On 2/11/20 at 7:15 PM a review of the TAR (Treatment Administration Record) revealed that the facility nurses were "circling" their initials on the TAR. Circling initials indicates a treatment was not done. The back of the TAR is where they document why it was not done. On the back of Resident #25's TAR was written "Declined". On 2/11/20 at approximately 7:20 PM an interview with LPN B who stated "The importance of a Bi-Pap machine is to force air to keep the airway open during sleep when the patient tends to stop breathing." "Without the Bi-Pap the Resident can get hypoxic ." On 2/12/20 at approximately 1:00 PM the DON was asked about the Bi-Pap machine and she stated that she was unaware of it not functioning.	F 908	recommendations.	

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F 908	Continued From page 67 She was also unaware that the nurses were signing off that the Resident "declined" her Bi Pap machine. On 2/13/20 at approximately 4:00 PM an interview was conducted with Resident #25 who stated that the DON had spoken with her and they should have the missing part by 2/13/20 before she went to sleep. The administrator was made aware of the concerns during the end of day meeting and no further information was provided.	F 908		