PRINTED: 04/12/2021 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		495201	B. WING			04	C (04/2024
NAME OF F	PROVIDER OR SUPPLIER	433201	51 77.11.0		EET ADDRESS, CITY, STATE, ZIP CODE	041	01/2021
	DE HEALTH & REHAE	3 CENTER		4201	1 GREENWOOD DRIVE RTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	survey was conduct 04/01/21. The faci compliance with 42 Requirement for Lo emergency prepare investigated during INITIAL COMMEN	ong-Term Care Facilities. No edness complaints were the survey. TS	F	000			may p
	conducted 03/30/2 Corrections are rec CFR Part 483 Feder requirements. The	Medicare standard survey was 1 through 04/01/21. quired for compliance with 42 eral Long Term Care Life Safety Code survey/report mplaint was investigated during 50961.			RECE		D
	resident or staff wh COVID-19 virus. The census in this 95 at the time of the	ourvey, there were no current no tested positive for the 132 certified bed facility was be survey. The survey sample sident reviews: 36 current			APR 2		1
SS=E	Resident reviews a Request/Refuse/D CFR(s): 483.10(c) The discontinue treatm to participate in exformulate an adva §483.10(c)(8) Noticonstrued as the rithe provision of meservices deemed in the services dee	and 6 closed record reviews. scntnue Trmnt; FormIte Adv Dir (6)(8)(g)(12)(i)-(v) right to request, refuse, and/or ent, to participate in or refuse perimental research, and to nce directive. ning in this paragraph should be ight of the resident to receive edical treatment or medical medically unnecessary or		578	1. Resident #453's advanced directives her via the Social Services Initial Ass she remained a full code status and facility on 4/6/202. Resident #457's advanced directives him via the Social Services Initial As he remained a full code status and facility on 4/10/2021. Resident #456's advanced directives her via the Social Services Initial Ass she remained a full code and discharges and 4/6/2021.	essment or discharged were revi- sessment of lischarged were revi- sessment o	n 4/1/2021; I from the ewed with in 4/1/2021; from the ewed with in 4/1/2021; the facility
LABORATOR	Y DIRECTOR'S OR PROV	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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		495201	B. WING	;		04/0	01/2021
PORTSI	PROVIDER OR SUPPLIER DE HEALTH & REHAE	S CENTER STEMENT OF DEFICIENCIES	ID	42	REET ADDRESS, CITY, STATE, ZIP CODE 01 GREENWOOD DRIVE DRTSMOUTH, VA 23701 PROVIDER'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 578	inappropriate. §483.10(g)(12) The requirements spec subpart I (Advance (i) These requirements form and provide residents concerning medical or surgical resident's option, formation information or articles to furnish the legally responsible requirements of the (iv) If an adult indivitime of admission information or articles are executed an amay give advance individual's resident with State Law. (v) The facility is not provide this information or articles able to refollow-up procedute information to appropriate time. This REQUIREME by: Based on clinical resident interview documents, it was staff failed to ensure (R#453, #457 and the subpart of the substantial to the su	e facility must comply with the ified in 42 CFR part 489, Directives). ents include provisions to written information to all adulting the right to accept or refuse i treatment and, at the ormulate an advance directive. written description of the implement advance directives te law. ermitted to contract with other his information but are still for ensuring that the	F	578	 In-house and new admissions are a opportunity to formulate an Advan back on in-house and new admission documentation of an Advance Dire 4/15/2021 by the DON/ADON and 4/19/2021. Education on the Policy for Advance with the Licenses Practical nurses a Nurses initiated and completed 4/1 of Nursing. Per A Quality Monitoring Tool New Readmissions and residents requir Advance Directive shall be audited then monthly times 2. Results to b facility QAPI committee for further recommendations. Compliance Date 4/30/2021 	ce Directive ons for offer ctive was in completed e Directive and the Reg 19/2021 by Admission ing a chang is 5x weekly e forwarde	reviewed istered the Director is, e in their x 1 month d to the

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Event ID: 8H5Y11

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		495201	B. WING	.		04/0	; 1/2021
NAME OF E	PROVIDER OR SUPPLIER	400201			STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/0	11/2021
	DE HEALTH & REHAE	CENTER		4	4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 578	The findings includ 1. Resident #453 w facility on 3/25/21 w faci	e: vas admitted to the nursing with diagnoses that included pressure and atrial fibrillation. Her own authorized simum Data Set (MDS) 3/31/21 coded the resident on for Mental Status (BIMS) with a set total score of 15 which ent was moderately impaired in for daily decision making. The sed with the ability to express and was able to fully so the resident was not coded oral or mood symptoms. p.m., Resident #453 stated on Advance Directive and had need by any facility personnel one. She stated she did not and wanted everything to be had a medical emergency. p.m., an interview was a Administrator, Regional cal Services (RSCS) and to (DON). They stated if there irective upon admission, a eath" team (Administrator, DON, anager, MDS/Case Manager	F	578	DEFICIENCY)		
		r) should ensure they meet with r family member as soon as			APR	2 8 202	1
	possible within 3-5 pertinent informati	days of admission to discuss on regarding the patient's nation on the components of an			VD	HOL	C

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		SURVEY PLETED
		495201	B. WING		·	0410	01/2021
	PROVIDER OR SUPPLIER DE HEALTH & REHAE	,			STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701	1 04/0	31/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	Advance Directive they so chose. The meeting was late, the Advance Directive the resident. The meeting was on 3/2 an advance directive one. 2. Resident #457 we facility on 3/22/21 we right hip osteoarthmasthma. The Admission MD resident on the Brie (BIMS) with a score 15 which indicated cognitive skills for cresident was not composed symptoms. The was able to fully composed in the ability to expend was able to fully composed in the Unit Nurse (LPN) #1 was plan meeting and knew the Unit Nurse (LPN) #1 was plan meeting (3/24) Directives or opposition of the Supervisor of Clini Director of Nursing was no Advance Directives or Advance Directives or Advance Directives or Advance Director of Nursing was no Advance Directives or Advance Directives or Advance Directives or Advance Director of Nursing was no Advance Directives or A	with an option to develop one if y stated Resident #453 Path hus the right to formulate had not been addressed with esident's base line care plan 26/21 which did not evidence we or opportunity to develop was admitted to the nursing with diagnoses that included itis, high blood pressure and as of 15 out of a total score of the resident possessed intact daily decision making. The oded to possess behavioral or the resident was assessed express ideas and wants and	F	578			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495201 B. WING		04/01/2021			
	PROVIDER OR SUPPLIER DE HEALTH & REHA			STREET ADDRESS, CITY 4201 GREENWOOD DE PORTSMOUTH, VA	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECT CROSS-REFEREIT	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	Continued From p Business Office M and Social Worke the resident and o possible within 3-t pertinent informat wishes, give inform Advance Directive they so chose. 3. Resident #456 facility on 3/24/21 sepsis, heart attact transplant. The Admission M assessment date with a score of 14 the Brief Interview indicated the resident decision assessed with the wants and was at The resident was behavioral or mod On 3/30/21 at 2:3 she had not been regarding either h	lanager, MDS/Case Manager r) should ensure they meet with or family member as soon as days of admission to discussion regarding the patient's mation on the components of an ewith an option to develop one if was admitted to the nursing with diagnoses that include ck, type 2 diabetes and kidney dinimum Data Set (MDS) diagnoses that include ck, type 2 diabetes and kidney dinimum Data Set (MDS) diagnoses that include ck, type 2 diabetes and kidney dinimum Data Set (MDS) diagnoses diagn	F				
	one. On 4/1/21 at 3:30 conducted with the Supervisor of Clir Director of Nursir was no Advance member of the "F Business Office National Property of the Telephone Te	meet with someone to develop p.m., an interview was ne Administrator, Regional nical Services (RSCS) and ng (DON). They stated if there Directive upon admission, a Path" team (Administrator, DON, Manager, MDS/Case Manager er) should ensure they meet with					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		495201	B. WING			04/	01/2021
PORTSIDE HEALTH & REHAB CENTER		3 CENTER	ļ	420	REET ADDRESS, CITY, STATE, ZIP CODE 01 GREENWOOD DRIVE DRTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 578	possible within 3-5 pertinent informatic wishes, give inform Advance Directive they so chose. The meeting was late, the resident. The remeeting was on 3/2	age 5 family member as soon as days of admission to discuss on regarding the patient's nation on the components of an with an option to develop one if by stated Resident #456 Path thus the right to formulate had not been addressed with esident's base line care plan 26/21 which did not evidence we or opportunity to develop	F (578			6/4/0021
F 684 SS=D	S 483.25 Quality of Quality of care is a applies to all treatr facility residents. E assessment of a rethat residents receaccordance with p practice, the comp care plan, and the This REQUIREME by: Based on observarecord review and the facility staff fail for 1 of 42 resident Resident #82. The findings included the facility staff fail for the facility staff fail for the facility staff fail for 1 of 42 resident Resident #82.	fundamental principle that ment and care provided to based on the comprehensive esident, the facility must ensure live treatment and care in refessional standards of brehensive person-centered residents' choices. ENT is not met as evidenced eation, staff interviews, clinical facility documentation review led to follow 2 physician orders its in the survey sample,	F	684	 Resident # 82 Scopolamine patch and the splint was placed for the the same resident by nurse #4 A review of discontinued medical was completed on 4/19/2021 to a processed appropriately and any were removed from the resident. An audit completed on 4/19/202 residents with splint device and to n person as ordered; no addition Education completed with the Liand Registered Nurses on the po Medication Administration and E with emphasis on removing discoplacing splint devices on as ordered; no addition and E with emphasis on removing discoplacing splint devices on as ordered; no addition and E with emphasis on removing discoplacing splint devices on as ordered; no addition and E with emphasis on removing discoplacing splint devices on as ordered; no manual emphasis on removing discoplacing splint devices on as ordered; no addition and E with emphasis on removing discoplacing splint devices on as ordered; no manual emphasis on removing discoplace to ensure orders were including but not limited to rembody/room and medication cart Per A Quality Monitoring Tool remonitored for use by the ADON month, then weekly for 1 month month. Results of audits/reviews to be QAPI committee for further reviews. Compliance Date 4/30/2021 	right upper ex tions delivered ensure orders discontinued ; no additional 1 to identify or that the splint nal findings. censed Practica licies: General Physicians/Pro continued patch r. Education co ved 5x weekly ne Unit Manag processed acco oval from a res esidents with s or designee 5 r, then monthl forwarded to t	tremity on I via patch were patches findings. ther was applied al Nurses Dose and vider orders nes and ompleted on x 1 month, ers or ordingly sident's plints will be a weekly for 1 by for 1 the facility

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION) COM	E SURVEY MPLETED
		495201	B. WING	· · · · · · · · · · · · · · · · · · ·		C 01/2021
	ROVIDER OR SUPPLIER DE HEALTH & REHA			STREET ADDRESS, CITY, STATE, ZIP (4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION DATE
F 684	admitted to the fact #82 was discharge and readmitted to Diagnosis included 2 Diabetes Mellitu contracture, unsperinfarction due to use infarction due to use infarction, the MR esident #82 as resident #82 infarction due to the infarction due to the infarction of the i	th. Resident #82 was originally bility on 04/21/2017. Resident ed to the hospital on 03/19/2020 the facility on 03/23/2020. It be facility on 03/23/2020. It be facility on 03/23/2020. It be to the hospital on 03/19/2020 the facility on 03/23/2020. It be without complications, ecified joint and Cerebral enspecified occlusion or stenosis abral artery. Resident #82's to (an assessment protocol) with eference Date of 03/10/2021 exit (an assessment protocol) with eference Date of 03/10/2021 exit (an assessment protocol) with eference Date of 03/10/2021 exit (an assessment protocol) with eference Date of 03/10/2021 exit (an assessment protocol) with eference Date of 03/10/2021 exit (an assessment protocol) with eference of 1 for daily decision making. In immum Data Set coded equiring total dependence of 2 eansfer, dressing and toilet use, ence of 1 for eating, personal eng. approximately 12:55 p.m., ent #82's bedside with Licensed in the stated, "Oh that's her round white patch on Resident PN #4 stated, "Oh that's her ch. It was discontinued she got "LPN #4 removed the ch from Resident #82's left necked when was the Scopolamine be discontinued, LPN #4		584		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILL			c	
		495201	B. WING			04/0	01/2021
NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB CENTER			•	420	REET ADDRESS, CITY, STATE, ZIP CODE 11 GREENWOOD DRIVE RTSMOUTH, VA 23701	:	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	review of Resident Administration Red documented in par Patch 72 Hour 1 M patch transdermal excess secretions Start Date - 03/24/Date - 03/23/2021 documentation unorder revealed the Apply 0900, Remo Remove 1935, a column under the On 04/01/2021 at Administrator and aware of finding. expectations of nustated, "Follow stimedication adminicopy of facility polymedication administration administrat	#82's Medication cord revealed and is rt, as follows: Scopolamine IG (Milligram)/3 Days Apply 1 ly every 72 hours for drying and remove per schedule. /2020 0900 D/C (Discontinue) 1936. Review of der the Hours column for this e following: Remove 0859, ove 1935. On the same line as blank space observed in the	F	584			
	PHARMACY SER MANUAL The facility policy Preparation and M Effective Date: 12 05/01/10; 01/01/1 Applicability: This procedure relating and medication ag should also refer medication admin	ong Term Care) FACILITY VICES AND PROCEDURES titled: 6.0 General Dose Medication Administration 2/01/07 Revision Date: 13 5 Policy 6.0 sets forth the 19 to general dose preparation 15 dministration. Facility staff 16 to facility policy regarding 17 istration and should comply with 18 the State Operations Manual					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		LE CONSTRUCTION	COM	E SURVEY PLETED
		495201	B. WING	;		i	O1/2021
	PROVIDER OR SUPPLIER DE HEALTH & REHAI			، ا	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	The facility policy to Orders Effective Date: 01 03/22/2021 POLICY: The Chareview all physicia secretary, with der when available, medication orders	g medications. used medication portions in	F	684			
	ensure orthotic de physician orders. admitted to the fact #82 was discharge and readmitted to Diagnosis include 2 Diabetes Mellitu contracture, unsperinfarction due to use if unspecified cere Minimum Data Sean Assessment R was coded with sellong-term memorismpaired cognitive In addition, the M Resident #82 as a for bed mobility, to	82, the facility staff failed to evices were applied per Resident #82 was originally cility on 04/21/2017. Resident ed to the hospital on 03/19/2020 the facility on 03/23/2020. d but were not limited to, Type is without complications, ecified joint and Cerebral inspecified occlusion or stenosis ebral artery. Resident #82's et (an assessment protocol) with eference Date of 03/10/2021 nort-term memory problems, by problems and with moderately eskills for daily decision making. Inimum Data Set coded requiring total dependence of 2 ransfer, dressing and toilet use, ence of 1 for eating, personal ing.					

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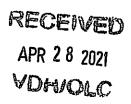
NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB CENTER CA) 10 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAGE (EACH DEFICIENCY MIST BE PROVIDERS PLAN OF CORRECTION BROULD BE CROSS-REFERENCE ACTION BROULD BE COMPLETED. FREETY TAGE PRECEDE TO PREMY STATEMENT OF PROVIDED THE APPROPRIATE COMPLETED. FREETY TAGE PRECEDE TO PROVIDE TO PREMY STATEMENT OF PROVIDED THE APPROPRIATE COMPLETED. FREETY TAGE PROVIDED TO PREMY STATEMENT OF PROVIDED THE APPROPRIATE COMPLETED. FREETY TAGE PROVIDED TO PROVIDE TO PREMY STATEMENT OF PROVIDED TO PREMY STATEMENT. FREETY TAGE FREETY TAGE FROM THE PROVIDED TO PREMY STATEMENT OF PROVIDED TO PREMY STATEMENT. FREETY TAGE FREETY TAGE FROM THE PR	STATEMENT OF AND PLAN OF C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
PORTSIDE HEALTH & REHAB CENTER X401 IG REENWOOD DRIVE PORTSMOUTH, VA 23701			495201	B. WING				
F 684 Continued From page 9 On 03/30/2021 review of Resident #82's clinical record revealed the following: Review of Clinical Physician Orders revealed and is documented in part, as follows: Order: Pt (Patient) may wear right kwik splint and right elbow extension splint) alternating days up to 4-6 hours / day. Bilateral splints for contracture management and preventing skin breakdown UE's (Upper Extremities). Directions: No directions specified for order. Category: Other Status: Active Revision Date: 05/13/2020; Order: Nursing to don / doff UE orthotics, monitor for adverse reactions and implement wearing schedule. Directions: one time a day Category: Other Status: Active Start Date: 05/14/2020 09:00 Revision Date: 05/13/2020. Review of Resident #82's comprehensive care plan revealed the following: "(Resident Name) has limited physical mobility rt (Related to) right hemiplegia and contractures. Date Initialed: 09/23/2019 Revision on: 03/24/2021 Interventions: Contracture devices as ordered and tolerated; Use of hand / elbow splints					42	201 GREENWOOD DRIVE		
On 03/30/2021 review of Resident #82's clinical record revealed the following: Review of Clinical Physician Orders revealed and is documented in part, as follows: Order: Pt (Patient) may wear right kwik splint and right elbow extension splint (right hand cloth roll with elbow extension splint) alternating days up to 4 - 6 hours / day. May wear left kwik splint up to 4 - 6 hours / day. May wear left kwik splint up to 4 - 6 hours / day. Bilateral splints for contracture management and preventing skin breakdown UE's (Upper Extremitles). Directions: No directions specified for order. Category: Other Status: Active Revision Date: 05/13/2020; Order: Nursing to don / doff UE orthotics, monitor for adverse reactions and implement wearing schedule. Directions: one time a day Category: Other Status: Active Start Date: 05/14/2020 09:00 Revision Date: 05/13/2020. Review of Resident #82's comprehensive care plan revealed the following: "(Resident Name) has limited physical mobility /ft (Related to) right hemiplegia and contractures. Date Initialed: 09/23/2019 Revision on: 03/24/2021 Interventions: Contracture devices as ordered and tolerated; Use of hand / elbow splints	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
Review of Resident #82's Minimum Data Set revealed and is documented in part, as follows: Section G 0400 Functional limitation in Range of Motion A. Upper extremity (shoulder, elbow, wrist, hand) 2 = Impairment on both sides. On 03/31/2021 at approximately 3:00 p.m., did not observe splints on upper extremities during the shift.	Ore Risi(Fele) 6 6 mUdi S C fc s C O R phh h O li a b F risi M v O n	on 03/30/2021 relected revealed the Review of Clinical solumented in patient) may weallow extension selbow e	Physician Orders revealed and part, as follows: Order: Pt ar right kwik splint and right plint (right hand cloth roll with plint) alternating days up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splint up to 4 - by wear left kwik splints; No entities). Directions: No bed for order. Category: Other bed for order. Category: Other bed for order. Category: Other bed for sand implement wearing cons: one time a day Category: Other bed for start Date: O5/13/2020; Other bed following: "(Resident Name) by beat mobility r/t (Related to) right contractures. Date Initialed: Soin on: O3/24/2021 ontracture devices as ordered by bed for hand / elbow splints bed for hand / elbow splints bed for hand / elbow splints bed for extremity (shoulder, elbow, lampairment on both sides.		684			

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		495201	B. WING	·	1 3	C 01/2021
	PROVIDER OR SUPPLIER DE HEALTH & REHAI			STREET ADDRESS, CITY, STATE, ZIP CO 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 684	#82 lying in bed, r did not observe sp right hand. On 04/01/2021 at 1 #82's Treatment A and is documented to don/doff UE orth reactions and implitime a day. Start I Hours 0900 Obseunder 31 is initiale On 04/01/2021 at Certified Nursing A sheet to expose le When asked if Re hands, upper extre When asked if Re hands, upper extre Con 04/01/2021 at Licensed Practica surveyor to Resided does Resident #82 extremities, LPN exposing the resident when the control we can put them of the control we can put them of you ever put the sesident #82, LP putting them on." responsible for put LPN #4 stated, "In the control was to the control was t	8:40 a.m., observed Resident ight arm was uncovered and lint on right upper extremity or 9:00 a.m., review of Resident dministration Record revealed in part, as follows: "Nursing notics, monitor for adverse ement wearing schedule one Date - 05/14/2020 0900." erved that space in column		584		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		495201	B. WING			04/	01/2021
,	PROVIDER OR SUPPLIER DE HEALTH & REHAE	3 CENTER		42	REET ADDRESS, CITY, STATE, ZIP CODE 101 GREENWOOD DRIVE ORTSMOUTH, VA 23701	; ;	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 745	splints, orthotic decon 03/31/2021, LP my time." Reviewe the Treatment Admithat your initials we order on 03/31/202 does it indicate wh space, LPN #4 state the kardex. The When asked shou wearing splints on 03/31/2021, LPN stated, "I spoke to resident can not wright hand roll splir would overlap." Life order." On 04/01/2021 at #4 to Resident #8/2 place to both upper the control of the Nursing stated, "I asked what does it the Treatment Administrator state performed." No fur presented about the Provision of Medic CFR(s): 483.40(d) The face of the treatment Admit of the CFR(s): 483.40(d) The face of the treatment Admit of the treatment of the t	sked did Resident #82 have vices on her upper extremities PN #4 stated, "No, not during ed with LPN #4 that review of inistration Record revealed ere in the space next to the 21 0900. When asked what en you initial, sign off in the ated, "I saw that when I looked at means that it was done." Id Resident #82 have been her upper extremities on #4 stated, "Yes." LPN #4 therapy and they said that the ear the right elbow splint and in at the same time due to they PN #4 stated, "Will fix the 1:25 p.m., accompanied LPN 2's bedside and splints were in er extremities. 3:00 p.m., during briefing the Director of Nursing was made When asked what her enurses were, Director of fyou are doing it sign it." When it indicate when the space on ministration Record is signed, ed, "That the task is urther information was the finding.		745			

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STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:					COMPLETED	
			1				c	
		495201	B. WING				01/2021	
NAME OF I	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODI	E		
DODTOI	DE HEALTH & REHAE	D CENTED		1	201 GREENWOOD DRIVE		į į	
PURIOR	JE MEMLITI & NEITHE	3 CENTER		P	PORTSMOUTH, VA 23701			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 745	maintain the higher and psychosocial value and psychosocial value and psychosocial value and psychosocial value assed on observal interviews, clinical the facility's policy, ensure medically reinclude resident's a assessments were in the survey sampland #456. The findings included the facility staff related social services and psychosocial services and	est practicable physical, mental well-being of each resident. ENT is not met as evidenced ations, resident interviews, staff record review, and a review of the facility staff failed to related social services to appointments and provided for 4 of 42 residents ple, Resident #57, #453, #457,	F -	745	Manager on 3/30/21; is without in ability. Dental appointment attend infection and resident at that time 2. An in-house resident oral assessmand completed 4/14/2021 for each initiated based on findings by the discontinitiated based on Dental Service appointments by the Director of Non 4/19/2021. 4. Per A Quality Monitoring Tool: residiscomfort will have an oral assess appointment for dental services a completed 5x weekly x 1 month, the Results to be forwarded to the fact further review and recommendations. 5. Compliance Date 4/30/2021	creased pain or ded on 4/16/20 enot in pain. ent was initiate h resident and r Clinical Manage d Practical Nursices and facilitat Jursing; educati sidents with consment complete rranged. Monitien monthly X cility QAPI commi	r altered eating 21; no signs of ed on 4/7/2021 referrals ers. es and ting ion completed mplaints of oral ed and toring tool to be 2 months. mittee for	
	Resident #57 was on 07/23/19 and reacute care hospital included; Diabetes condition with Diabetes condition with Diabetes assessment with a (ARD) of 02/19/21 completing the Bri (BIMS) and scorin indicated Resident decision making with Section "G" (Ph	on, Minimum Data Set (MDS) an assessment reference date 1 coded the resident as ief Interview for Mental Status ng 15 out of a possible 15. This at #57 cognitive abilities for daily			 Resident #453 Social Services Asse and she has been discharged as of Resident #457 Social Services Asse and he has discharged home as of Resident #456 Social Services Asse and she has discharged home as o An audit was completed on 4/17/2 look back period from 3/21/2021 Services Assessments; no addition Education on the Policy for the Social Services Assessments; and ADON was completed by the Dire Per a Quality Monitoring Tool New Social Services Assessment validated 1 month, then 1 x weekly x 2 months facility QAPI committee for fur recommendations. Compliance Date 4/30/2021 	4/6/2021. essment comple 4/10/2021. essment comple f 4/6/2021. 2021 for new ac for the complet ial findings. ocial Worker Cli Activities Direct ector of Nursing w Admissions w ted for complet iths. Results to	eted on 4/1/2021 eted on 4/1/2021 dmissions with a tion of the Social inical Assessment or and the graph 4/19/2021 vill have their tion 5x weekly x be forwarded to	
	one person with tr	ransfers, bed mobility, dressing, sonal hydiene. Requiring					·	

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Facility ID: VA0217

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			7. BUILL	>11 V C			c
		495201	B. WING	;		04/	01/2021
NAME OF I	PROVIDER OR SUPPLIEF	ŧ	•	Γ	STREET ADDRESS, CITY, STATE, ZIP CODE		
PORTSI	DE HEALTH & REHA	B CENTER			4201 GREENWOOD DRIVE	i	! !
			 	L	PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 745	supervision of one	page 13 e person with eating. Walking in motion on and off the units does	F	74	5		
	follows: Focus: Tr oral/dental health Mouth and Tooth tooth abscess on will be free of infe oral cavity. Interve as ordered, Asset (Medical Doctor) symptoms of oral attention: Pain, do or bleeding, teeth decayed, ulcers of dental appointme	ent's Care plan reads as the resident has actual risk for problems. Complained of Pain on 3/11/21. Diagnoses of 3/12/21. Goals: The resident action, pain or bleeding in the entions: Administer Medications as, document and report to MD PRN (as needed) sign and addental problems needing ebris in the mouth, lips cracked missing, loose, broken, eroded or lesions in mouth. Facilitate ant as appropriate.					
	clinical record ind referral/appointm surveyor initiating	n was found in the resident's licating that a dental ent was made prior to the a conversation with Resident t approximately, 2:28 PM.					
		tation reveal that all necessary tendance at the IDT meeting at 1:15 PM.					
	3/12/2021 at 13:1 (Interdisciplinary The facility staff paware that Resid would require de Reads: Residen (Intravenous) AB infection/abscess	esident's clinical record shows on 15 (1:15 PM) an IDT Team) Meeting was conducted. bresent at the IDT meeting were ent #57 had dental issues that intal services. The Progress Note t review: Currently on IV T for UTI and po ABT for tooth is. In attendance: Unit Managers, Data Set staff) RD (Registered					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COME	SURVEY PLETED
		495201	B. WING	_		C 04/01/2021	
	PROVIDER OR SUPPLIER DE HEALTH & REHAE	CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		• • •		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFICIENCY)		BE	(X5) COMPLETION DATE	
F 745	On 3/30/21 at appritelephone interview #57. Resident #57 dental concerns. Sextracted. I've had days. I asked for two hollow tooth. I think when I use my CPA Pressure. Machine teeth. I was supposyear ago when I was mobile dental servifrom my nurse." On 3/31/21 at 11:0 conducted with LP #2 concerning spe Worker) to follow under the worker worker in two On 3/31/21 at 11:1 conducted with the Practical Nurse) #2 dental issues. She an order." She's neabout this." On 4/01/21 at apprinterview was concerning Assistant) having dental issue complained of have	rector of Nursing) SW (Social py. oximately, 2:48 PM a was conducted with Resident was asked if she had any he stated, "I need my teeth a tooth ache for about two wo Tylenol's. I think I have a the pain is getting worse AP (Continuous Positive Airway) at night. That irritates my sed to get them extracted a as in another facility they had ces. I got Tylenol on yesterday O AM a brief interview was N (Licensed Practical Nurse) aking to the facility SW (Social up on a dental appointment for stated, "We have not had a	F	745			

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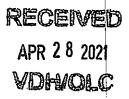
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495201	B. WING			C 04/01/2021	
	PROVIDER OR SUPPLIER DE HEALTH & REHA		4201 GREENWOOD DRIVE		TREET ADDRESS, CITY, STATE, ZIP CODE 201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 745	On 4/01/21 at 8:38 conducted with LF She stated, "She spain. She had an aware and he put On 4/01/21 at app telephone intervied facility physician (Resident #57. She ago she complain said I'm going to go nursing staff make Mostly, the right share broken. The farmate a dentist come to you take care of it fairly large person food. She's a nonoriented x 4. She affect her teeth. I Tylenol. I did feel pulled. The facility would come. On 04/01/21 at 11 call was made to	age 15 8 am an interview was N #2 concerning Resident #57. aid something about mouth abscess. She made the doctor her on Amoxicillin." roximately, 9:30 AM a w was conducted with the Other Staff #5) concerning e stated, "Two or Three weeks ed about her teeth hurting. I give you an antibiotic then have e an appointment for you. Ide molars or half of her teeth acility was saying they will have the facility. I said make sure if they don't come. She's a that wanted double portions of compliant diabetic, alert and eats a lot of sugar which could prescribed liquid Ambusol and she needed to have her teeth assured me the mobile dental :00 AM a follow up telephone Resident #57 concerning her s. She stated, "I had been telling	F	745			
	the male nurse at manager said she thought it was odd dentist appointmed down in the root. facility from a mol side is hurting. The to be extracted. The eat on that side. It now. She gave mentioned the said of	wout my mouth hurting. The unit would try to find a dentist. I if they were willing to make a ent now. I have a hollow tooth I got 3 extracted while in another oile dental unit. The whole right here are 3 on that side that need hese last few days I try not to My Pain is about a 6 out of 10 e a Tylenol at 10:00 AM this complaining about this the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495201	B. WING			C 01/2021
	PROVIDER OR SUPPLIER DE HEALTH & REHAI		STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		I SHOULD BE	(X5) COMPLETION DATE
F 745	situation. They (fame they were look by stretcher. Some patients. The unit is places. She said the have a dental appoint of the places. She said the have a dental appoint of the places. She said the have a dental appoint of the places. She said the places of the place	eek now it's on a daily acility staff) came in and told ing for a place. I have to go out a places don't take stretcher manager said she tried two ney were booked up. I don't pointment yet." roximately, 2:36 PM the above ed with the Administrator, g (DON) and Corporate ON stated, "We are trying to Medicine/Dental Services) in will work diligently on getting ing hard to get a company (to vices) in now to help out. The ed, "The facility will absorb the		745		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· •		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495201	B. WING			1	C 01/2021
NAME OF F	PROVIDER OR SUPPLIER	110000		_	STREET ADDRESS, CITY, STATE, ZIP CODE	1	01/2021
BORTOL	CHEALTH O DELLA	OCNTED		4	201 GREENWOOD DRIVE	!	
PORTSIL	E HEALTH & REHAE	CENTER		ı	PORTSMOUTH, VA 23701	į	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 745	left abruptly withou He stated the dutie distributed to the unursing staff and his was hired. On 3/31/21 at 4:30 of Nursing (DON), assumed many of to include the Social Conducted with the Practical Nurse (LF Licensed Practical the Social Services important to the webecause it gave the resident's family his Directives and coneducation/work expension, mental, poetc.) and return to They presented Relinitial assessment at 8:49 a.m. They assessment shoul hours, but we did to duties until last niger on 4/1/21 at 3:30 conducted with the Supervisor of Clini Director of Nursing was provided prior	d the Social Services Director to adequate notice on 3/21/21. It is of the Social Worker were not managers, other key imself initial a replacement in p.m., according to the Director the two Unit Managers the duties of the Social Worker at Services Initial assessment. D.m., an interview was a Unit I Manager, Licensed PN) #2 and the Unit II Manager, Nurse (LPN) #1. They stated a Initial assessment was all-being of the resident a staff a picture of the story, reviewed the Advance firmed code status, perience, religious preferences, activity preferences, needs diatry, dental, mobility devices, community desires and needs. Accommunity desires and	F	745			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG	COM	(X3) DATE SURVEY COMPLETED	
		495201	B. WING_			C 01/2021
	PROVIDER OR SUPPLIER DE HEALTH & REHAI	3 CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 745	revised on 12/18/2 be completed withi would have Reside 3/26/21.	ces Policy" dated 5/2009, last 0 the initial assessment would in 24 business hours, which ent #453's assessment due by	F 74	15		
	Services Initial Ass 24 hours of Reside Resident #457 was on 3/22/21 with dia	failed to ensure the Social ressment was completed within ent #457's admission admitted to the nursing facility regnoses that included right hip blood pressure and asthma.				
	resident on the Bri (BIMS) with a scor 15 which indicated cognitive skills for resident was not c mood symptoms. with the ability to e	oS dated 3/29/21 coded the ef Interview for Mental Status e of 15 out of a total score of the resident possessed intact daily decision making. The oded to possess behavioral or The resident was assessed express ideas and wants and emprehend others.				
	Administrator state left abruptly withou He stated the dutie distributed to the u	roximately 10:30 a.m., the ed the Social Services Director at adequate notice on 3/21/21. es of the Social Worker were unit managers, other key himself until a replacement was				
	of Nursing (DON), assumed many of	p.m., according to the Director the two Unit Managers the duties of the Social Worker al Services Initial assessment.				
	On 4/1/21 at 1:45	p.m., an interview was				

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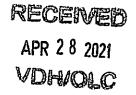
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495201	B. WING			04/0	01/2021
NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB	B CENTER		420	REET ADDRESS, CITY, STATE, ZIP CODE 01 GREENWOOD DRIVE DRTSMOUTH, VA 23701	i	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETION DATE
Practical Nurse (LF Licensed Practical the Social Services important to the we because it gave the resident's family his Directives and confeducation/work expbehaviors, social ar (vision, mental, poretc.) and return to They presented Re Initial assessment at 8:23 a.m. They sassessment should hours, but we did not duties until last nig On 4/1/21 at 3:30 producted with the Supervisor of Clinic Director of Nursing was provided prior According to the fatitled "Social Service revised on 12/18/2 be completed with would have Resided 3/23/21. 4. The facility staff Services Initial Ass 24 hours of Resident #456 was on 3/24/21 with dia	Unit I Manager, Licensed PN) #2 and the Unit II Manager, Nurse (LPN) #1. They stated a Initial assessment was all-being of the resident estaff a picture of the story, reviewed the Advance firmed code status, perience, religious preferences, ctivity preferences, needs diatry, dental, mobility devices, community desires and needs. esident #457's Social Services dated as completed on 4/1/21 estated, "We know the d have been done within 24 not know it was one of our ht (3/31/21)." p.m., a debriefing was a Administrator, Regional cal Services (RSCS) and g (DON). No further information		745			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495201	B. WING				01/2021
	PROVIDER OR SUPPLIER DE HEALTH & REHAE	CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 745	Continued From pa	•	F7	745			
	assessment dated with a score of 14 of the Brief Interview findicated the reside for daily decision massessed with the awants and was able	imum Data Set (MDS) 3/30/21 coded the resident out of a possible score of 15 on for Mental Status (BIMS) which ent had intact cognitive skills taking. The resident was ability to express ideas and the to fully comprehend others. The tot coded to possess tot symptoms.					
	Administrator state left abruptly withou He stated the dutie distributed to the u	oximately 10:30 a.m., the d the Social Services Director t adequate notice on 3/21/21. Is of the Social Worker were nit managers, other key imself until a replacement was					
	of Nursing (DON), assumed many of	p.m., according to the Director the two Unit Managers the duties of the Social Worker al Services Initial assessment.					l L
	conducted with the Practical Nurse (LI Licensed Practical the Social Services	o.m., an interview was e Unit I Manager, Licensed PN) #2 and the Unit II Manager, Nurse (LPN) #1. They stated is Initial assessment was					
	because it gave the resident's family his Directives and content education/work extended behaviors, social at (vision, mental, po	ell-being of the resident e staff a picture of the story, reviewed the Advance firmed code status, perience, religious preferences, activity preferences, needs diatry, dental, mobility devices, community desires and needs.					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							C
		495201	B. WING			04/01/2021	
ļ	PROVIDER OR SUPPLIER DE HEALTH & REHAE	B CENTER		42	REET ADDRESS, CITY, STATE, ZIP CO 201 GREENWOOD DRIVE ORTSMOUTH, VA 23701	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORI PREFIX (EACH CORRECTIVE ACTION OF CROSS-REFERENCED TO THE ADEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE	
	Initial assessment at 12:35 p.m. They assessment should hours, but we did r duties until last nig On 4/1/21 at 3:30 p conducted with the Supervisor of Clini-Director of Nursing was provided prior According to the fatitled "Social Service and 12/18/2 be completed with would have Reside 3/25/21. Routine/Emergenc CFR(s): 483.55(b) §483.55 Dental Service and 24-hours and 24-hours facility must a routine and 24-hours facility- §483.55(b) (1) Must a routine and 24-hours facility- §483.55(b) (1) Must a routine and 24-hours facility- §483.55(b) (1) Must a routine dental under the State plus file part, the found of the state plus file part, the found of the state plus file part, the found of the state plus file part, the state plus file part file p	esident #456's Social Services dated as completed on 4/1/21 stated, "We know the d have been done within 24 tot know it was one of our ht (3/31/21)." o.m., a debriefing was a Administrator, Regional cal Services (RSCS) and g (DON). No further information to survey exit. acility's policy and procedures ces Policy" dated 5/2009, last to the initial assessment would in 24 business hours, which ent #456's assessment due by cy Dental Srvcs in NFs (1)-(5) ervices assist residents in obtaining our emergency dental care. If provide or obtain from an in accordance with §483.70(g) llowing dental services to meet resident: services (to the extent covered an); and ntal services;		745	 Resident # 57 had an oral asses Manager on 3/30/21; is withou ability. Dental appointment att infection and resident at that ti An immediate oral assessment house residents on 4/7/2021; r and placed on the Dental Servician to provide the providents on 4/1 relationship with Dental Servician-house services. Per a Quality Monitoring Tool: dental services will be assessed initiated Monitoring tool to be then 1 x weekly x 2 months. The facility QAPI committee for fur recommendations. Compliance Date 4/30/2021 	at increased pain tended on 4/16/2 time not in pain. It was completed cresidents identificated education was polyable. Facility has of SE Virginia tresident identification and an appoint a completed 5x wine results to be for	or altered eating 1021; no signs of 1021; no signs of 1021; no signs of 1021; no current index wish list. It licensed 1022; no meet 1022; no current will see 1022; no current will be 1022; no cut line 1022; no
	§483.55(b)(2) Mu	st, if necessary or if requested,					•

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If continuation sheet Page 22 of 35



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:) MULTIPLE CONSTR BUILDING	COM	(X3) DATÉ SURVEY COMPLETED	
4952	01 B. W	WING			C 01/2021
NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB CENTER	· · · · · · · · · · · · · · · · · · ·	4201 GREE	DRESS, CITY, STATE, ZIP C NWOOD DRIVE DUTH, VA 23701		
(X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC IDENTIFYING INFO	D BY FULL P	REFIX (E/	PROVIDER'S PLAN OF CO ACH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 791 Continued From page 22 assist the resident- (i) In making appointments; and (ii) By arranging for transportation to dental services locations; §483.55(b)(3) Must promptly, within residents with lost or damaged dent dental services. If a referral does not a days, the facility must provide door what they did to ensure the resident and drink adequately while awaiting services and the extenuating circum led to the delay; §483.55(b)(4) Must have a policy id circumstances when the loss or dark dentures is the facility's responsibility charge a resident for the loss or dark dentures determined in accordance policy to be the facility's responsibility to be the facility's responsibility of the delay; §483.55(b)(5) Must assist residents eligible and wish to participate to appreciate to appr	3 days, referures for occur within sumentation of could still eat dental estances that entifying those mage of ty and may not mage of with facility ty; and who are oply for s an incurred an. It is evidenced erviews, staffer a review of failed to vices needed of 40 vey sample.	F 791			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495201	B. WING			04/01	
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP (4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 791		page 23 es Mellitus due to underlying abetes Mononeuropathy and	 F	791			
	assessment with (ARD) of 02/19/2 completing the B (BIMS) and scori indicated Reside decision making In Section "G" (P was coded as reone person with toilet use and pe supervision of or	ion, Minimum Data Set (MDS) an assessment reference date 1 coded the resident as rief Interview for Mental Status ng 15 out of a possible 15. This nt #57 cognitive abilities for daily were intact. Thysical functioning) the resident quiring extensive assistance of transfers, bed mobility, dressing, rsonal hygiene. Requiring he person with eating. Walking insmotion on and off the units does					
	follows: Focus: Toral/dental health Mouth and Tooth tooth abscess on will be free of inforal cavity. Intervas ordered, Asse (Medical Doctor) symptoms of orattention: Pain, cor bleeding, teet decayed, ulcers	dent's Care plan reads as The resident has actual risk for in problems. Complained of in Pain on 3/11/21. Diagnoses of in 3/12/21. Goals: The resident ection, pain or bleeding in the ventions: Administer Medications ess, document and report to MD in PRN (as needed) sign and al/dental problems needing debris in the mouth, lips cracked in missing, loose, broken, eroded or lesions in mouth. Facilitate ent as appropriate.					
	clinical record in referral/appointn	on was found in the resident's dicating that a dental nent was made prior to the g a conversation with Resident					

PRINTED: 04/12/2021 FORM APPROVED OMB NO. 0938-0391

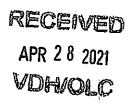
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		COM	(X3) DATE SURVEY COMPLETED	
	495201	B. WING			C /01/2021	
PROVIDER OR SUPPLIER DE HEALTH & REHAE	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP (4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION	N SHOULD BE	(X5) COMPLETION DATE	
#57 on 3/30/21 at a Clinical documents parties were in atterned on 3/12/21 at A review of Reside Administration Received at 25 MG give hours as needed for pain. Start Date: 02 A review of Reside Administration Received Administration Received Amoxicillin 875 mg 12 hours for tooth Start Date 03/12/2 Completion Date: 6 A review of the nur following: Resident c/o pain for pain on 3/29/20 Acetaminophen Ta 3/16/2021 3:53 PM remains on Amoxicilinection. 3/15/2021 6:19 PM and able to make (Antibiotics) Amox 3/14/2021 5:56 PM resting in bed with alert and able to make the complete and able to make the comp	ation reveal that all necessary endance at the IDT meeting 1:15 PM. Int's MAR (Medication cord) Reads: Acetaminophen 2 tablets by mouth every 6 or pain related to other chronic 2/02/21. Int's MAR (Medication cord) reads: Administer 1, give 1 tablet by mouth every infection/abscess for 5 days. I. Time: 8:00 AM and 8:00 PM. Int's MAR (Medication cord) reads: Administer 1, give 1 tablet by mouth every infection/abscess for 5 days. I. Time: 8:00 AM and 8:00 PM. Interest of the serve all the serve al		791			
3/13/2021 5:51 PN	// Nursing Note: Resident alert				i	
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa #57 on 3/30/21 at a Clinical document parties were in atte held on 3/12/21 at A review of Reside Administration Rec tablet 325 MG give hours as needed fo pain. Start Date: 0/ A review of Reside Administration Rec Amoxicillin 875 mg 12 hours for tooth Start Date 03/12/2 Completion Date: A review of the nur following: Resident c/o pain for pain on 3/29/20 Acetaminophen Ta 3/16/2021 3:53 PM remains on Amoxi infection. 3/15/2021 6:19 PM and able to make (Antibiotics) Amox 3/14/2021 5:56 PM resting in bed with alert and able to m ABT(antibiotics) A	PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 #57 on 3/30/21 at approximately, 2:28 PM. Clinical documentation reveal that all necessary parties were in attendance at the IDT meeting held on 3/12/21 at 1:15 PM. A review of Resident's MAR (Medication Administration Record) Reads: Acetaminophen tablet 325 MG give 2 tablets by mouth every 6 hours as needed for pain related to other chronic pain. Start Date: 02/02/21. A review of Resident's MAR (Medication Administration Record) reads: Administer Amoxicillin 875 mg, give 1 tablet by mouth every 12 hours for tooth infection/abscess for 5 days. Start Date 03/12/21. Time: 8:00 AM and 8:00 PM. Completion Date: 8/16/21 Time: 8:00 PM A review of the nurses notes revealed the following: Resident c/o pain to left tooth, med administered for pain on 3/29/2021 18:14 (6:14 PM) Acetaminophen Tablet 325 MG. 3/16/2021 3:53 PM Nursing note: Resident remains on Amoxicillin Tablet 875 MG for tooth infection. 3/15/2021 6:19 PM Nursing Note: Resident alert and able to make needs known. Resident on ABT (Antibiotics) Amoxicillin for tooth abscess. 3/14/2021 5:56 PM Nursing Note: Resident resting in bed with call bell within reach. Resident resting in bed with call bell within reach. Resident	ROVIDER OR SUPPLIER DE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 #57 on 3/30/21 at approximately, 2:28 PM. Clinical documentation reveal that all necessary parties were in attendance at the IDT meeting held on 3/12/21 at 1:15 PM. A review of Resident's MAR (Medication Administration Record) Reads: Acetaminophen tablet 325 MG give 2 tablets by mouth every 6 hours as needed for pain related to other chronic pain. Start Date: 02/02/21. A review of Resident's MAR (Medication Administration Record) reads: Administer Amoxicillin 875 mg, give 1 tablet by mouth every 12 hours for tooth infection/abscess for 5 days. Start Date 03/12/21. Time: 8:00 AM and 8:00 PM. 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STREET ADDRESS, CITY, STATE, ZIP CODE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 24 #57 on 3/30/21 at approximately, 2:28 PM. Clinical documentation reveal that all necessary parties were in attendance at the IDT meeting held on 3/12/21 at 1:15 PM. A review of Resident's MAR (Medication Administration Record) Reads: Acetaminophen tablet 325 MG give 2 tablets by mouth every 6 hours as needed for pain related to other chronic pain. Start Date: 02/02/21. A review of Resident's MAR (Medication Administration Record) reads: Administer Amoxicillin 875 mg, give 1 tablet by mouth every 12 hours for tooth infection/abscess for 5 days. Start Date 03/12/21. Time: 8:00 AM and 8:00 PM. Completion Date: 8/16/21 Time: 8:00 PM and 8:00 PM. 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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 8H5Y11

Facility ID: VA0217

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PRINTED: 04/12/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) PREFIX		OF DEFICIENCIES OF CORRECTION			(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB CENTER X49 ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE) TAGE TAGE PROVIDERS PLAN OF CORRECTION BROWN AND AND AND AND AND AND AND AND AND AN			405004			<u> </u>	1 '	
PORTSIDE HEALTH & REHAB CENTER CX4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIUST BE PRECEDED BY FULL TAGE (EACH DEFICIENCY MIUST BE PRECEDED BY FULL TAGE) F791 Continued From page 25 and able to make needs known. Resident on ABT Amoxicillin for tooth abscess. 3/12/2021 13:15 (1:15 PM) IDT (Interdisciplinary Tearn) Meeting Progress Note Reason: Resident review: Currently on IV (Intervenous) ABT for UTI and po ABT for tooth infection/abscess. In attendance: Unit Managers, MDS, (Minimum Data Set staff, RD (Registered Dietician) DON (Director of Nursing) SW (Social Worker) and Therapy. 3/30/2021 14:54 Alert Note Text: This writer in to assess resident's mouth related to c/o minor mouth pain, mouth assessed, there is on crack tooth noted on the right upper mouth, beside the broken tooth is a tooth with noted cavity, she was asked if she needed anything for pain, she stated "If it gets bad I will let the nurse know. This writer asked resident if she had a particular dentist that she has seen came out to the last facility to see her. This writer made resident aware that NP (Nurse Practitioner) will be called to so we can get a dental consult. RP (Responsible Party/Daughter) was on the phone during the call and is aware. On 3/30/21 at approximately, 2:48 PM a telephone interview was conducted with Resident			<u> </u>	B. WING		TREET ADDRESS SITE OF THE SORE	<u> 04/0</u>	01/2021
FREEK TAG PEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 791 Continued From page 25 and able to make needs known. Resident on ABT Amoxicillin for tooth abscess. 3/12/2021 13:15 (1:15 PM) IDT (Interdisciplinary Team) Meeting Progress Note Reason: Resident review: Currently on IV (Intravenous) ABT for UTI and po ABT for tooth infection/abscess. In attendance: Unit Managers, MDS, (Minimum Data Set staff) RD (Registered Dietician) DON (Director of Nursing) SW (Social Worker) and Therapy. 3/30/2021 14:54 Alert Note Text: This writer in to assess resident's mouth related to c/o minor mouth pain, mouth assessed, there is on crack tooth noted on the right upper mouth, beside the broken tooth is a tooth with noted cavity, she was asked if she needed anything for pain, she stated "If it gets bad I will let the nurse know. This writer asked resident if she had a particular dentist that she has seen in the past, she stated the last dentist she seen came out to the last facility to see her. This writer made resident aware that NP (Nurse Practitioner) will be called to so we can get a dental consult. RP (Responsible Party/Daughter) was on the phone during the call and is aware. On 3/30/21 at approximately, 2:48 PM a telephone interview was conducted with Resident					42	201 GREENWOOD DRIVE	ļ !	
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#57. Resident #57 was asked if she had any dental concerns. She stated, "I need my teeth extracted. I've had a tooth ache for about two days. I asked for two Tylenol's. I think I have a hollow tooth. I think the pain is getting worse when I use my CPAP (Continuous Positive Airway Pressure. Machine) at night. That irritates my teeth. I was supposed to get them extracted a	F 791	and able to make Amoxicillin for too 3/12/2021 13:15 (Team) Meeting Prreview: Currently and po ABT for to attendance: Unit I Data Set staff) RE (Director of Nursin Therapy. 3/30/2021 14:54 / assess resident's mouth pain, mout tooth noted on the broken tooth is a asked if she need "If it gets bad I wil asked resident if she has seen in the dentist she	needs known. Resident on ABT th abscess. 1:15 PM) IDT (Interdisciplinary ogress Note Reason: Resident on IV (Intravenous) ABT for UTI oth infection/abscess. In Managers, MDS, (Minimum D) (Registered Dietician) DON ng) SW (Social Worker) and Alert Note Text: This writer in to mouth related to c/o minor h assessed, there is on crack a right upper mouth, beside the tooth with noted cavity, she was led anything for pain, she stated it let the nurse know. This writer is he had a particular dentist that he past, she stated the last came out to the last facility to be remade resident aware that NP er) will be called to so we can ult. RP (Responsible was on the phone during the call proximately, 2:48 PM a lew was conducted with Resident 7 was asked if she had any She stated, "I need my teeth d a tooth ache for about two two Tylenol's. I think I have a nk the pain is getting worse PAP (Continuous Positive Airwayne) at night. That irritates my		791			

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

Event ID: 8H5Y11

Facility ID: VA0217

If continuation sheet Page 26 of 35



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
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		495201	B. WING		<u>-</u>		1/01/2021	
NAME OF I	PROVIDER OR SUPPLIE	R			EET ADDRESS, CITY, STATE, ZIP CODE			
DODTSII	DE HEALTH & REHA	AR CENTER			1 GREENWOOD DRIVE			
FURISI	DE REALITI & KENA	AB CENTER		PO	RTSMOUTH, VA 23701			
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F 791	mobile dental ser from my nurse." On 3/31/21 at 11: conducted with the Practical Nurse) dental issues. She an order." She's about this." On 4/01/21 at ap interview was conducted was conducted to the property of the prope	rvices. I got Tylenol on yesterday 215 AM an interview was ne Unit manager, LPN (Licensed #2 concerning Resident #57 ne stated, "I told her I would get never complained to me before proximately, 8:36 AM an nducted with CNA (Certified t) Concerning Resident #57 nues/pain. She stated, "She aving a toothache. She told the	F	791				
	medication." On 4/01/21 at 8: conducted with L She stated,"She pain. She had ar aware and he put On 4/01/21 at aptelephone intervifacility physician Resident #57. Slago she complains said I'm going to nursing staff ma Mostly, the right are broken. The a dentist come to you take care of fairly large persone."	ast week that she needed pain 38 am an interview was PN #2 concerning Resident #57. said something about mouth a abscess. She made the doctor at her on Amoxicillin." proximately, 9:30 AM a new was conducted with the (Other Staff #5) concerning the stated, "Two or Three weeks and about her teeth hurting. I give you an antibiotic then have the an appointment for you. side molars or half of her teeth facility was saying they will have to the facility. I said make sure the it if they don't come. She's a on that wanted double portions of						
	oriented x 4. She	n-compliant diabetic, alert and e eats a lot of sugar which could I prescribed liquid Ambusol and					!	

	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			TÈ SURVEY MPLETED		
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	PROVIDER OR SUPPLIE DE HEALTH & REH			STREET ADDRESS, CITY, STATE, ZIP 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
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F 791	pulled. The facili would come. On 04/01/21 at 1 call was made to dental care need the male nurse a manager said shifth thought it was oddentist appointed down in the root facility from a menting. There are extracted. These that side. My Pagave me a Tyler started complair last week now it (facility staff) callooking for a pla Some places do unit manager said.	I she needed to have her teeth ty assured me the mobile dental and a solitow up telephone of Resident #57 concerning her is. She stated, "I had been telling about my mouth hurting. The unit he would try to find a dentist. I did they were willing to make tent now. I have a hollow tooth it. I got 3 extracted while in another obile unit. The whole right side is the action of 10 now. She is about a 6 out of 10 now. She is about a 6 out of 10 now. She is about this the latter part of its on a daily situation. They me in and told me they were ce. I have to go out by stretcher. I have to go out by stretcher. I destrict the said she tried two places. She said and up. I don't have a dental		791		
	Last revised on: facility will assis and 25-hour em meet the needs also be respons dentures in cert and will make p lost or damaged services are avaneeds. #9. The his/her designer	icy titled Dental Services Policy. 8/11/2020. The policy reads: The tresidents in obtaining routine tergency dental care/services to of each resident. The facility will sible for loss or damage of ain circumstances listed below rompt referrals for residents with dentures. PROCEDURE: Dental ailable to meet the resident's DON (Director of Nursing), or e, or any clinical staff member is notifying Social Services of a				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				СОМ	(X3) DATÉ SURVEY COMPLETED	
		495201	B. WING				01/2021	
	ROVIDER OR SUPPLIER DE HEALTH & REHAI			4201	EET ADDRESS, CITY, STATE, ZIP CODE I GREENWOOD DRIVE RTSMOUTH, VA 23701			
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F 800	Services personne or requested, assis representative in mand transportation dental services loc On 4/01/21 at app findings were shar of Nursing (DON) DON stated, "We Medicine/Dental Swork diligently on hard to get a comp Services) in now to stated, "The facilit #57/Dental Care). Provided Diet Med CFR(s): 483.60 §483.60 Food and The facility must prourishing, palata meets his or her of dietary needs, tak preferences of ea This REQUIREMI by: Based on observed document review, staff failed to main of 135 degrees or steam table. The findings inclued to the control of the findings inclued the findings inclued the control of the co	dental services. #10. Social el or designee will, if necessary st the resident/resident naking dental appointments arrangements to and from the eation. roximately, 2:36 PM the above red the Administrator, Director and Corporate Consultant. The are trying to get them (General revices) in our building. We will getting them." "We are trying pany (to provide Social to help out. The Administrator y will absorb the cost (Resident with a ble, well-balanced diet that laily nutritional and special ing into consideration the ch resident. ENT is not met as evidenced ation, staff interview and facility it was determined that facility intain hot foods at a temperature in higher while holding on the	F7	91	better fit the steam table. The Cook education related to ensuring prope steam table, on keeping hot Items at served and on the Importance of tak temperatures at every meal. Educat Regional Dietician on 4/28/2021. No residents were identified to be at items at a temperature below 135. Serving hot foods below recomment potential to affect residents who reckitchen.	and OSM #3 in pans are in on a proper temping and recording and recording provided fected by sere aff related to a pans that fit intil served and are and a pans that fit intil served and are are and are	received use on the peratures until rding food by the rving these ures has the om the facility serving foods properly in the nd taking and	
l			i				<u> </u>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		DNSTRUCTION		E SURVEY IPLETED
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PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
temperatures before same time (8:00 at to the unit. At 8:10 getting temperature table. When asked taken prior to the staken staken table. The scrambled eggs-Oatmeal- 123.1 d. The scrambled eggs-Oatmeal- 123.1 d. The scrambled eggep pan that wasteam table. The Styrofoam cups a with cellophane with the staken table and the staken table and the staken table and the staken table, osm #3 warming up of the staken table, osm #3 stated the staken table, osm #3 stated the staken table, osm #3 stated the staken is they were	was asked to provide the food one tray line had started. At the L.m.) one cart had been sent out 0 a.m., OSM #3 was observed res of the food on the steam d if the food temperature were start of tray line, OSM #3 stated only documented two food sausage at 173.0 degrees e corn beef hash at 167.0 reation was then conducted of imperatures of the rest of the steam table. The following low re recorded: 131.0 degrees Fahrenheit egrees Fahrenheit egrees Fahrenheit in as not fitting properly on the oatmeal was observed in and some were in plastic bowls grapped over the top, sitting on steam table.		5.	An observation of tray line with conducted 5 times per week at v weekly for 2 months. Observation correct temperatures when delivite steam table properly and temper Observation to be completed by designee. Results of observations to be for committee for further review and Compliance date: 4/30/2021	varying meals for a cons to include hot evered to residents eratures are taken or the Dietary Mans rwarded to the fa	4 weeks then items holding is, pans fit in the and recorded. ager or

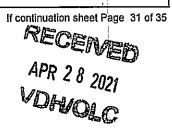
PRINTED: 04/12/2021 FORM APPROVED OMB NO. 0938-0391

AND DIAM OF CORRECTION INDENTIFICATION NUMBER.		l , ,	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495201	B. WING	·		C /01/2021
	PROVIDER OR SUPPLIER DE HEALTH & REHAI		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 800	that he would rehe out to the units. When continued the stated, "To ensure When asked if the at least 135 degree were not. OSM #3 decided to move the OSM #3 stated that properly on the state heat it should heat heat it should heat heat it should heat heat was holding degrees or higher, was not, and that heat making it to or important to temperior to sending the stated that it was, had obtained all te two items. OSM #3 been overwhelmed how we would knothous we would knothous we would knothous temps on all find going out at 8:00 a was not document On 4/1/21 at approximation. ASI Nursing) and Corp Regional Clinical Nabove concerns. Facility policy titled documented in pattemperatures of heat states.	age 30 at the items before they went hen asked why he would ems if they were not holding a east 135 degrees, OSM #3 we are serving safe foods." eggs were at a temperature of es, OSM #3 stated that they stated that that is when he he eggs to a better fitting pan. It the deep pan was not fitting have been. When asked if the high a heat of at least 135 OSM #3 stated the oatmeal he probably should but the the steam table pan, rather der. When asked if it was all food items and document the trays to the units, OSM #3 OSM #3 stated that the cook mperatures, but only recorded a stated that the cook may have do that morning. When asked we that the cook really obtained food items prior to the first cart hum.; OSM #3 stated that if it ed then "we wouldn't know." Doximately 4:00 p.m., ASM aff Member) #1, the forate staff member #1, the following: "Keep the ot foods no less than 135 est, or a temperature that meets est, or a temperature that meets		800		

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

Event ID: 8H5Y11

Facility ID: VA0217



PRINTED: 04/12/2021 FORM APPROVED OMB NO. 0938-0391

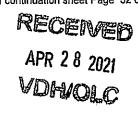
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	((X3) DATE SURVEY COMPLETED	
		495201	B. WING					01/2021
	ROVIDER OR SUPPLIER BE HEALTH & REHAE	B CENTER		42	REET ADDRESS, CITY, STATE, ZIP COI 101 GREENWOOD DRIVE DRTSMOUTH, VA 23701	DE	ļ	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD E		(X5) COMPLETION DATE
F 804	food items may not Fahrenheit while he No further informat Nutritive Value/App CFR(s): 483.60(d) Food a Each resident recessive states and at a temperature. This REQUIREME by: Based on observed document review, staff failed to serve temperatures. The findings included on 4/1/21 at 7:45 line was conducted were observed be (Brand Name) marking included the served of	arroughout tray assembly. Hot t fall below 135 degrees olding after cooking" tion was presented prior to exit. tear, Palatable/Prefer Temp (1)(2) and drink elives and the facility provides- d prepared by methods that value, flavor, and appearance; d and drink that is palatable, a safe and appetizing ENT is not met as evidenced ation, staff interview and facility it was determined that facility a food at palatable ded: a.m., observation of the tray d. All plate bottom warmers ing warmed up from an Aladdin chine. Plates were then placed her, food placed on the plates		804		ook and (roper pan ns at proj king and i at palata ideal Die tempera nave had ry staff re using pan not until i s and sen on compl ng staff o latable te e on 4/19 including varying m on timeli perature rwarded	OSM #3 rain are in us per temp recording able temp retician on a ture has an adverse at the fact an adverse at the fact an action of the per temp retician of the per temp rate of the per temp rate of the per temp rate of the fact of the fact the	eceived se on the erature until s food peratures. 4/28/2021 the potential cility kitchen; se effect. serving foods properly in the aking and s at a the Registered s meal trays are, education ray will be 4 weeks then ray pass and cility QAPI
	asked to provide to tray line had started	I (Other Staff Member) #3 was he food temperatures before ed. At the same time (8:00 a.m.) sent out to the unit. At 8:10 s observed getting						

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NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB CENTER PORTSIDE HEALTH & REHAB CENTER Condinued From page 32 Lemperatures of the food on the steam table. When asked if the food temperature were taken prior to the stard for trey line, DSM #3 stated that the cook had only documented two food items on the steam table. Observation was then conducted of OSM #3 taking temperatures of the food oil tems on the steam table. The following temperatures were taken prior to the stard of the provided in degrees Fahrenheit and the corn beef hash at 167.0 Fahrenheit. Observation was then conducted of OSM #3 taking temperatures of the rest of the food items on the steam table. The following temperatures were recorded in degrees Fahrenheit. Observation was then conducted of OSM #3 taking temperatures of the rest of the food items on the steam table. The following temperatures were recorded in degrees Fahrenheit. Scrambled eggs- 131.0 Outmeal- 123.1 Turkey Sausage: 183.5 Corn Beef- 152.5 Pork Sausage: 187.5 Gravy-158.0 Puree Bread- 140.3 The scrambled eggs were observed to be in a deep pan that was not fitting properly on the steam table. The oatmeal was observed in Styrofoam cups and some were in plastic bowls with collophane wrapped over the top, sitting on top of a lid on the steam table. On 4/1/21 at 8:36 a.m., the tray line for the last cart was conducted. A test tray was requested after the last food tray was prepared. On 4/1/21 at 8:36 a.m., the last food cart was observed leaving the kitchen. The last food cart was observed to be enclosed.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER PORTSIDE HEALTH & REHAB CENTER ### PORTSIDE HEALTH & REHAB CENTER ### PORTSINDUTH, VA 23701 ### PORTSINDUTH, VA 23701 ### PORTSINDUTH, VA 23701 ### PROVIDERS PLAND OF CORRECTION FREEDRICE DEVELL (EACH OPERIOR VIMST) BE PRECEDED BY FULL (EACH OPERIOR VIMST) #### PORTSINDUTH, VA 23701 ### PORTSINDUTH, VA 23701 ### PROVIDERS PLAND OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPORT OF TAKE OF TAKE OPERIOR VIMST BE PRECEDED BY FULL (EACH OPERIOR VIMST) ### PORTSINDUTH, VA 23701 ### PROVIDERS PLAND OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMENT. ### PORTSINDUTH, VA 23701 ### PROVIDERS PLAND OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMENT. ### PORTSINDUTH, VA 23701 ### PROVIDERS PLAND OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMENT. ### PROVIDERS PLAND OF CORRECTION CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMMENT. ### PORTSINDUTH, VA 23701 ### PROVIDERS PLAND OF CORRECTION CORRECTION COMMENT. ### PROVIDERS PLAND OF CORRECTION COMMENT. ### PROVIDERS PLAND OF CORRECTION CORRECTION COMMENT. ### PROVIDERS PLAND OF CORRECTION. ### PROVIDER PLAND. ### P			495201					
PORTSIDE HEALTH & REHAB CENTER (XA) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREGULATORY OR LSC IDENTIFYING INFORMATION) FROM CONTINUED FROM LSC IDENTIFYING INFORMATION FROM CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE	NAME OF F	PROVIDER OR SUPPLIEF		<u>'</u>	STREET ADDRESS,	CITY, STATE, ZIP CODE	<u> </u>	7.7.2021
FORTISMOUTH, VALUE FORTISM	DORTOI	SELIEALTILO DELLA	D OFNITED	ļ	4201 GREENWOO	D DRIVE		
PREFIX TAG REGULATORY OR LSc IDENTIFYING INFORMATION) F 804 Continued From page 32 temperatures of the food on the steam table. When asked if the food temperature were taken prior to the start of tray line, OSM #3 stated that the cook had only documented two food items: The turkey sausage at 173.0 degrees Fahrenheit and the corn beef hash at 167.0 Fahrenheit. Observation was then conducted of OSM #3 taking temperatures of the rest of the food items on the steam table. The following temperatures were recorded in degrees Fahrenheit: Scrambled eggs-131.0 Oatmeal-123.1 Turkey Sausage: 163.5 Corn Beef-152.5 Pork Sausage: 167.5 Gravy-158.0 Puree Bread- 140.3 The scrambled eggs were observed to be in a deep pan that was not fitting properly on the steam table. The oatmeal was observed in Styrofoam cups and some were in plastic bowls with cellophane wrapped over the top, sitting on top of a lid on the steam table. On 4/1/21 at 8:12 a.m., OSM #3 was observed moving the eggs from the deep pan into a shallow pan on the steam table. On 4/1/21 at 8:36 a.m., the tray line for the last cart was conducted. A test tray was requested after the last food tray was prepared. On 4/1/21 at 8:54 a.m., the last food cart was observed leaving the kitchen. The last food cart	PORTSIL	JE HEALIH & KEHA	BCENTER		PORTSMOUTH,	VA 23701		
temperatures of the food on the steam table. When asked if the food temperature were taken prior to the start of tray line, OSM #3 stated that the cook had only documented two food items: The turkey sausage at 173.0 degrees Fahrenheit and the corn beef hash at 167.0 Fahrenheit. Observation was then conducted of OSM #3 taking temperatures of the rest of the food items on the steam table. The following temperatures were recorded in degrees Fahrenheit: Scrambled eggs- 131.0 Oatmeal- 123.1 Turkey Sausage: 163.5 Com Beef- 152.5 Pork Sausage- 187.5 Gravy-158.0 Puree Bread- 140.3 The scrambled eggs were observed to be in a deep pan that was not fitting properly on the steam table. The oatmeal was observed in Styrofoam cups and some were in plastic bowls with cellophane wrapped over the top, sitting on top of a lid on the steam table. On 4/1/21 at 8:12 a.m., OSM #3 was observed moving the eggs from the deep pan into a shallow pan on the steam table. On 4/1/21 at 8:36 a.m., the tray line for the last cart was conducted. A test tray was requested after the last food tray was prepared. On 4/1/21 at 8:54 a.m., the last food cart was observed leaving the kitchen. The last food cart	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF	X (EACH CO	RRECTIVE ACTION SHOULD ERENCED TO THE APPROP) BE	
On 4/1/21 at 8:57 a.m., the last food cart was	F 804	temperatures of the When asked if the prior to the start of the cook had only. The turkey sausay and the corn beef Observation was taking temperatur on the steam table were recorded in Scrambled eggs-Oatmeal- 123.1 Turkey Sausage: Corn Beef- 152.5 Pork Sausage- 18 Gravy-158.0 Puree Bread- 140 The scrambled eggep pan that was steam table. The Styrofoam cups a with cellophane we top of a lid on the On 4/1/21 at 8:12 moving the eggspan on the steam On 4/1/21 at 8:36 cart was conduct after the last food On 4/1/21 at 8:54 observed leaving was observed to	ne food on the steam table. It food temperature were taken If tray line, OSM #3 stated that If documented two food items: It ge at 173.0 degrees Fahrenheit It hash at 167.0 Fahrenheit. It hen conducted of OSM #3 It hen conducted of OSM #3 It hen conducted of the food items It hen conducted of the food items It hen conducted of OSM #3 It he food items It hash at 167.0 Fahrenheit. 131.0 163.5 163.5 163.5 163.5 163.5 163.5 163.5 163.5 164.5 165.6 165.6 165.7 165.7 165.7 165.7 166.7 166.7 166.7 167.7		304			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		495201	B. WING	·		C 01/2021
	PROVIDER OR SUPPLIER DE HEALTH & REHA		1	STREET ADDRESS, CITY, STATE 4201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 804	on 4/1/21 at 9:23 of OSM #3 taking on the test tray. T recorded in degre Pork Sausage-97 Turkey Sausage-Puree Bread-101 scrambled eggs-Oatmeal-109.2 On 4/1/21 at 9:24 conducted a test the test tray had to the test tray had to the steam table, rosM #3 stated the test 135 degrees that he would rehout to the units. V remove the food temperature of at stated, "To ensure When asked if the test 135 degree that he would rehout to the units. V remove the food temperature of at stated, "To ensure When asked if the test 135 degree that he would rehout to the units. V remove the food temperature of at stated, "To ensure When asked if the test 135 degree were not. OSM # decided to move OSM #3 stated the s	a.m., every resident had been unit. a.m., an observation was made temperatures of the food items he following temperatures were es Fahrenheit: 7.2 99.1 .8 93.2 a.m., two surveyors had tray. All the above food items on asted cold. 0 a.m., an interview was SM #3. When asked at what lid he remove the hot foods from wheat or choose not to serve, at the would remove hot food a not holding a temperature of at s Fahrenheit. OSM #3 stated eat the items before they went when asked why he would items if they were not holding a least 135 degrees, OSM #3 e we are serving safe foods." e eggs were at a temperature of ses, OSM #3 stated that they 3 stated that that is when he the eggs to a better fitting pan. nat the deep pan was not fitting		804		
	properly on the state the heat it should	team table and was not receiving have been. When asked if the	3	!		

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Event ID: 8H5Y11

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495201	B. WING			04/0	01/2021
	PROVIDER OR SUPPLIER DE HEALTH & REHAE	CENTER		4	TREET ADDRESS, CITY, STATE, ZIP CODE 201 GREENWOOD DRIVE PORTSMOUTH, VA 23701		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 804	degrees or higher, was not, and that h oatmeal directly in that making it to ordinportant to temp a prior to sending the stated that it was. Ohad obtained all ter two items. OSM #3 been overwhelmed how we would know food temps on all fe going out at 8:00 a was not documente. When asked why the plate warmers foods warm, but no OSM #3 stated than ursing unit and sit may have played a temperature. OSM on the test tray had temperature. On 4/1/21 at appro (Administrative Sta Administrator, ASM Nursing) and Corpe Regional Clinical Nabove concerns. Facility policy titled documented in par	g a heat of at least 135 OSM #3 stated the oatmeal e probably should but the the steam table pan, rather der. When asked if it was all food items and document e trays to the units, OSM #3 OSM #3 stated that the cook inperatures, but only recorded stated that the cook may have that morning. When asked w that the cook really obtained and items prior to the first cart in.; OSM #3 stated that if it ed then "we wouldn't know." The food at dropped so low in test tray, OSM #3 stated that and lids were great for keeping at for a long period of time. If the 30 minute journey to the ting until everyone was served part in the food dropping #3 agreed that the food items I dropped significantly in Eximately 4:00 p.m., ASM off Member) #1, the If #2, the DON (Director of corate staff member #1, the iturse were made aware of the I "Food Temperatures" It, the following: "Hot foods when served, which is		304			
			t i		!		!